

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0017165</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>01/15/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CONNIE HOME LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1312 CONGRESS AVE<br/>OSHKOSH, WI 54901</b> |                                                                                                                          |                                                                |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                       |
| {M 000}                                                    | <p><b>INITIAL COMMENTS</b></p> <p>On 01/08/2025, Surveyor conducted a standard survey and verification visit at Connie Home LLC. Additional information was collected through 01/15/2025. All previous deficiencies were corrected and no new deficiencies were identified.</p> <p>Census: 3</p> <p>Under statutory provisions of WI Stat. Ch. 50 a \$200 revisit fee is being assessed.</p> | {M 000}                                                                                 |                                                                                                                          |                                                                |

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

TITLE

(X6) DATE