STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015905	A. BUILDING: _____ B. WING _____	10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF SHOREWOOD	1111 E CAPITOL DR SHOREWOOD, WI 53211

(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 10/23/2023, Surveyor conducted a desk review for Harborchase of Shorewood. One deficiency was identified.	U 000		
U 301	89.53(4)(b) Certification Renewal Certification shall be renewed if the owner or operator continues to comply with the provisions of this chapter, submits an application for renewal at least 30 days before the certification expires and pays the required certification fee. If an application for renewal is denied, the owner or operator shall be given written notice of the denial which shall include the reasons for denial and notice of opportunity to appeal the decision under s. DHS 89.59. This Rule is not met as evidenced by: Based on record review, the operator did not ensure the annual report and certification fee were submitted to the department within 30 days prior to the certification expiration date. Findings include: On 09/25/2022, the department sent a notice to Administrator A informing them the certification for Harborchase of Shorewood, would expire on 11/30/2022. The notice indicated the annual report and certification fee were due to the department by 10/31/2022.	U 301		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015905	A. BUILDING: _____ B. WING _____	10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF SHOREWOOD	1111 E CAPITOL DR SHOREWOOD, WI 53211

(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 301	Continued From page 1 On 11/04/2022, the department sent a second notice to Administrator A by certified letter, indicating the annual report and certification fee were past due. The notice indicated if the annual report and certification fee were not received by 12/30/2022, the Division of Quality Assurance will proceed with enforcement action, which may include certification revocation. On 11/14/2022, the department received confirmation of certified mail delivery. On 11/04/2022, the department sent a second notice to Administrator A by email, indicating the annual report and certification fee were past due. The notice indicated if the annual report and certification fee were not received by 12/30/2022, the Division of Quality Assurance will proceed with enforcement action, which may include certification revocation. On 11/04/2022, the department received a confirmation of email delivery. On 09/11/2023, the department sent a third notice to Administrator B by email, indicating the annual report and certification fee were past due. The notice indicated if the annual report and certification fee were not received by 12/30/2022, the Division of Quality Assurance will proceed with enforcement action, which may include certification revocation. On 09/11/2023, the department received a confirmation of delivery. On 10/23/2023, Surveyor reviewed department records and found no evidence an annual report and certification fees were received from the provider.	U 301		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015905	A. BUILDING: _____ B. WING _____	10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF SHOREWOOD	**1111 E CAPITOL DR SHOREWOOD, WI 53211**

(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