

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017217	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/23/2024
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NAME OF PROVIDER OR SUPPLIER EAGLE POINT SENIOR LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 955 E JOHN ST APPLETON, WI 54911
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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>On 09/20/2024 with information gathered through 09/23/2024, Surveyor conducted a complaint investigation at Eagle Point Senior Living Inc.</p> <p>No deficiencies were identified.</p> <p>The complaint was unsubstantiated.</p> <p>Census: 22</p>	U 000		

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

TITLE

(X6) DATE