

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017970	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2025
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NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS OF STRUM	STREET ADDRESS, CITY, STATE, ZIP CODE 208 ELM STREET PO BOX 182 STRUM, WI 54770
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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 05/02/2025, a 3 complaint investigation was conducted at Rolling Meadows of Strum. Data collection continued through 05/05/2025.</p> <p>Three of the 3 complaints were unsubstantiated.</p> <p>No deficiencies were identified.</p> <p>Census: 20</p>	N 000		

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

TITLE

(X6) DATE