

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015582	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/11/2025
NAME OF PROVIDER OR SUPPLIER HAVEN DRIVE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 220 HAVEN DR SHEBOYGAN FALLS, WI 53085		
(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 02/11/2025, Surveyor conducted an abbreviated survey and one (1) complaint investigation at Haven Drive Assisted Living. As a result of the survey, 1 complaint was unsubstantiated, no deficiencies were identified. Census: 70	N 000		

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

TITLE

(X6) DATE