

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 09/28/2023
NAME OF PROVIDER OR SUPPLIER SOUTH HARTFORD AFH			STREET ADDRESS, CITY, STATE, ZIP CODE 3088 STATE HIGHWAY 83 HARTFORD, WI 53027		
(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	
{M 000}	INITIAL COMMENTS On 09/28/2023. Surveyors conducted a verification visit at South Hartford AFH. As A result of the survey previous deficiencies have been corrected, no new deficiencies identified. Under statutory provisions of Wis. stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}			

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

TITLE

(X6) DATE