

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019492	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/30/2025
NAME OF PROVIDER OR SUPPLIER CARRINGTON ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2626 FINGER RD GREEN BAY, WI 54302		
(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 01/31/2025, Surveyor conducted a verification visit at Carrington Assisted Living. As a result of the survey all previous deficiencies were corrected, no new deficiencies were identified. Under statutory provision of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 14	{N 000}		

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

TITLE

(X6) DATE