

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0018591</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/27/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CREEKSIDE ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>325 SOUTH WATER ST SPARTA, WI 54656</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 10/25/2023, Surveyor conducted a complaint investigation and a standard licensure survey at Creekside Assisted Living.</p> <p>Information for this survey was received and reviewed through 10/27/2023.</p> <p>The complaint was not substantiated.</p> <p>No new deficiencies were identified.</p> <p>Census: 31</p>	U 000		

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

TITLE

(X6) DATE