

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012426	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/30/2024
NAME OF PROVIDER OR SUPPLIER COMFORTS OF HOME RIVER FALLS CBRF		STREET ADDRESS, CITY, STATE, ZIP CODE 2328 AURORA CIRCLE 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 07/30/2024, Surveyors conducted a standard survey, verification visit and seven complaint investigations at Comforts Of Home River Falls CBRF. Seven complaints were unsubstantiated. The deficiencies identified in Statement of Deficiency (SOD) 1DMC13, dated 10/04/2023 were corrected. No deficiencies were identified. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 27	{N 000}		

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

TITLE

(X6) DATE