

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012659	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/26/2024
NAME OF PROVIDER OR SUPPLIER ARBORWOOD LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1175 BLUE IRIS CT WISCONSIN RAPIDS, WI 54494		
(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 03/19/2024, Surveyor conducted a desk review survey to investigate 1 complaint and 1 self-reported incident. Additional information was gathered through 03/26/2024. The complaint was unsubstantiated and no deficiencies were identified. Census: 43	U 000		

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

TITLE

(X6) DATE