

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020393	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/28/2025
NAME OF PROVIDER OR SUPPLIER FRANKLIN PLACE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 9201 W DREXEL AVE FRANKLIN, WI 53132		
(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 01/28/2025, Surveyor conducted a verification visit and 1 complaint investigation. No deficiency was identified. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 29	{N 000}			

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

TITLE

(X6) DATE