

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018668	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/03/2024
NAME OF PROVIDER OR SUPPLIER BELLA VISTA			STREET ADDRESS, CITY, STATE, ZIP CODE 631 HAZEL STREET OSHKOSH, WI 54901		
(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 On 09/03/2024, Surveyor conducted a complaint investigation at Bella Vista. No deficiencies were identified. Complaint was unsubstantiated. Census: 85	U 000			

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

TITLE

(X6) DATE