

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/06/2026
NAME OF PROVIDER OR SUPPLIER AUTUMNS PROMISE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 SPARTAN RD GREEN BAY, WI 54311		
(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 05/06/2026, with additional information obtained through 05/14/2026. Surveyor conducted a complaint investigation at Autumns Promise Assisted Living. As a result, 1 complaint was unsubstantiated, and no new deficiencies were identified. Census: 27	N 000		

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

TITLE

(X6) DATE