STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019800	A. BUILDING: _____ B. WING _____	R 11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS FOX (THE)	**611/613 E ALBERT ST PORTAGE, WI 53901**

(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 11/24/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Rivers Fox (The). As a result of the survey, no deficiencies were identified. Nine (9) previous deficiencies from Statement of Deficiency (SOD) C6Q911, dated 08/11/2025, were substantially corrected. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. A regular license will be granted on 11/30/2025. Census: 18	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE