

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0016033</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/02/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WATERFORD AT WISCONSIN RAPIDS-MEMOR</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2440 BAKER ST<br/>WISCONSIN RAPIDS, WI 54494</b> |                                                                                                                          |                                                                |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                       |
| {N 000}                                                                        | <p>Initial Comments</p> <p>On 07/02/2026, Surveyor conducted an onsite visit at The Waterford At Wisconsin Rapids Memory Care to complete a complaint investigation and verification visit for Statement of Deficiency (SOD) LEEP11, dated 01/22/2026.</p> <p>The complaint was unsubstantiated. Two (2) of 2 previous deficiencies associated with SOD LEEP11 were corrected. No new deficiencies were identified.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 16</p> | {N 000}                                                                                      |                                                                                                                          |                                                                |

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

TITLE

(X6) DATE