

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016553	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER HARBOR COVE I CBRF		STREET ADDRESS, CITY, STATE, ZIP CODE 333 W WALTERS STREET PORT WASHINGTON, WI 53024		
(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	Initial Comments On 12/06/2024, Surveyor conducted one (1) complaint and reviewed one (1) self-report at Harbor Cove I. Additional information was gathered through 12/11/2024. As a result of the survey no findings with the self-report, 1 complaint was unsubstantiated, no deficiencies identified. Census: 42	N 000		

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

TITLE

(X6) DATE