

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 R-C 04/24/2025
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 04/24/2025, Surveyor conducted a verification visit and investigated 1 complaint at Southern Horizons Assisted Living. Three of 3 previous deficiencies were corrected. The complaint was unsubstantiated and no new deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 28	{U 000}		

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

TITLE

(X6) DATE