

Wisconsin Department of Health Services

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|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0010929</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/19/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SCHUMACHER HOUSE</b> |                                                                                                                                                                                                                                        |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2831 FERNDAL DR</b><br><b>GREEN BAY, WI 54313</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 11/18/2024 with additional information gathered through 11/19/2024, Surveyor conducted a complaint investigation at Schumacher House. As a result, no deficiencies were identified.</p> <p>Census: 5</p> | N 000                                                                       |                                                                                                                          |  |                                                                    |

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

TITLE

(X6) DATE