

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0015626</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/04/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MEADOW VIEW ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4606 MISHICOT RD</b> <b>TWO RIVERS, WI 54241</b>
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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	<p>Initial Comments</p> <p>On 12/04/2024, Surveyor conducted a complaint investigation at Meadow View Assisted Living in Two Rivers.</p> <p>One of 1 complaints were unsubstantiated.</p> <p>As a result of the survey, no deficiencies were issued.</p> <p>Census: 24</p>	N 000		

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

TITLE

(X6) DATE