

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>410168</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/17/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODSIDE MANOR I II III &amp; IV</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1060 PILGRIM WAY</b> <b>GREEN BAY, WI 54304</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
N 000	<p>Initial Comments</p> <p>On 12/17/2024, Surveyor conducted a complaint investigation at Woodside Manor I, II, III and IV in Green Bay. As a result, 2 of 2 complaints were unsubstantiated and no deficiencies were identified.</p> <p>Census: 125</p>	N 000		

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

TITLE

(X6) DATE