

Wisconsin Department of Health Services

|                                                     |                                                                             |                                                                        |                                                                |
|-----------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0019671</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/18/2024</b> |
|-----------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------|

|                                                                           |                                                                                                 |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ELLENS HOME OF PORT WASHINGTON</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1800 GRANITE LANE<br/>PORT WASHINGTON, WI 53074</b> |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| {N 000}                  | <p>Initial Comments</p> <p>On 07/18/2024, Surveyor conducted a verification visit. As a result, 3 of 3 deficiencies were corrected. No new deficiencies were identified.</p> <p>Census 38</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> | {N 000}             |                                                                                                                          |                          |

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

TITLE

(X6) DATE