

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015333	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 11/03/2023
NAME OF PROVIDER OR SUPPLIER SEBRING ASSISTED CARE RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 7710 SOUTH BROOKLINE DRIVE MADISON, WI 53719		
(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 11/03/2023, Surveyor conducted 1 verification visit and 1 complaint investigation. Three of 3 deficiencies from Statement OF Deficiency (SOD) #KSK211, dated 06/02/2023 were corrected. The complaint was unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 48	{N 000}			

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

TITLE

(X6) DATE