STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**475 GOLFVIEW AMERY, WI 54001**

(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 01/24/2024, Surveyor conducted a complaint investigation at Riverbend. Data was collected through 01/25/2024. The complaint was substantiated. Nine deficiencies were identified. One of 9 deficiencies was a repeat violation. See Statement of Deficiency 5KCX11, dated 05/14/2018. Census: 5	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.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not report caregiver misconduct to the Department after they concluded a staff member slapped the hand of a resident. The provider did not investigate allegations of neglect when staff reported a caregiver sleeping while working. Findings include: Wis. Admin. Code § DHS 13.03(1)(a)4. Defines abuse as: "A course of conduct or repeated acts by a caregiver which serve no legitimate purpose and which, when done with intent to harass, intimidate, humiliate, threaten or frighten a client, causes or could reasonably be expected to cause the client to be harassed, intimidated, humiliated, threatened or frightened." Wis. Admin. Code § DHS 13.03(1)(a)2. Defines neglect as: "Substantially disregards a client's rights under either ch. 50 or 51, Stats., or a caregiver's duties and obligations to a client." On 01/25/2024, Surveyor reviewed the provider's policy, Resident Safety Abuse Policy, which read, in part: "It is the policy of our facility to maintain a work and living environment that is professional and free from threat and/or occurrence of harassment, abuse (verbal, physical, mental or sexual), neglect, corporal punishment, involuntary seclusion, physical or chemical restraints not required to treat the resident's medical symptoms, exploitation and misappropriation of resident property. Providing a safe environment is one of the most basic and essential duties of the facility. Employees have a unique position of trust with vulnerable residents. Having access to private information, being in a physically intrusive	N 158		

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N 158	Continued From page 2 position and having elevated status and special relationships with residents, makes ethical and professional behavior essential. Our facility promotes an atmosphere of sharing with residents and staff without fear of retribution. Residents have the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, visitors, friends, or other individuals. This system cannot guarantee that abuse will never occur. It can only assure that the facility is doing all that is within its control to prevent occurrences... PHYSICAL ABUSE includes, but is not limited to hitting, slapping, pinching, or kicking. It also includes controlling behavior through corporal punishment... NEGLECT means the failure of the facility, its employees or service providers, to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress... All facility staff members shall ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injures of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause allegation do not involve abuse and do not result in serious bodily injury, to the administrator and the administrator will ensure reporting to other officials (including to the State Survey Agency and adult protective services where state law provides jurisdiction in long-term care facilities) in accordance with state law... All alleged violations will be thoroughly investigated and all investigations are conducted by or coordinated through facility administration..."	N 158		

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N 158	Continued From page 3 On 11/17/2023, the Department received a complaint alleging an incident of caregiver misconduct was not reported to the Department. The complaint included documentation of emails between the former administrator and the current administrator, Administrator A, who was also the Regional Director of Operations. On 01/24/2024, Surveyor reviewed the emails between Former Administrator (FA) J and Administrator A. The emails included a typed statement about an incident where Caregiver K witnessed Caregiver L slap Resident 3, and also a typed document of resident interviews. The statement read: "[Caregiver K] was assisting [Caregiver L] in toileting [Resident 3] in apartment [number]. While sitting on the toilet, [Resident 3] swung [his/her] left hand out at [Caregiver L]. [Caregiver L] knelt down and slapped the top of [Resident 3]'s left hand, and stated, 'you don't hit.' [Caregiver K] is unable to recall if [s/he] assisted in getting [Resident 3] off of the toilet, or if [s/he] left the apartment at that point. [Caregiver K] is also unsure of the exact date, but states the incident did occur in the month of April 2023; prior to [him/her] getting [his/her] CBRF (community based residential facility) certification." The emails read as follows: An email, dated 10/05/2023, from FA J to Administrator A, Staff M, Staff N, and Registered Nurse (RN) O, read: "Here are the interviews I had with the residents. I will do specific education with [Caregiver K] when [s/he] works next ([s/he]'s gone for the day), and reporting education for all staff asap (as soon as possible)."	N 158		

