STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014923	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT THE LOG CABIN	W7641 STATE HWY 47 ANTIGO, WI 54409

(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 03/06/2024, Surveyor conducted a standard licensure survey at Assisted Living at the Log Cabin. One deficiency was identified. Census: 4	M 000		
Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity. This Rule is not met as evidenced by: Based on record review and interview, the provider did not request information specified in sub. (2) (b) 1. to 5. every 4 years or at any other time within that period for Caregiver B. Findings include: On 03/06/2024, Survey reviewed Caregiver B's file. Caregiver B was hired on 01/22/2019. Caregiver B's file contained a background check, dated 01/18/2019. Caregiver B's file did not contain evidence that any part of the 4-year background check process was completed.	Z 022		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014923	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT THE LOG CABIN	**W7641 STATE HWY 47 ANTIGO, WI 54409**

(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
Z 022	Continued From page 1 On 03/06/2024 at 2:00 PM, Surveyor interviewed House Manager (HM) A. HM A verified the following information: Caregiver B was hired on 01/22/2019; Caregiver B's background check was completed on 01/18/2019; and Caregiver B's file did not contain an updated background check. HM A contacted Owner C via telephone in Surveyor's presence. HM A asked Owner C if Caregiver B had an updated background check since being hired on 01/22/2019. Owner C responded, "No." After ending the phone call with Owner C, HM A stated that Owner C would be conducting a 4-year background check on Caregiver B.	Z 022		