STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008949	A. BUILDING: _____ B. WING _____	R-C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE BERNARD ON HOFFMAN	898 E HOFFMAN RD ALLOUEZ, WI 54301

(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
{N 000}	Initial Comments A verification visit for SOD (Statement of Deficiency) 8QL411 and a complaint investigation were conducted at Clarity Care Bernard on Hoffman on 06/28/2023 with information gathered through 06/29/2023. As a result of this survey all previous deficiencies were corrected. The complaint was unsubstantiated. Per state statutes a $200.00 re-visit fee was assessed. Census: 6	{N 000}		

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