

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 C 04/13/2026
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NAME OF PROVIDER OR SUPPLIER NEW DAY ASSISTED LIVING- ELKHORN	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 COUNTRY CLUB PARKWAY ELKHORN, WI 53121
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(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 04/13/2026, Surveyor conducted a complaint investigation at New Day Assisted Living, a CBRF in Elkhorn. The survey resulted in no deficiencies. The complaint was unsubstantiated. Census: 32	N 000		

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

TITLE

(X6) DATE