

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0009274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 03/13/2024
NAME OF PROVIDER OR SUPPLIER LAUREL GROVE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1308 S 22ND ST 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}	Initial Comments An investigation into 3 complaints and a verification visit for Statement of Deficiency JHYP11 was conducted on 03/13/2024. As a result of this survey 3 of 3 complaints were unsubstantiated with no new deficiencies identified. All previous deficiencies were corrected. Per state statutes a \$200.00 re-visit fee was assessed. Census: 85	{N 000}		

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

TITLE

(X6) DATE