

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019869	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/03/2025
NAME OF PROVIDER OR SUPPLIER SONNET AT TENNYSON (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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 10/03/2025, the bureau of assisted living southern regional office conducted a complaint investigation at The Sonnet at Tennyson a CBRF located in Madison, WI. As a result of the survey, 0 violations of DHS Chapter 83 were issued. The complaint was unsubstantiated. Census: 48	N 000			

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

TITLE

(X6) DATE