

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014653	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/10/2024
NAME OF PROVIDER OR SUPPLIER MCKINLEY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE W56 N225 MCKINLEY BLVD CEDARBURG, WI 53012		
(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 06/10/2024, Surveyor investigated one complaint and conducted a verification visit. The complaint was unsubstantiated and no new deficiencies were identified. Two out of 2 deficiencies were corrected. Census 28 Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.	{N 000}			

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

TITLE

(X6) DATE