

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/05/2023
NAME OF PROVIDER OR SUPPLIER LILAC SPRINGS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 403 ONEIL ST LAKE MILLS, WI 53551		
(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 09/05/2023, Surveyor conducted a verification visit at Lilac Springs Assisted Living LLC. No deficiencies were identified; 7 previous deficiencies from statement of deficiency #S9RD11, dated 06/23/2023, have been substantially corrected. Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed. The facility is to be issued a regular license after the probationary license expires on 10/28/2023. Census: 22	{N 000}		

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

TITLE

(X6) DATE