

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016637	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2024
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NAME OF PROVIDER OR SUPPLIER ASPIRE SENIOR LIVING RCAC	STREET ADDRESS, CITY, STATE, ZIP CODE 825 COBBLESTONE LN KIMBERLY, WI 54136
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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>INITIAL COMMENTS</p> <p>An abbreviated survey was conducted at Aspire Senior Living RCAC on 05/23/2024. As a result of this survey no deficiencies were identified.</p> <p>Census: 30 Assisted Living Tenants</p>	U 000		

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

TITLE

(X6) DATE