

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0016711</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/24/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WILLOWICK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2860 LIBERTY LANE</b> <b>JANESVILLE, WI 53545</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>On April 23, 2025, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation and standard survey at Willowick, a RCAC in Janesville.</p> <p>The survey resulted in no deficiencies.</p> <p>The complaint unsubstantiated.</p> <p>Census: 29</p>	U 000		

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

TITLE

(X6) DATE