Wisconsin Department of Health Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019689 | A. BUILDING: _____ B. WING _____ | R-C 09/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **APPLE CREEK PLACE III** | **5117 N CHERRYVALE AVE APPLETON, WI 54913** |

| (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 |
|---|---|---|---|---|
| {N 000} | Initial Comments<br><br>On 09/30/2026, Surveyor conducted a verification visit and 4 complaint investigations at Apple Creek Place III in Appleton. All previous citations were corrected.<br><br>Four (4) of 4 complaints were unsubstantiated.<br><br>As a result of the survey, no deficiencies were issued.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed.<br><br>Census: 17 | {N 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE