

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018774	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 06/26/2023
NAME OF PROVIDER OR SUPPLIER SHILOH ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 140 S MAYFLOWER DRIVE APPLETON, WI 54914		
(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 06/26/2023, Surveyor conducted a verification visit at Shiloh Assisted Living. As a result of the visit previous deficiency has been corrected, no new deficiencies identified. Under statutory provision of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 14	{N 000}			

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

TITLE

(X6) DATE