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N 158	Continued From page 4 An email, dated 10/09/2023, from Administrator A to FA J, read: "Thank you, [FA J]. Have you completed the education of abuse policy yet?" An email, dated 10/10/2023, from FA J to Administrator A, read: "Not yet. I've gotten most everyone, but there's some casuals that I still have to get who just haven't worked since this all happened." An email, dated 10/10/2023, from Administrator A to FA J, read: "Ok, keep me posted. Thank you!" An email, dated 10/23/2023, from FA J to Administrator A, read: "Is there anything else to be done with this? The staff training on abuse is complete." An email, dated 10/23/2023, from Administrator A to FA J, read: "Nope, just put in a file and keep safe incase [sic] it ever comes up. Thanks." On 01/24/2024 at approximately 11:00 a.m., Surveyor interviewed Administrator A. Surveyor explained the purpose of the survey and requested information including all investigations into caregiver misconduct in 2023 and 2024. On 01/24/2024 at approximately 11:30 a.m., Surveyor interviewed Caregiver B, who was the staff working in the facility at that time. Surveyor asked if s/he had any concerns about staff mistreating the residents. Caregiver B said a former caregiver, Caregiver C, would scream and yell at Resident 1, which s/he explained would "set [Resident 1] off" and said Resident 1 was "freaking out." Caregiver B said s/he talked to Administrator A about it. Caregiver B said Caregiver D, who worked in the adjacent RCAC (residential care apartment complex), would also	N 158		

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N 158	Continued From page 5 yell at Resident 1 and tell Resident 1 s/he was going to call the cops on him/her. On 01/24/2024 at 1:05 p.m., Administrator A told Surveyor there were no investigations into caregiver misconduct from 2023 to present. On 01/24/2024 at approximately 2:30 p.m., Surveyor interviewed Caregiver E, who worked in the adjacent RCAC, and Caregiver F. Surveyor asked if they had any concerns about caregivers mistreating the residents. Caregiver E said s/he would come over from the RCAC to assist Caregiver G giving Resident 2 a shower. Caregiver E said Caregiver G would yell at Resident 2 and tell Resident 2 to "knock it off." Caregiver E said Resident 2 would scream "bloody murder" in the shower. Caregiver E also explained there were multiple times when s/he observed Caregiver H sleeping on the job. Caregiver E said s/he reported it to Administrator A. Caregiver E said s/he was not 18 years old and could not work in the CBRF. Caregiver H had to stay over from working the night shift and told Caregiver E s/he was going to sleep. On 01/25/2024, Caregiver E emailed Surveyor pictures of a person lying on the floor under the desk with a blanket covering them. Caregiver E included screenshots of text messages s/he sent to Administrator A. The text message indicated it was from 11/15/2023 at 7:16 a.m. The messages read as follows: Caregiver E: "hey [Administrator A]. [Caregiver H] was sleeping when i [sic] got here this morning. and [sic] now has been sleeping again since 6. [s/he] had stated [s/he] wanted me to wake [him/her] up at breakfast. i [sic] don't believe this is fair. or [sic] safe for [his/her] residents."	N 158		

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N 158	Continued From page 6 Administrator A: "Thank you [Caregiver E]. I will talk to [him/her]." Caregiver E: "your [sic] welcome. this [sic] also isn't the first time i've [sic] had to [sic] this problem with [him/her]." Caregiver E: "[s/he] still isn't waking up for me and [his/her] residents need meds and to eat breakfast" Picture of person sleeping on the floor under the desk with a blanket covering them. Administrator A: "[S/he] won't wake up?" Caregiver E: "i [sic] keep saying [his/her] name and [s/he] says huh or mumbles something and goes right back to bed" Administrator A: "[S/he] needs to get up ASAP." Caregiver E: "i've [sic] been trying since 7:20" Administrator A: "If you need help, go get someone in the care center." Caregiver E: "okay. thank you" On 01/25/2024, Surveyor reviewed the employee schedule for November 2023. The employee schedule indicated that on 11/14/2023, Caregiver H was scheduled to work from 10:00 p.m. - 6:00 a.m. in the CBRF. On 11/15/2023, there was no staff on the schedule starting at 6:00 a.m. in the CBRF. Caregiver E was scheduled to work in the RCAC starting at 6:00 a.m. on 11/15/2023. The staff schedule corroborated what Caregiver E told Surveyor and his/her pictures and text messages,	N 158		

