

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/12/2025
NAME OF PROVIDER OR SUPPLIER ASTER ASSISTED LIVING OF MARSHFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 305 SOUTH CHESTNUT AVE MARSHFIELD, WI 54449		
(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	INITIAL COMMENTS On 05/12/2025, Surveyor conducted an onsite visit investigate one complaint and conduct a standard survey. Additional information was received through 05/13/2025. The complaint was unsubstantiated and no deficiencies were identified. Census: 61	U 000			

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

TITLE

(X6) DATE