STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014833	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE ADULT FAMILY HOME	**W3629 LEMONWEIR CT MAUSTON, WI 53948**

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M 000	INITIAL COMMENTS On 03/20/2026, Surveyor conducted a two-complaint investigation and licensure survey. Date collection continued through 04/01/2026. One of two complaints were substantiated. Three deficiencies were identified. Census: 3	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department within 24 hours, a significant change in Resident 1's condition when s/he eloped from the facility. Findings include: On 02/27/2026, the department received a complaint related to resident services. The provider is licensed to care for 4 residents in the client groups of developmentally disabled,	M 134		

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

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M 134	Continued From page 1	M 134		

traumatic brain injury, alcohol/drug dependent, correctional clients, and emotionally disturbed/mental illness.

On 03/20/2026 at approximately 10:30 AM, Surveyor interviewed Facility Supervisor (FS) E. FS E stated Resident 1 and Resident 3 were at risk for elopement.

On 03/20/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 12/04/2023 and had a guardian. Resident 1 had diagnoses that included dissociative identity disorder, adjustment disorder with mixed anxiety and depressed mood, Asperger's syndrome, attention-deficit hyperactivity disorder, bipolar disorder, current episode depressed, and oppositional defiant disorder. Resident 1's last updated Behavioral Support Plan (BSP) indicated Resident 1 had multiple elopements since his/her admission.

Surveyor reviewed incident reports from the past 3 months involving Resident 1. An incident report indicated Resident 1 had eloped from the facility on 03/13/2026. The incident report indicated Resident 1 was agitated and left the facility walking down the driveway. The incident report indicated Resident 1 walked down the road and staff called the police who brought Resident 1 back to the facility.

Surveyor reviewed the facility e-file and found two self-reports for 2025 reported to the Department regarding Resident 1 eloping on 02/26/2025 and 03/19/2025. There were no incident reports for 2026.

On 03/31/2026 at 3:00 PM, Surveyor interviewed Director A. Director A stated s/he did not send in a

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M 134	Continued From page 2 self-report for the elopement on 03/13/2026 as s/he was unclear if it needed to be reported. Director A stated it was his/her error and s/he would correct this moving forward. The provider did not report to the department, within 24 hours, a significant change in Resident 1's condition when s/he eloped from the facility on 03/13/2026. Cross Reference M0412 DHS 88.06(3)(d)1 Description Of Services	M 134		
M 234	88.04(2)(g)2 COMMUNICABLE DISEASE The licensee shall ensure that no one who has a communicable disease reportable under ch. HSS 145 may work in a position in the adult family home where the disease would present a significant risk to the health or safety of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each service provider was screened for illness detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse, or a physician's assistant, within 90 days before the start of providing service, for 1 of 3 staff (Caregiver C) reviewed. Findings include: This facility is licensed to serve up to 4 residents in the client groups emotionally disturbed/mental illness, traumatic brain injury, developmentally disabled, correctional clients, and alcohol/drug	M 234		

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M 234	Continued From page 3	M 234		

dependent.

On 03/20/2026, Surveyor requested and reviewed Caregiver C's record.

Caregiver C had a hire date of 02/17/2026. Caregiver C's record contained a TB test administered on 02/17/2026 and read on 02/19/2026. Caregiver C's record did not contain documentation of a communicable disease screening with a signature by a physician, a registered nurse, or a physician's assistant.

On 03/20/2026 at 12:41 PM, Surveyor interviewed Director A. Director A stated they were having trouble working with community partners to have employees screened for communicable disease upon hire company-wide. Director A showed Surveyor a TB screening form the county used for employees when getting their TB tests, but it was specific to TB only.

On 03/31/2026 at 3:00 PM, Surveyor interviewed Director A. Director A stated they were working on correcting staff screenings for communicable disease through a community entity due to them not having a Registered Nurse (RN) on staff. Surveyor gave Director A a deadline until 12:00 PM on 04/01/2026 to get Caregiver C's communicable disease screening.

On 04/01/2026 at 1:24 PM, Surveyor received an email from Director A that did not contain documentation of a communicable disease screening with a signature by a physician, a registered nurse, or a physician's assistant.

On 04/01/2026 at 3:01 PM, Surveyor received a phone call from Director A inquiring if documentation requested at the exit conference

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M 234	Continued From page 4 on 03/31/2026 was received. Surveyor confirmed some documentation was received, but asked about a communicable disease screening for Caregiver C. Director A stated s/he thought they had one and Surveyor gave Director A a deadline of 5:00 PM on 04/01/2026. On 04/01/2026 at 4:14 PM, Surveyor received an email from Director A that included a document titled "Team Member Communicable Disease Statement". The document included a communicable disease screening, but was signed by a Certified Medical Assistant (CMA). Caregiver C's record did not contain documentation of a communicable disease screening with a signature by a physician, a registered nurse, or a physician's assistant.	M 234		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure each resident's Individual Service Plan (ISP) or Behavioral Support Plan (BSP) contained a description of services the licensee would provide for 2 of 2 residents reviewed. Resident 1's ISP or BSP did not identify that staff	M 412		

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M 412	Continued From page 5	M 412		

were required to go outside with him/her to smoke and that Resident 1 was not allowed upstairs near Resident 2's bedroom.

Resident 2's ISP or BSP did not identify safety interventions after an incident of physical aggression towards another resident while riding in the facility vehicle on 02/13/2026.

Findings include:

On 02/27/2026, the department received a complaint related to resident services.

The provider is licensed to care for 4 residents in the client groups of developmentally disabled, traumatic brain injury, alcohol/drug dependent, correctional clients, and emotionally disturbed/mental illness.

