

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020366	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/27/2026
NAME OF PROVIDER OR SUPPLIER LILI GARDENS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1408 LILI LANE SCHOFIELD, WI 54476		
(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 01/27/2026, Surveyor conducted a standard licensure survey, verification visit and complaint investigation at Lili Gardens Assisted Living. The complaint was unsubstantiated. The deficiencies from SOD 5K7M11, dated 07/28/2025, were corrected. No deficiencies were identified. Census: 22 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