Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020448	A. BUILDING: _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE	**2201 EAGLE SUMMIT STEVENS POINT, WI 54482**

(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 An investigation into 3 complaints was conducted at North Ridge on 03/12/2025 with information gathered through 03/13/2025. As a result of this investigation 1 of 3 complaints were substantiated with 1 deficiency identified. Census: 23	N 000		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and staff interviews the provider did not issue a 30 day notice of involuntary discharge was provided to 1 of 1 residents. Findings include: On 03/12/2025 Surveyor investigated a concern, dated 11/11/2024, of an involuntary discharge without proper notice.	N 326		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 326	Continued From page 1 On 03/12/2025 Surveyor reviewed Resident 1's record which showed Resident 1 was admitted on 03/08/2024 with diagnoses of Schizoaffective Disorder, COPD, History of Traumatic Brain Injury and was non-aggressive. Resident 1 was discharged from the facility on 11/07/2024 after being sent to the hospital from aggression to staff on 11/06/2024. On 03/12/2025 Surveyor reviewed facility self-reports showed Resident 1 was in an exercise group on 10/29/2024 at 10:15 AM when s/he walked away. AD (Activity Director) - A asked if s/he was okay. Resident 1 grabbed AD - A by the hair and struck his/her head with a closed fist. Staff intervened. Police were called. Resident 1 indicated s/he knew s/he hit AD- A and apologized daily to him/her after this. Resident 1's ISP was changed to follow Resident 1 if leaving group area to ensure safety of others. On 11/06/2024 at 6 pm, Resident 1 held the delayed egress door until it opened. CG (Caregiver) - C attempted to re-direct him/her inside as it was cold and dark out and offered a walk tomorrow. Resident 1 grabbed CG - C by the shirt and threw him/her to the ground resulting in a shoulder injury and 911 being called. Police arrived and Resident 1 began hitting staff again in front of the Police. Police escorted Resident 1 to the hospital on a Chapter 51 commitment order. The facility self-reported these incidents to the State Agency. In an interview with Surveyor on 03/12/2025 at approximately 2:00 PM, RD (Regional Director) - B indicated the provider could not bring Resident 1 back because s/he was a danger to frail residents and was able to throw an able bodied staff to the ground causing injury. RD - B	N 326		

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N 326	Continued From page 2 confirmed they did not issue a 30 day notice before discharge but did issue an Emergency Discharge Notification to him/her on 11/07/2024. RD - B confirmed Resident 1 did not return to the facility after being taken to the hospital on 11/06/2024 and was transferred from the hospital to a different facility.	N 326		