

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/23/2024
NAME OF PROVIDER OR SUPPLIER ALL SAINTS ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 04/23/2024, Surveyor conducted 2 complaint investigations at All Saints Assisted Living and Memory Care, a CBRF in Madison. No deficiencies were identified. Two of 2 complaints were unsubstantiated. Census: 30	N 000		

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

TITLE

(X6) DATE