

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0013688</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/09/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MORAINES RIDGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2929 SAINT ANTHONY DR GREEN BAY, WI 54311</b>
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(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	<p><b>INITIAL COMMENTS</b></p> <p>On 03/09/2023, Surveyor conducted 2 complaint investigations at Moraine Ridge in Green Bay.</p> <p>Two (2) of 2 complaints were unsubstantiated.</p> <p>As a result of the survey, no deficiencies were issued.</p> <p>Census: 66</p>	U 000		

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

TITLE

(X6) DATE