

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019594	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 06/07/2024
NAME OF PROVIDER OR SUPPLIER SYCAMORE OF RIVER FALLS (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 745 SYCAMORE ST RIVER FALLS, WI 54022		
(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 06/07/2024, Surveyor conducted a verification visit at The Sycamore of River Falls. The deficiencies identified in Statement of Deficiency (SOD) OVN511, dated 03/08/2024 were corrected. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 14	{N 000}			

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

TITLE

(X6) DATE