

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
NAME OF PROVIDER OR SUPPLIER HEATHERWOOD (CBRF)		STREET ADDRESS, CITY, STATE, ZIP CODE 4510 GATEWAY DR EAU CLAIRE, WI 54701		
(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 08/15/2023, Surveyor conducted a verification visit at Heatherwood CBRF. Data collection continued through 08/16/2023. The deficiency identified in Statement of Deficiency (SOD) F5LS12, dated 01/24/2023 was corrected. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 8	{N 000}		

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

TITLE

(X6) DATE