

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016902	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 09/15/2025
NAME OF PROVIDER OR SUPPLIER ALBANY OAKS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 750 CAROLAN DR ALBANY, WI 53502		
(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 09/15/2025, Surveyor conducted a verification visit at Albany Oaks Assisted Living, a CBRF in Albany. As a result of this survey, 0 violations of Chapter DHS 83 were issued. One (1) deficiency from previous statement of deficiency (SOD) # TK0D11, dated 06/04/2025a was substantially corrected. Under statutory provisions of Wis. Stat. Ch50, \$200 revisit fee is being assessed. Census: 15	{N 000}			

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

TITLE

(X6) DATE