

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019881	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/09/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE CEDARBURG		STREET ADDRESS, CITY, STATE, ZIP CODE W56 N225 MCKINLEY BLVD CEDARBURG, WI 53012		
(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 06/05/2025, Surveyor conducted a verification visit at LakeHouse Cedarburg. Additional information was gathered through 06/09/2025. As a result of the survey previous deficiencies are corrected, no new deficiencies identified. Under statutory provisions of Wis. Stat. Ch., a \$200 revisit fee is being assessment. Census: 25	{N 000}		

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

TITLE

(X6) DATE