On 03/20/2026 at approximately 10:30 AM, Surveyor interviewed Facility Supervisor (FS) E. FS E stated Resident 1 and Resident 3 were at risk for elopement.

On 03/20/2026 at 10:36 AM, Surveyor interviewed Resident 1. Resident 1 stated Resident 2 had been physically aggressive towards him/her. Resident 1 stated there was also a recent incident while riding in a vehicle where police were called. Resident 1 stated staff had split him/her and Resident 2 up in the facility. Resident 1 stated s/he was not allowed upstairs where Resident 2's room was located. Resident 1 stated s/he was scared being in the home, because s/he did not know when Resident 2 would become physically aggressive.

On 03/20/2026 at 11:07 AM, Surveyor interviewed Director A. Director A stated there was a recent

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M 412	Continued From page 6	M 412		

incident between Resident 1 and Resident 2 in the facility vehicle where Resident 2 became physically aggressive towards Resident 1 when Resident 1 kept calling him/her a liar.

On 03/20/2026 at approximately 11:50 AM, Surveyor observed Caregiver D go outside with Resident 1 while s/he smoked.

On 03/20/2026 at 12:26 PM, Surveyor interviewed Caregiver D. Caregiver D confirmed Resident 1 was not allowed upstairs and s/he had to be with Resident 1 while s/he smoked outside due to his/her elopement risk.

On 03/20/2026, Surveyor reviewed Resident 1's and Resident 2's records.

An incident report dated 02/13/2026, indicated while in the facility vehicle Resident 1 called Resident 2 a liar and Resident 2 became physically aggressive towards Resident 1. Resident 2 hit Resident 1 on the back of the head and staff immediately pulled over for safety. The report indicated verbal intervention from staff was partially successful in de-escalating the situation. When they returned to the facility, Resident 2 grabbed Resident 1's MP3 player and threw it on the ground, breaking it. Law enforcement was called, and Resident 2 received 2 citations. The report indicated Resident 1 and Resident 2 were monitored the remainder of the day and kept separate. Resident 1 kept entering the same room as Resident 2 and staff had to continuously redirect Resident 1 for the rest of the shift. The report indicated on days when Resident 1 and/or Resident 2 were agitated they would not be able to safely transport due to safety concerns.

An incident report indicated Resident 1 had

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eloped from the facility on 03/13/2026. The incident report indicated Resident 1 was agitated and left the facility walking down the driveway. The incident report indicated Resident 1 walked down the road and staff called the police who brought Resident 1 back to the facility.

Resident 1 was admitted on 12/04/2023 and had a guardian. Resident 1 had diagnoses that included dissociative identity disorder, adjustment disorder with mixed anxiety and depressed mood, Asperger's syndrome, attention-deficit hyperactivity disorder, bipolar disorder, current episode depressed, and oppositional defiant disorder.

Resident 1's ISP updated 12/31/2025, indicated Resident 1 struggled with peer and staff interactions. The ISP indicated Resident 1 needed redirection by staff multiple times per day.

Resident 1's BSP updated 09/16/2025, indicated Resident 1 had the following target behaviors:
1. Verbal and emotional manipulation of others to meet his/her own needs. This is defined by lying, blaming others for his/her behaviors, splitting (pitting staff against staff or client against client).
2. Elopement
3. Unnecessary/inappropriate use of emergency services, spurious calls to 911, unnecessary use of Emergency Room (ER).

Resident 2 was admitted on 01/03/2018 and had a guardian. Resident 2 had diagnoses that included developmental disability, attention-deficit hyperactivity disorder, childhood emotional disorder, and oppositional defiant disorder.

Resident 2's ISP updated 11/21/2025, indicated Resident 2 had a history of physical aggression

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towards others. The ISP indicated the provider was responsible for providing Resident 2 transportation.

Resident 2's BSP updated 06/17/2025, indicated Resident 2 had the following target behaviors:
1. Lying/stealing
2. Arguing/Bullying
3. Self-harm/Boundaries.

On 03/26/2026 at 8:13 AM, Surveyor interviewed Guardian F. Guardian F stated Resident 1 would try to elope every time s/he went out to smoke, so now staff had to be with her. Guardian F stated s/he communicated weekly with Resident 1 and spoke with Director A biweekly regarding Resident 1's behavior report. Guardian F stated s/he also met monthly with the provider and Managed Care Organization (MCO) to discuss Resident 1's care plan. Guardian F stated they were struggling to connect the MCO's BSP with the provider's ISP. Guardian F stated the provider's ISP had minimal detail, but s/he was told the provider was working on revamping their ISP structure.

On 03/31/2026 at 3:00 PM, Surveyor interviewed Director A. Director A stated s/he was unsure when it was implemented for Resident 1 to have staff with him/her while smoking outside and when s/he was not allowed to go upstairs. Director A confirmed both interventions were not in the ISP. Director A stated after Resident 2's physical aggression incident in the facility vehicle on 02/13/2026, staff were instructed to utilize on-call staff if Resident 1 or Resident 2 was agitated to stay with them at the facility while the other resident was transported. Director A stated they were combining their ISP and BSP together for staff to have only one place to look up

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M 412	Continued From page 9 information on a resident. Resident 1's ISP or BSP did not address Resident 1 requiring staff to go outside with him/her to smoke and that s/he was not allowed to go upstairs where Resident 2's bedroom was located. Resident 2's ISP or BSP did not address transportation safety interventions after an incident of physical aggression towards another resident. Cross Reference M0134 DHS 88.03(5)(e)1 Significant Change To The Resident	M 412		