

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016822	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/18/2024
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NAME OF PROVIDER OR SUPPLIER REFLECTIONS AT MORAINES RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2919 ST ANTHONY DR GREEN BAY, WI 54311
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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
N 000	<p>Initial Comments</p> <p>On 10/03/2024 with additional information gathered through 10/18/2024, Surveyor conducted 2 complaint investigations at Reflections at Moraine Ridge. As a result, no deficiencies were identified. The complaints were unsubstantiated.</p> <p>Census: 18</p>	N 000		

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

TITLE

(X6) DATE