

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>0017805</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>03/26/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARTFORD ESTATES I</b> |                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>109 LONE OAK LN</b><br><b>HARTFORD, WI 53027</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 03/26/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Hartford Estates I, a community-based residential facility (CBRF) located in Hartford, WI.</p> <p>As a result of the survey, 0 deficiencies were identified.</p> <p>The complaint was unsubstantiated.</p> <p>Census: 8</p> | N 000                                                                                        |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE