

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017364	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/19/2025
NAME OF PROVIDER OR SUPPLIER COURTYARD AT BELLEVUE (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 HOFFMAN ROAD BELLEVUE, WI 54311		
(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 03/17/2025, with information gathered through 03/19/2025, Surveyor conducted a complaint investigation at The Courtyard at Bellevue. One (1) of 1 complaint was unsubstantiated. As a result of the survey, no deficiencies will be issued. Census: 40	N 000		

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

TITLE

(X6) DATE