

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/16/2024
--------------------------------------------------	--------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER COUNTRY VILLA ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1415 WEST MAIN STREET LITTLE CHUTE, WI 54140
--------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------

(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	<p>Initial Comments</p> <p>On 07/16/2024, Surveyor conducted an abbreviated licensure survey and 3 complaint investigations. No deficiencies were identified.</p> <p>Three of 3 complaints were unsubstantiated.</p> <p>Census: 26</p>	N 000		

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

TITLE

(X6) DATE