

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/24/2024
NAME OF PROVIDER OR SUPPLIER STOUGHTON MEADOWS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2321 JACKSON ST STOUGHTON, WI 53589		
(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 01/24/2024, the Bureau of Assisted Living, Southern Regional Office conducted a complaint investigation at Stoughton Meadows Assisted Living, an CBRF located in Stoughton, WI. As a result of the investigation, 0 violations of Chapter DHS 83 were issued. Complaint was unsubstantiated Census: 37	N 000		

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

TITLE

(X6) DATE