STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016005	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBI CARING HEARTS A LLC	1612 HENRY JOHNS BLVD BANGOR, WI 54614

(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 05/27/2025, Surveyor conducted a complaint investigation at RBI Caring Hearts A LLC. Data collection continued through 05/29/2025. The complaint was substantiated. Two deficiencies were identified. Census: 9	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, upon learning of alleged misconduct, the provider did not take immediate steps to ensure residents	N 158		

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

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N 158	Continued From page 1 were protected from subsequent episodes of misconduct. On 03/06/2025, the provider became aware of multiple incidents of alleged caregiver misconduct. Adult Protective Services (APS) met with the provider regarding concerns for Resident 1 and alleged Caregiver I was the offender. The provider continued to allow Caregiver I to work and did not take steps to ensure residents were protected from subsequent episodes of misconduct. The provider did not start investigating until 03/10/2025, 4 days after the initial notification of alleged caregiver misconduct. Findings include: On 03/17/2025, the department received a complaint alleging caregiver misconduct. On 05/27/2025, at 2:55 PM, Surveyor emailed Manager F and requested the provider's staff misconduct reports completed in 2025. On 05/28/2025, at 12:02 PM, Surveyor received an email with multiple attachments from Manager F that included the following: -A self-report, dated 03/06/2025, indicated Resident 1's counseling provider reported concerns of allegations made by Resident 1 during an appointment. APS met with the provider to initiate an investigation. Resident 1 had made allegations that staff refused to help him/her up after a fall and was left alone on the ground. Resident 1 reported s/he had witnessed staff pinch another resident and caused them to "call out." Resident 1 reported s/he was left alone in his/her bed all weekend.	N 158		

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N 158	Continued From page 2 On 05/29/2025, at 7:03 AM, Surveyor received an email from RN G, including the following: -A document titled, "Grievance Form," signed on 03/19/2025. Under Resident and/or Staff involved, it identified Caregiver I and Resident 1. The description read, in part, "On 2/2/25, 2/1/25, 2/15, and 2/16 [Resident 1] gots [sic] up around 6:15-6:30 as [his/her] normal, [sic] [s/he] called to me to see what time it was ...one of our hospice patients will call out when being changed or at the table anytime staff touch [him/her] or walls [sic] by." The date of grievance on the form was blank. -A second grievance form, with dates of grievances identified on the weekends of 02/01/25-02/02/25 and 02/08/25-02/09/25, was signed on 03/19/2025. -A third grievance form, with no known date of grievance, was signed on 03/19/2025. -A fourth grievance form, with date of grievance identified as 03/19/2025, was signed on 03/19/2025. -A handwritten document with a heading titled, "3/19/25 meeting w/ (with) staff on the alleged weekends." At 12:02 PM, Surveyor interviewed APS J via phone. APS J stated s/he met with Manager F, RN G, and Administrator H on 03/06/2025 and shared caregiver misconduct allegations related to Resident 1 and Caregiver I. At 1:00 PM, Surveyor interviewed Manager F, RN G, and Administrator H via Microsoft Teams meeting. Surveyor expressed concerns related to their response to the misconduct allegations. Administrator H stated Resident 1 had a history of making allegations toward staff members. Administrator H stated the timeline did not work out and part of the reason they did not get to it right away was because the staff that needed to	N 158		

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N 158	Continued From page 3 be interviewed were not available. When asked when their internal investigation was started, RN G stated APS met with them on 03/06/2025. RN G stated s/he met with Resident 1 on 03/10/2025 and met with staff on 03/19/2025. RN G stated staff was removed from the provider at one point but was not sure of the exact date. When asked when their investigation was concluded, RN G stated it was concluded on 03/26/2025. When asked about Caregiver I's schedule, RN G stated s/he met with Caregiver I the day after the APS visit and officially met with him/her on 03/19/2025. Manager F stated 03/19/2025 was the last day that Caregiver I was working in Resident 1's facility. RN G stated Caregiver I did work in Resident 1's facility until 03/19/2025. Manager F stated they were in the process of hiring another staff so they could move Caregiver I to the adjacent facility. Administrator H stated the investigation should have been completed faster. Administrator H stated the self-report was submitted to the Office of Caregiver Quality. At 1:31 PM, Surveyor received an email from Manager F with multiple attachments, including staff schedules. Caregiver I was on the schedule in Resident 1's facility on the following dates: 03/07/2025, 03/10/2025, 03/12/2025, 03/13/2025, 03/14/2025, 03/15/2025, 03/16/2025, 03/17/2025, 03/19/2025. The provider did not take immediate steps to ensure residents were protected from subsequent episodes of misconduct when an allegation of staff misconduct was not investigated until 4 days after the allegations were made. The caregiver involved in the allegations was on the staff schedule and working with residents prior to the conclusion of the investigation.	N 158		

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N 397	Continued From page 4	N 397		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on observation, and interview, the provider did not ensure at least one qualified resident care staff was present in the Community Based Residential Facility (CBRF) on 05/27/2025, when residents were present. Findings Include: The provider is licensed provide care for up to 10 residents within the following client groups: advanced aged, physical disabilities, and	N 397		

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N 397	Continued From page 5 irreversible dementia/Alzheimer's. On 05/27/2025 at approximately 10:30 AM, Surveyor interviewed Caregiver A. When asked about the provider's typical staffing pattern, Caregiver A stated there was usually 1 caregiver working per shift. Caregiver A stated s/he was scheduled 6:00 AM to 2:00 PM, and was the only staff currently in the building. At approximately 10:45 AM, Surveyor heard a door alarm and observed what appeared to be another caregiver enter the building. The other caregiver requested assistance from Caregiver A and stated a resident had fallen and was too heavy to lift safely. Caregiver A followed the other caregiver out of the building. There were 8 residents in the building at the time. At approximately 10:49 AM, Caregiver A returned to the building. The department licensed the assisted living facility located next door. The facility operated under a different license. Caregiver A stated Caregiver B (scheduled at the other licensed facility) was working alone and needed help transferring a resident. Caregiver A stated it was the second time s/he had to go assist with resident transfers next door. Caregiver A confirmed that in his/her absence, there was not a staff member present in the building. On 05/29/2025, at 1:00 PM, Surveyor interviewed Manager F, Registered Nurse (RN) G, and Administrator H via Microsoft Teams meeting. Surveyor shared concerns that Caregiver A left the facility and residents were left unsupervised. RN G stated there was a float staff available on some days to support both licensed facilities. RN G stated resident appointments had been heavy lately which impacted the availability of float staff.	N 397		

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N 397	Continued From page 6 Administrator H stated s/he did not condone staff leaving the residents unsupervised and it was rare that another person was not in the building with Caregiver A. Manager F stated staff knew that they were not allowed to leave the building and that was emphasized during their training sessions. Administrator H stated they had a good plan in place moving forward to address the concerns.	N 397		