

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>0015633</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>03/05/2024</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOW BROOKE POINT SENIOR LIVING RCAC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1801 LILAC LN</b><br><b>STEVENS POINT, WI 54481</b> |
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| (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 |
|--------------------|---|---------------|---|--------------------|
| U 000              | <p><b>INITIAL COMMENTS</b></p> <p>An investigation of 2 complaints was conducted on 03/04/2024 through 03/05/2024 at Willow Brooke Point Senior Living RCAC. As a result of this survey both complaints were unsubstantiated and no deficiencies were identified.</p> <p>Census: 23</p> | U 000         |   |                    |

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

TITLE

(X6) DATE