

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/22/2025
NAME OF PROVIDER OR SUPPLIER EMERALD BAY ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 650 CENTENNIAL CENTRE BLVD ONEIDA, WI 54155		
(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
U 000	INITIAL COMMENTS An investigation into a complaint was conducted on 04/21/2025 with information gathered through 04/22/2025 at Emerald Bay Assisted Living. As a result of this survey the complaint was unsubstantiated with no deficiencies identified. Census: 110 tenants	U 000		

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

TITLE

(X6) DATE