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
	0017474	A. BUILDING: _____ B. WING _____	R-C 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITES AT BELOIT (THE)	2122 PIONEER DRIVE BELOIT, WI 53511

(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 08/014/2025, Surveyor conducted 2 verification visits (statement of deficiency (SOD) TWL811, dated 04/03/2025 and SOD 4V2G12, dated 01/29/2025) at Suites At Beloit, a CBRF in Beloit. As a result of this survey, 0 violations of Chapter DHS 83 were issued. Two (2) deficiencies from previous statement of deficiency (SOD) # TWL811, dated 04/03/2025 were substantially corrected. One (1) violation from previous SOD #4V2G12, dated 01/29/2025 were substantially corrected. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed. Census: 43	{N 000}		

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