

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0009040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 850 CITY LIMITS ST LANCASTER, WI 53813		
(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 09/28/2023, The Bureau of Assisted Living, Southern Regional Office conducted an abbreviated survey at Morningside Assisted Living, a CBRF in Lancaster, WI. As a result of this survey, 0 violations of Chapter DHS 83 were issued. Census: 22	N 000		

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

TITLE

(X6) DATE