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
	0019869	A. BUILDING: _____ B. WING _____	R-C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR MEMORY CARE ASSISTED LIVING OF	1936 TENNYSON LN MADISON, WI 53704

(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 01/30/2025, Surveyors conducted a verification visit at Bay Harbor Memory Care Assisted Living of Madison, a CBRF in Madison. No deficiencies were identified. Statement of Deficiency (SOD) MXVF14, dated 12/10/2024, was corrected. The facility will be identified by the department as facility ID #0019869. The facility will be able to serve up to 60 individuals with a primary diagnoses including advanced age, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness and physically disabled. The facility will be issued a regular license effective 02/01/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 39	{N 000}		

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