

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015398	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/26/2026
NAME OF PROVIDER OR SUPPLIER BAY HARBOR ASSISTED LIVING SUAMICO I		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 LONGVIEW LN SUAMICO, WI 54173		
(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 01/26/2026, Surveyor conducted a complaint investigation and verification visit at Bay Harbor Assisted Living Suamico I. All previous deficient practices were corrected, the complaint was unsubstantiated, and no new deficient practices were identified. Under statutory provisions, a \$200 revisit fee is being assessed for the follow-up licensing visit. Census: 17	{N 000}		

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

TITLE

(X6) DATE