

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014170	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 09/27/2024
NAME OF PROVIDER OR SUPPLIER DURHAM		STREET ADDRESS, CITY, STATE, ZIP CODE 2671-2673 DURHAM RD GREEN BAY, WI 54311		
(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 09/18/2024, with information gathered through 09/27/2024, Surveyor conducted a verification visit and standard survey. Eight of 8 previous deficiencies were corrected. As a result of the standard survey, no deficiencies were cited. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census 6	{N 000}		

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

TITLE

(X6) DATE