

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015612	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/25/2025
NAME OF PROVIDER OR SUPPLIER CLASSIC AT HILLCREST GREENS SENIOR LIVING (TI		STREET ADDRESS, CITY, STATE, ZIP CODE 2455 SAWGRASS PLACE ALTOONA, WI 54720		
(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
U 000	INITIAL COMMENTS On 02/25/2025, Surveyors conducted a standard survey and complaint investigation at The Classic At Hillcrest Greens Senior Living. The complaint was unsubstantiated. No deficiencies were identified. Census: 31 tenants; 30 apartments	U 000		

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

TITLE

(X6) DATE