Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015957	A. BUILDING: _____ B. WING _____	R-C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD AT WISCONSIN RAPIDS (THE)	**491 25TH ST N WISCONSIN RAPIDS, WI 54494**

(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 05/20/2025, Surveyors conducted an onsite visit at The Waterford At Wisconsin Rapids to investigate 4 complaints and to complete a verification visit for Statement of Deficiency (SOD) FMFT15, dated 05/20/2024 and SOD BK4Y11, dated 08/08/2024. Additional information was collected through 05/21/2025. Four (4) of 4 complaints were unsubstantiated. Four (4) of 4 previous deficiencies associated with SOD FMFT15 were corrected. Nine (9) of 9 previous deficiencies associated with SOD BKRY11 were corrected. No new deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 41	{N 000}		

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