

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>510321</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C</b><br><b>10/01/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARBORVIEW CBRF</b> |                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>910 E 5TH STREET</b><br><b>SUPERIOR, WI 54880</b> |                                                                                                                          |                                                                      |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                             |
| {N 000}                                                    | <p>Initial Comments</p> <p>On 10/01/2025, the Department conducted a verification visit at Harborview CBRF.</p> <p>One of 1 violations identified in Statement of Deficiencies (SOD) RHY711, dated 07/03/2024, was corrected.</p> <p>No new violations were identified.</p> <p>Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 6</p> | {N 000}                                                                                       |                                                                                                                          |                                                                      |

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

TITLE

(X6) DATE