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
	410480	A. BUILDING: _____ B. WING _____	R 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABODE ON ONTARIO (THE)	**503 ONTARIO AVE 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 12/03/2024, with information gathered through 12/04/2024, Surveyor conducted 2 verification visits for Statement of Deficiencies (SOD) WOPN11, dated 11/09/2023 and SOD L47211, dated 04/09/2024, at Abode on Ontario (The). Two of 2 deficiencies were corrected for SOD WOPN11, dated 11/09/2023. One of (1) deficiency was corrected for SOD L47211, dated 04/09/2024. No new deficiencies were identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 0	{N 000}		

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