

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/11/2025
NAME OF PROVIDER OR SUPPLIER WILKINSON WOODS		STREET ADDRESS, CITY, STATE, ZIP CODE 999 EAST SUMMIT AVENUE OCONOMOWOC, WI 53066		
(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 02/11/2025, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey and complaint investigation at Wilkinson Woods located at 999 East Summit Avenue in Oconomowoc, WI. No citations of noncompliance were issued. The complaint was unsubstantiated. Census: 53	U 000		

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

TITLE

(X6) DATE