

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015732	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/06/2026
NAME OF PROVIDER OR SUPPLIER NEW DAY ASSISTED LIVING- ELKHORN			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 COUNTRY CLUB PARKWAY ELKHORN, WI 53121		
(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 01/06/2026, Surveyor conducted a complaint investigation and verification visit at New Day Assisted Living-Elkhorn. No deficiencies were identified. The deficiency from Statement of Deficiency (SOD) NLJO14, dated 08/05/2025 was substantially corrected. The complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a \$200.00 revisit fee is being assessed. Census: 28	{N 000}			

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

TITLE

(X6) DATE