

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-C 02/03/2026
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 02/03/2026, Surveyor conducted a verification visit at Lilac Springs Assisted Living LLC, a community-based residential facility (CBRF) located in Lake Mills, WI. As a result of the survey, no deficiencies were identified. Three (3) previous deficiencies from statement of deficiency (SOD) ZOLI15, dated 09/16/2025 were substantially corrected. Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed. Census: 12	{N 000}		

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

TITLE

(X6) DATE