Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018671	A. BUILDING: _____ B. WING _____	R-C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE MANOR	**711 BAYSHORE ROAD 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
N 000	Initial Comments On 07/15/2024, Surveyor conducted 2 complaints and a verification visit at Lakeshore Manor, a CBRF located in Oshkosh, WI. As a result of the survey, 0 violations of Chapter DHS 83 were issued. Both complaints were unsubstantiated. Five violations from previous Statement of Deficiency (SOD) # EXJH13 dated 01/29/2024 were corrected. Census: 39 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE