

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014833	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 09/03/2026
NAME OF PROVIDER OR SUPPLIER RIVERSIDE ADULT FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE W3629 LEMONWEIR CT MAUSTON, WI 53948		
(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 09/03/2026, Surveyor conducted a complaint investigation and verification visit at Riverside Adult Family Home. The complaint was unsubstantiated. The deficiencies identified in Statement of Deficiency (SOD) CYIS11 were corrected. No deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}		

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

TITLE

(X6) DATE