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
	0019545	A. BUILDING: _____ B. WING _____	R-C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER ROAD ESTATES	1848 RIVER ROAD SPARTA, WI 54656

(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 04/10/2024, Surveyor conducted a complaint investigation and a verification visit at River Road Estates. The complaint was substantiated. One deficiency related to the complaint was identified. The deficiencies in SOD CQOM11 were substantially corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 14	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure a written report was submitted to the Department within 3 working days of when law enforcement was called to the facility as a result of an incident that jeopardized the health, safety, or welfare of residents and	N 164		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019545	A. BUILDING: _____ B. WING _____	R-C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER ROAD ESTATES	1848 RIVER ROAD SPARTA, WI 54656

(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 164	Continued From page 1 employees of the facility. Findings include: The provider is licensed to care for 14 residents within the client groups of advanced aged, physical disabilities, irreversible dementia/Alzheimer's disease, terminally ill, and developmental disabilities. On 04/11/2024 at approximately 12:00 PM, Surveyor interviewed Administrator A about law enforcement presence at the facility due to issues or concerns with staff or residents. Administrator A stated s/he terminated an employee, packed the employee's belongings, and told the terminated employee they were no longer allowed on the property due to threats made by the terminated employee against the facility and Administrator A. Administrator A stated the terminated employee showed up at the facility on 01/21/2024 and was yelling and screaming in front of residents. The police were called and arrived at the facility around 5:15. Administrator A stated residents who witnessed the incident were upset. Administrator A stated s/he did not notify the department of this incident. Surveyor reviewed a written statement authored by Administrator A. The statement contained the following information: The employee was terminated from his/her position with the company on 01-21-2024, and was told s/he was no longer allowed on the premises. At 5:15 PM, police were notified by Administrator A of the chance for retaliation by the terminated employee. At 6:20 PM on 01/21/2024, the terminated employee arrived at the facility. Police were called. Police escorted the terminated employee through the facility so that s/he could collect any belongings of	N 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019545	A. BUILDING: _____ B. WING _____	R-C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER ROAD ESTATES	**1848 RIVER ROAD SPARTA, WI 54656**

(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 164	Continued From page 2 his/hers. Surveyor looked for a self-report concerning this issue in the department file. Surveyor did not locate evidence of a self-report regarding this concern.	N 164		