Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016128	A. BUILDING: _____ B. WING _____	R-C 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN BAY ADULT FAMILY HOME LLC	**1111 N GREEN BAY RD MOUNT PLEASANT, WI 53406**

(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
{M 000}	INITIAL COMMENTS On 03/03/2026, Surveyor completed a complaint survey and verification visit at Green Bay Adult Family Home. As a result, all deficiencies have been corrected. No new deficiencies were identified. One of 1 complaint was unsubstantiated. Under statutory provisions of Wis. Stat. C. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE