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
	0015453	A. BUILDING: _____ B. WING _____	R-C 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAISERS OAKHAVEN S&C LLC	**142 OAK CT SHAWANO, WI 54166**

(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 A standard survey, verification visit, and investigation into 6 complaints was completed at Paisers Oakhaven S&C LLC BLDG II on 03/19/2024 with information gathered through 03/25/2024. As a result of this investigation all previous deficiencies were noted corrected. All 6 complaints were unsubstantiated with no new deficiencies identified. Per state statutes a $200.00 re-visit fee was assessed. Census: 10	{N 000}		

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