Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012409	A. BUILDING: _____ B. WING _____	R 09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SAINTS ASSISTED LIVING AND MEMORY CARE	**8210 HIGHVIEW DRIVE MADISON, WI 53719**

(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 09/23/2026, Surveyor conducted a verification visit at All Saints Assisted Living and Memory Care, a CBRF in Madison. No deficiencies were identified. One of 1 deficiency was corrected from Statement of Deficiency (SOD) 5X7H11, dated 10/07/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 32	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE