

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018349	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/17/2023
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NAME OF PROVIDER OR SUPPLIER PARKSIDE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 6902 PARKSIDE CIRCLE DE FOREST, WI 53532
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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 02/17/2023, Surveyor conducted a verification visit at Parkside Assisted Living.</p> <p>No deficiencies were identified.</p> <p>All previous citations from statement of deficiency (SOD) #CU7912, dated 10/13/2022 have been substantially corrected.</p> <p>Census: 32</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p>	{U 000}		

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

TITLE

(X6) DATE