

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0018411</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/25/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RESIDENCE AT OSHKOSH II (THE)</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1110 WEST MURDOCK AVENUE 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 11/25/2024, Surveyors conducted an abbreviated survey and reviewed one (1) self-report at The Residence at Oshkosh II. As a result of the survey, no deficiencies were identified, the self-report had no findings. The facility can serve up to 32 residents and can begin admitting residents as of 11/25/2024.</p> <p>Census: 0</p>	N 000		

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

TITLE

(X6) DATE