

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016370	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FRONTIDA OF MANITOWOC	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 DUFEK DRIVE MANITOWOC, WI 54220
--	--

(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 03/13/2024, with information gathered through 03/20/2024, Surveyors investigated two (2) complaints and conducted a standard survey. 2 out of 2 complaints were unsubstantiated. As a result of the standard survey, no new deficiencies were identified.</p> <p>Census 44</p>	N 000		

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

TITLE

(X6) DATE