

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/05/2025
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLA ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 190 LAKE POINTE DRIVE OSHKOSH, WI 54904		
(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 05/05/2025, Surveyor conducted an onsite verification visit at Lake Pointe Villa Assisted Living. The previous deficiency was corrected and no new deficiencies were identified. Census: 19 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