

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 C 05/16/2024
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 05/16/2024, the bureau of assisted living southern regional office completed a complaint investigation at Morningside Assisted Living a CBRF located in Lancaster, WI. As a result of this survey, 0 violations of DHS Chapter 83 were issued Complaint was unsubstantiated Census: 22	N 000		

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

TITLE

(X6) DATE