

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019517	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/14/2024
NAME OF PROVIDER OR SUPPLIER MIRACLES HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 443 S 5TH AVE WEST BEND, WI 53095		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{M 000}	INITIAL COMMENTS On 03/06/2024, Surveyor conducted a verification visit at Miracles House. Additional information was gathered througuh 03/14/2024. All previous deficiencies were corrected. No deficiencies identified. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}			

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

TITLE

(X6) DATE