

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0010312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/17/2024
NAME OF PROVIDER OR SUPPLIER CEDAR BAY WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 5555 CEDAR BAY DRIVE WEST BEND, WI 53095		
(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
U 000	INITIAL COMMENTS On 07/17/2024, Surveyor completed a complaint investigation at Cedar Bay West, a RCAC in West Bend. No deficiencies were identified. The complaint was unsubstantiated. Census: 69	U 000		

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

TITLE

(X6) DATE