

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0018803</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>01/31/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WILKINSON WOODS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>999 EAST SUMMIT AVENUE</b> <b>OCONOMOWOC, WI 53066</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 01/31/2023, Surveyor conducted a verification visit and standard survey at Wilkinson Woods.</p> <p>No deficiencies were identified; 1 previous citation from statement of deficiency (SOD) JXYX11 was substantially corrected.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 47</p>	{U 000}		

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

TITLE

(X6) DATE