

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 03/04/2024
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 02/28/2024 with additional information gathered through 03/04/2024, Surveyors conducted a complaint investigation at Autumns Promise Assisted Living in Green Bay. As a result, the complaint was unsubstantiated and no deficiencies were identified. Census: 28	N 000			

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

TITLE

(X6) DATE