

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/22/2025
NAME OF PROVIDER OR SUPPLIER PRIMROSE MEMORY CARE OF APPLETON			STREET ADDRESS, CITY, STATE, ZIP CODE 5717 MEADE ST APPLETON, WI 54913		
(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 A standard survey and an investigation of a complaint were conducted on 05/21/2025 with information gathered through 05/22/2025 at Primrose Memory Care of Appleton. As a result of this survey no deficiencies were identified. The complaint was unsubstantiated. Census: 25	N 000			

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

TITLE

(X6) DATE