

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018121	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/23/2026
NAME OF PROVIDER OR SUPPLIER EAGLE CREST SOUTH ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 622 BENNORA LEE COURT LA CROSSE, WI 54601		
(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 07/22/2026, Surveyor conducted an abbreviated survey and complaint investigation at Eagle Crest South Assisted Living. Data collection continued through 07/23/2026. The complaint was unsubstantiated. No deficiencies were identified. Census: 33	U 000			

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

TITLE

(X6) DATE