

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0017335</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/08/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GARDEN VIEW ASSISTED LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>729 PARK STREET</b> <b>ANTIGO, WI 54409</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
N 000	<p>Initial Comments</p> <p>On 04/08/2026, Surveyor conducted a standard licensing survey, self-report and complaint investigation at Garden View Assisted Living Center.</p> <p>The complaint was unsubstantiated.</p> <p>The self-report was closed.</p> <p>No deficiencies were identified.</p> <p>Census: 17</p>	N 000		

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

TITLE

(X6) DATE