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N 158	Continued From page 7 dated 11/15/2023. On 01/25/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A on the phone. Surveyor asked if Administrator A was aware of an incident when Caregiver L allegedly slapped Resident 3's hand. Administrator A told Surveyor, "It doesn't ring a bell to me." Surveyor asked if Administrator A made any reports to the Office of Caregiver Quality. Administrator A said s/he had on the skilled nursing facility side, but not on the assisted living side. Surveyor explained to Administrator A that Surveyor had copies of emails between him/her and FA J, where s/he told FA J to file the investigation. Administrator A said s/he was reviewing his/her emails and then did remember the incident. Administrator A told Surveyor, Caregiver K no longer worked at the facility at the time of investigation and there were no further concerns, so s/he told FA J to file the report. Surveyor asked Administrator A about allegations related to Caregiver H sleeping on the job. Administrator A said s/he was aware of those allegations and they were addressed. Administrator A said s/he counseled Caregiver H. Surveyor asked if Administrator A conducted an investigation. Administrator A said s/he did not as Caregiver H denied the allegation. Administrator A told Surveyor s/he did not consider the allegation to be caregiver misconduct. Surveyor asked if s/he was aware of allegations of Caregiver C yelling at Resident 1. Administrator A said s/he was not aware. Surveyor asked if Administrator A was aware of allegations of Caregiver D yelling at Resident 1. Administrator A said Caregiver D worked in the adjacent RCAC and did not know why s/he would be in the CBRF. Administrator A said s/he was not aware of these allegations. Surveyor asked if Administrator A was aware of	N 158		

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N 158	Continued From page 8 allegations of Caregiver G yelling at Resident 2. Administrator A said s/he was not aware. Administrator A, who was the Regional Director of Operations, did not report to the Department when s/he discovered Caregiver L slapped a resident. Administrator A did not investigate allegations of Caregiver H sleeping.	N 158		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the Department of multiple changes in administrators. Findings include: On 01/24/2024 at approximately 11:00 a.m., Surveyor conducted an unannounced survey at the facility. The Department documentation indicated Former Administrator (FA) P was the administrator. Caregiver B was working in the facility at the time. Caregiver B told Surveyor they did not have an administrator. At approximately 11:15 a.m., Administrator A came to the facility. Surveyor conducted an entrance conference with Administrator A. Surveyor reviewed contact information on the facility's face sheet for the Department. Administrator A, who was also the Regional Director of Operations, told Surveyor that s/he should be listed as the interim administrator. Surveyor reviewed email contacts, which were also outdated.	N 200		

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N 200	Continued From page 9 On 01/25/2024 at approximately 3:30 p.m., Surveyor conducted an exit interview with Administrator A. Surveyor asked questions related to an incident that was investigated in October 2023. Administrator A told Surveyor FA J was the administrator at that time. The Department did not receive notification when FA J became the administrator. Surveyor reviewed the requirement to notify the Department within 7 days after there was a change in an administrator with Administrator A. The licensee did not notify the Department of multiple changes in administrators.	N 200		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on record review and interview, the administrator did not supervise the daily operations, including: supervision to ensure received proper care and services, that the residents' health and safety were protected and promoted, and their rights were respected.	N 214		

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N 214	Continued From page 10 Findings include: The provider is licensed to care for up to 11 residents in the client groups of irreversible dementia/Alzheimer's disease, and advanced age. On 11/17/2023, the Department received a complaint with multiple allegations, including concerns with staffing and no oversight by the administrator. On 01/24/2024, at approximately 11:00 a.m., Surveyor entered the facility to conduct an unannounced complaint investigation. Caregiver B was working in the community based residential facility (CBRF). Surveyor asked who was in charge. Caregiver B said, "We lost our administrator and lead." Administrator A, who was the Regional Director of Operations, came to the CBRF. Surveyor conducted an entrance conference with him/her. Administrator A was not listed as the administrator on the Department's documentation for the facility. Administrator A said s/he should be listed as the interim administrator. Surveyor asked Administrator A who was in charge when s/he was not present at the facility. Administrator A said staff could contact Registered Nurse (RN) O, who was the regional nurse, or the nursing home administrator, or the director of nursing at the skilled nursing facility located next door. On 01/24/2024 at approximately 11:30 a.m., Surveyor interviewed Caregiver B. Caregiver B said Administrator A was in charge of all the buildings. Caregiver B said Administrator A did not respond to emails and text messages. Surveyor asked what happened when they were not able to	N 214		

