

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014923	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/12/2024
NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING AT THE LOG CABIN			STREET ADDRESS, CITY, STATE, ZIP CODE 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 08/12/2024, Surveyor conducted a verification visit at Assisted Living at the Log Cabin. The deficiency identified in statement of deficiency (SOD) TZ9E11, dated 03/06/2024, was corrected. No deficiencies were identified. Under statutory provisions of Wis Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}			

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

TITLE

(X6) DATE