

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012206	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/13/2025
NAME OF PROVIDER OR SUPPLIER EAGLE CREST NORTH ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 351 MASON ST ONALASKA, WI 54650		
(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	
U 000	INITIAL COMMENTS On 03/13/2025, Surveyor conducted a complaint investigation at Eagle Crest North Assisted Living. The complaint was unsubstantiated. No deficiencies identified. Census: 42	U 000			

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

TITLE

(X6) DATE