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N 214	Continued From page 11	N 214		

get a hold of Administrator A. Caregiver B said, "If I can't get a hold of [him/her], we have to figure it out." Caregiver B told Surveyor s/he did not know who RN O was. S/he said s/he has called the nursing home administrator to help with maintenance issues. S/he said s/he did not know who the director of nursing in the nursing home was. Caregiver B explained concerns the administrator's office was locked and contained resident records and resident funds. Caregiver B said they had people call to be admitted and nobody calls them back. S/he said people have applied for open positions and nobody is getting back to them.

On 01/24/2024 at approximately 12:00 p.m., Surveyor interviewed Caregiver R. Caregiver R was working in the adjacent residential care apartment complex (RCAC). Caregiver R said s/he was starting to job shadow in the CBRF as well. Surveyor asked Caregiver R who was in charge. Caregiver R said there was not anyone in charge currently, but after s/he gets trained s/he will be the lead. Caregiver R said s/he would reach out to Administrator A if s/he had any problems. S/he said Administrator A was present in the facility (facility is combined CBRF and RCAC) 2 days a week.

On 01/24/2024 at approximately 12:30 p.m., Surveyor interviewed Cook S. Cook S told Surveyor there was no administrator right now. S/he said, "Been on our own last month, doing the best we can."

On 01/24/2024 at approximately 2:30 p.m., Surveyor interviewed Caregiver F. Caregiver F said Administrator A was present twice per week. S/he said when Administrator A was not present, they "figure it out." Caregiver F said a nurse, the

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N 214	Continued From page 12 MDS coordinator from the nursing home, has assisted. S/he said that in the evenings, staff could call Caregiver F or Administrator A. Caregiver F confirmed she held the keys for the administrator's office and only lived a couple miles from the provider. On 01/24/2024 and 01/25/2024, Surveyor reviewed resident records, employee records and staffing schedules. Based on Surveyor's interviews and record reviews, Surveyor substantiated the complaint and identified the following deficiencies: 83.12(2)(a) Caregiver: Investigating Abuse & Neglect 83.14(2)(e) Notify Within 7 Days Of Administrator Change 83.15(3)(a) Administrator Shall Supervise Daily Operation 83.16(2) Resident Care Staff At Least 18 Years Old 83.19 Orientation 83.21(1) - (3) All Employee Training 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake 83.36(2) Maintain Current Written Staffing Schedule 83.42(3) Access To Resident Records Administrator A did not ensure resident's rights, health and safety were protected by not investigating allegations of caregiver misconduct and not reporting caregiver misconduct to the Department. Administrator A did not ensure residents received proper care and services by not ensuring staff received training applicable to the CBRF. Administrator A did not ensure there was a delegated qualified care staff present at all times to provide oversight to the care and	N 214		

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N 214	Continued From page 13 services the residents received.	N 214		
N 218	83.16(2) Resident care staff at least 18 years old Resident care staff shall be at least 18 years old. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident care staff was at least 18 years old. Findings include: On 01/24/2024 at approximately 2:30 p.m., Surveyor interviewed Caregiver E, who worked in the adjacent residential care apartment complex (RCAC). Caregiver E told Surveyor s/he was not 18 years old and did not work in the community based residential facility (CBRF). S/he said s/he did come over to the CBRF to assist staff with giving Resident 2 a shower. On 01/25/2024, Surveyor emailed Caregiver E and asked what his/her date of birth was and how many times s/he assisted in the CBRF. Caregiver E replied, "My date of birth is 06/28/2006. I have helped with 3 different resident's showers. One of them was two to three different times and the other ones were just once. I have only helped because the attendants try to tell me they are allergic to their shampoo or that they can't do it alone..." On 01/25/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A on the phone. Surveyor asked if Administrator A had a waiver for Caregiver E to work and provide resident care in the CBRF. Administrator A told	N 218		

