Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015632	A. BUILDING: _____ B. WING _____	R-C 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY COURT ASSISTED LIVING I	**2230 14TH ST SOUTH WISCONSIN RAPIDS, WI 54494**

(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 A verification visit for SOD (Statement of Deficiency) LMER13, standard survey, and investigation of 3 complaints was conducted on 06/09/2026 with information gathered through 06/10/2026. As a result of this survey, 3 of 3 complaints were unsubstantiated, the previous citation was corrected, and there were no deficiencies with the standard survey. Per state statutes a $200 re-visit fee was assessed. Census: 18	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE