

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0015844</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/16/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>A NEW VISIONS AF LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>503 N 4TH AVE<br/>WAUSAU, WI 54401</b>                                       |                          |                                                                |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                |
| {M 000}                                                         | <p><b>INITIAL COMMENTS</b></p> <p>On 07/16/2026, Surveyor conducted a verification visit and standard licensure survey at A New Visions AF LLC.</p> <p>The deficiency identified in Statement of Deficiency (SOD) XQIT11, dated 03/11/2026, was corrected.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 2</p> | {M 000}                                                                     |                                                                                                                          |                          |                                                                |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE