

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013780	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/08/2024
NAME OF PROVIDER OR SUPPLIER GOLDEN HARBOR LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 505 S WATER ST SHEBOYGAN, WI 53081		
(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 11/08/2024, Surveyor conducted a verification visit at Golden Harbor for Statement of Deficiency (SOD) 7JQM11, dated 04/30/2024 and SOD VE6I11, dated 02/14/2024. Seven deficiencies were identified. Seven of 7 deficiencies were marked as corrected. No new deficiencies were identified. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 37	{N 000}		

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

TITLE

(X6) DATE