

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0008655	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/08/2023
NAME OF PROVIDER OR SUPPLIER SYLVAN CROSSINGS ON EVERGREEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1605 EVERGREEN RD WAUSAU, WI 54403		
(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
Z 001	Initial Comments On 07/24/2023 and 08/02/2023, Surveyor conducted 2 complaint investigations and a self-report survey at Sylvan Crossings on Evergreen. Data was reviewed through 08/08/2023. The complaints were unsubstantiated. No deficiencies were identified. Census: 20	Z 001		

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

TITLE

(X6) DATE