

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>0015627</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>03/19/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SHORES OF SHEBOYGAN ASSISTED LIVING I</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3319 SUPERIOR AVE<br/>SHEBOYGAN, WI 53081</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                                       |
| {N 000}                                                                          | <p>Initial Comments</p> <p>On 03/19/2024, Surveyor conducted a verification visit at Shores of Sheboygan Assisted Living II and investigated one complaint. As a result of the verification visit, two (2) out of 2 previous deficiencies were corrected. The complaint was unsubstantiated and no new deficiencies were identified.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census 19</p> | {N 000}                                                                     |                                                                                                                          |  |                                                                |

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

TITLE

(X6) DATE