

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016808	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/14/2025
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NAME OF PROVIDER OR SUPPLIER EMERALD BAY MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 650 CENTENNIAL CENTRE BLVD ONEIDA, WI 54155
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(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	<p>Initial Comments</p> <p>On 05/13/2025 with additional information gathered through 05/14/2025, Surveyor conducted an abbreviated survey and complaint investigation at Emerald Bay Memory Care. As a result, one (1) of 1 complaints was unsubstantiated and no deficiencies were identified.</p> <p>Census: 20</p>	N 000		

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

TITLE

(X6) DATE