

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 09/05/2023
NAME OF PROVIDER OR SUPPLIER LASATA CROSSING ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE W76 N673 WAUWATOSA RD CEDARBURG, WI 53012		
(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 09/05/2023, Surveyor conducted a standard survey and a verification visit at Lasata Crossings Assisted Living. Additional information was gathered through 09/06/2023. As a result of the survey, previous deficiencies were corrected, no new deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 51	{U 000}		

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

TITLE

(X6) DATE