

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/13/2026
NAME OF PROVIDER OR SUPPLIER MEADOWS OF FOND DU LAC LLC (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 620 W ROLLING MEADOWS DR FOND DU LAC, WI 54937		
(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
U 000	INITIAL COMMENTS On 08/13/2026, Surveyor conducted an abbreviated survey and one (1) complaint investigation at Meadows of Fond du Lac LLC, RCAC. As a result of the survey 1 complaint was unsubstantiated, no deficiencies identified. Census: 61	U 000		

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

TITLE

(X6) DATE