

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014496	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER MANAWA ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 4TH ST MANAWA, WI 54949		
(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	Initial Comments On 07/08/2024, Surveyor conducted a survey, a monitoring visit, and 1 complaint investigation at Manawa Assisted Living. Additional information was collected through 07/23/2024. The complaint was unsubstantiated. No deficient practices were identified. Census: 10	N 000			

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

TITLE

(X6) DATE