

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017238	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/15/2025
NAME OF PROVIDER OR SUPPLIER HYLAND CROSSINGS		STREET ADDRESS, CITY, STATE, ZIP CODE 1249 SCHOOL ST SUN PRAIRIE, WI 53590		
(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 01/15/2025, the bureau of assisted living Southern regional office conducted a complaint investigation at Hyland Crossings a CBRF located in Sun Prairie, WI. As a result of this survey, 0 violations of DHS Chapter 83 were issued. Complaint was unsubstantiated. Census: 23	N 000		

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

TITLE

(X6) DATE