

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017506	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/13/2024
NAME OF PROVIDER OR SUPPLIER OPEN ARMS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 9008 CHICORY CREEK DR MOUNT PLEASANT, WI 53177		
(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 09/13/2024, Surveyor conducted two complaint investigation at Open Arms Assisted Living in Sturtevant. No deficient practice was identified. Two complaints were unsubstantiated. Census: 3	M 000			

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

TITLE

(X6) DATE