

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/15/2024
NAME OF PROVIDER OR SUPPLIER RIVERS-FOX (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 611 E ALBERT STREET PORTAGE, WI 53901		
(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 10/15/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit for Statement of Deficiency (SOD) DZNW15, dated 06/05/2024, and SOD JQOI11, dated 04/19/2024, at Rivers-Fox (The), a community-based residential facility (CBRF) located in Portage, WI. As a result of the survey, 0 deficiencies were identified. Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed. Census: 16	{N 000}		

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

TITLE

(X6) DATE