

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015378	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/11/2024
NAME OF PROVIDER OR SUPPLIER JEFFERSON MEMORY CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 414 COUNTY HWY Y JEFFERSON, WI 53549		
(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	Initial Comments On 06/11/2024, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey and complaint investigaiton at 414 County Hwy Y in Jefferson, WI. No citations of noncompliance were issued. The complaint was unsubstantiated. Census: 54	N 000		

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

TITLE

(X6) DATE