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
	0016746	A. BUILDING: _____ B. WING _____	R-C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT PLACE RCAC	609 BROADWAY STREET BERLIN, WI 54923

(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
{U 000}	INITIAL COMMENTS On 02/12/2024 Surveyor conducted an onsite visit to conduct verification visits for Statement of Deficiency (SOD) TJJR12 and SOD WJ7113. Surveyor also investigated 1 complaint, reviewed 1 self-report and conducted a survey. Additional information was received through 02/14/2024. The previous citations from both SODs were corrected, the complaint was unsubstantiated and no deficiencies were identified. Census: 52 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{U 000}		

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