

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/15/2024
NAME OF PROVIDER OR SUPPLIER RIVERS-FOX (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 611 E ALBERT STREET 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 10/15/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Rivers-Fox (The). No deficiencies were identified. The results of the revisit are documented in the Statement of Deficiency (SOD) for survey event DZNW16.	N 000			

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

TITLE

(X6) DATE