

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017956	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/18/2025
NAME OF PROVIDER OR SUPPLIER SOUTHERN HORIZON ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 930 E CLIFFORD ST PLYMOUTH, WI 53073		
(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	
U 000	INITIAL COMMENTS On 07/18/2025, Surveyor conducted one (1) complaint investigation at Southern Horizon Assisted Living. As a result of the survey, 1 complaint was unsubstantiated, no deficiencies identified. Census: 23	U 000			

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

TITLE

(X6) DATE