

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017655	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/27/2023
NAME OF PROVIDER OR SUPPLIER RAPHA HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 7835 W FIEBRANTZ AVE MILWAUKEE, WI 53222		
(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
{M 000}	INITIAL COMMENTS On 07/27/2023, Surveyor completed a verification visit and complaint survey at Rapha House. All deficiencies were corrected. No new deficiencies were identified. One of 1 complaint was unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed. Census: 2	{M 000}		

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

TITLE

(X6) DATE