

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017577	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 09/10/2025
NAME OF PROVIDER OR SUPPLIER ROGERS MEMORIAL HOSPITAL WEST ALLIS I			STREET ADDRESS, CITY, STATE, ZIP CODE 11101 W LINCOLN AVE WEST ALLIS, WI 53227		
(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 09/10/2025, Surveyor conducted a standard survey, verification visit and complainant investigation at Rogers Memorial Hospital, West Allis Recovery Center. No deficiencies were identified. Complaint unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 12	{N 000}			

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

TITLE

(X6) DATE