

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016472	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 05/13/2024
NAME OF PROVIDER OR SUPPLIER WYNDEMERE ASPEN HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 RIVERSIDE DR GREEN BAY, 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 On 05/08/2024, Surveyor conducted 2 complaint investigations and a verification visit at Wyndemere Aspen House. Additional information was gathered through 05/13/2024. The complaints were unsubstantiated and all previous deficient practices were corrected. No deficient practices were identified. Under statutory provisions, a \$200 revisit fee is being assessed for the follow-up licensing visit. Census: 18	{N 000}		

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

TITLE

(X6) DATE