

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0017972</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COURTYARD AT OSHKOSH (THE)</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3851 JACKSON STREET</b> <b>OSHKOSH, WI 54901</b>
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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 06/13/2025, Surveyor conducted two (2) complaint investigations at Courtyard At Oshkosh. As a result of the survey, 2 complaints were unsubstantiated, no deficiencies identified.</p> <p>Census: 49</p>	N 000		

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

TITLE

(X6) DATE