

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/17/2024
NAME OF PROVIDER OR SUPPLIER CARRINGTON ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2626 FINGER RD GREEN BAY, WI 54302		
(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 01/16/2024, with information gathered through 01/17/2024, Surveyor conducted a standard survey and 2 complaint investigations. Two of 2 complaints will be unsubstantiated. As a result of the survey, no deficiencies will be issued. A regular license will be issued as of 01/17/2024. Census: 14	N 000		

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

TITLE

(X6) DATE