

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018616	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/24/2023
NAME OF PROVIDER OR SUPPLIER BRUCE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 405 BRUCE LAKE RD BRUCE, WI 54819		
(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
{M 000}	INITIAL COMMENTS On 10/18/2023, Surveyor conducted a verification visit at Bruce Assisted Living for Statement of Deficiency (SOD) T6KY12 and SOD FFBX11. Data was collected through 10/24/2023. No deficiencies were identified. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 2	{M 000}		

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

TITLE

(X6) DATE