

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017499	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/09/2024
NAME OF PROVIDER OR SUPPLIER ANNAS HOUSE ASSISTED LIVING I		STREET ADDRESS, CITY, STATE, ZIP CODE 5449 CTY K NEW FRANKEN, WI 54229		
(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 An abbreviated survey and a complaint investigation were conducted at Annas House Assisted Living 1 on 01/08/2024 with information gathered through 01/09/2024. As a result of this survey there were no deficiencies identified and the complaint was unsubstantiated. Census: 13	N 000		

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

TITLE

(X6) DATE