

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>0018487</b>                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/12/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OPEN ARMS CARNATION</b> |                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6541 CARNATION COURT</b><br><b>MOUNT PLEASANT, WI 53406</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 09/12/2023, Surveyor completed a complaint survey at Open Arms Carnation. No deficiencies were identified. One of 1 complaint was unsubstantiated.</p> <p>Census: 4</p> | N 000                                                                                                   |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE