

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017238	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/10/2025
NAME OF PROVIDER OR SUPPLIER HYLAND CROSSINGS		STREET ADDRESS, CITY, STATE, ZIP CODE 1249 SCHOOL ST SUN PRAIRIE, WI 53590		
(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 04/10/2025, the bureau of assisted living southern regional office conducted a verification visit at Hyland Crossings a CBRF located in Sun Prairie, WI. As a result of this survey. 0 violations of DHS Chapter 83 were identified. Four of 4 violations from previous statement of deficiency X9YQ11 dated 10/04/2024 were substantially corrected. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 21	{N 000}		

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

TITLE

(X6) DATE