

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0012537</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/08/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRILLION WEST HAVEN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>220 ACHIEVEMENT DR</b> <b>BRILLION, WI 54110</b>		
(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	<p>Initial Comments</p> <p>On 11/08/2023, Surveyor conducted a complaint investigation at Brillion West Haven.</p> <p>Complaint was unsubstantiated.</p> <p>No deficiencies were identified.</p> <p>Census 50</p>	N 000			

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

TITLE

(X6) DATE