

Wisconsin Department of Health Services

|                                                     |                                                                                                                                                             |                                                                                    |                                                                                                                          |                                                        |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0017343</b>        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/05/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OLSON 1</b>  |                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>847 OLSON ST<br/>SHAWANO, WI 54166</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                | ID<br>PREFIX<br>TAG                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| M 000                                               | <p>INITIAL COMMENTS</p> <p>On 05/05/2025, Surveyor conducted an abbreviated survey at Olson 1. No deficient practices were identified.</p> <p>Census: 3</p> | M 000                                                                              |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE