

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018121	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/16/2023
NAME OF PROVIDER OR SUPPLIER EAGLE CREST SOUTH ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 622 BENNORA LEE COURT LA CROSSE, WI 54601		
(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 06/14/2023, Surveyor conducted a complaint investigation and a standard licensure survey at Eagle Crest South Assisted Living. Information for this survey was reviewed and received through 06/16/2023. The complaint was not substantiated. No deficiencies identified. Census: 26	U 000		

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

TITLE

(X6) DATE