

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018841	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/15/2023
NAME OF PROVIDER OR SUPPLIER COPPER FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 450 LAKE DRIVE MELLEN, WI 54546		
(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 06/15/2023, Surveyor conducted a verification visit at Copper Falls Assisted Living. All deficiencies from SOD R2E911, dated 03/15/2023, were corrected. No deficiencies were identified. Census: 11 Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed.	{N 000}		

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

TITLE

(X6) DATE