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N 218	Continued From page 14 Surveyor s/he did not have a waiver for Caregiver E to work in the CBRF.	N 218		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees reviewed received training in recognizing and responding to resident changes of condition prior to the 3 of 3 employees performing their job duties. Findings include: The provider is licensed to care for up to 11 residents in the client groups of irreversible dementia/Alzheimer's disease and advanced age. On 11/17/2023, the Department received a complaint alleging staff were working in the facility that were not trained for the community based residential facility (CBRF).	N 230		

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N 230	Continued From page 15 On 01/24/2024, Surveyor reviewed employee files for Caregiver B and Certified Nursing Assistant (CNA) Q. Caregiver B's date of hire was 09/29/2023. CNA Q's date of hire was not listed on the roster. S/he was listed as skilled nursing facility staff that assisted in the CBRF. Caregiver B and CNA Q's training did not include documentation they received training in recognizing and responding to resident changes of condition. On 01/25/2024, Surveyor emailed Administrator A and requested any other documentation of training for Caregiver B and CNA Q. Surveyor also requested training documentation for Caregiver H. On 01/25/2024, Administrator A emailed Surveyor with the requested information. Caregiver H's date of hire was 01/14/2023. Surveyor did not receive documentation to indicate Caregiver B, CNA Q, and Caregiver H received training in in recognizing and responding to resident changes of condition. On 01/25/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A. Surveyor reviewed training requirements with Administrator A and explained concerns that Caregiver B, CNA Q, and Caregiver H did not have documentation in recognizing and responding to resident changes of condition. Surveyor told Administrator A to email Surveyor by 01/26/2024 with any	N 230		

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N 230	Continued From page 16 additional training. Surveyor did not receive any additional documentation of training.	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of	N 243		

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N 243	Continued From page 17 property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers reviewed obtained all training as required within 90 days after starting employment. Caregiver B and Caregiver H did not have training in resident rights within 90 days after starting employment. Caregiver B and Caregiver H did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment. Caregiver B and Caregiver H did not have training in required client groups within 90 days after starting employment. Findings include: On 01/24/2024 and 01/25/2024, Surveyor conducted a review of 2 caregivers to verify compliance with all employee training requirements. Surveyor requested training records from Administrator A for Caregiver B and Caregiver H. Resident Rights	N 243		

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N 243	Continued From page 18 The record for Caregiver B, hired 09/29/2023, did not contain evidence of training or evidence of meeting an exemption for resident rights. The record for Caregiver H, hired 01/14/2023, did not contain evidence of training or evidence of meeting an exemption for resident rights. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver B, hired 09/29/2023, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. The record for Caregiver H, hired 01/14/2023, did not contain evidence of training or evidence of meeting an exemption for challenging behavior training. Client Group The provider is licensed to provide care and services to residents within the client groups of irreversible dementia/Alzheimer's disease and advanced age. The record for Caregiver B, hired 09/29/2023, did not contain evidence of training or evidence of meeting an exemption for client group training. The record for Caregiver H, hired 01/14/2023, did not contain evidence of training or evidence of meeting an exemption for client group training. On 01/25/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A. Surveyor reviewed training requirements with Administrator A and explained concerns that caregivers	N 243		

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N 243	Continued From page 19 reviewed did not have documentation in: resident rights, challenging behavior, and client groups. Surveyor told Administrator A to email Surveyor by 01/26/2024 with any additional training. Surveyor did not receive any additional documentation of training.	N 243		
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 record review and interview, the provider did not ensure at least one qualified resident care staff was present, on duty and awake, when at least one resident was in need of	N 397		

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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. This had the potential to effect 5 of the 5 residents.

This is a repeat violation. See Statement of Deficiency (SOD) 5KCX11, dated 05/14/2018.

Findings include:

The provider is licensed to care for up to 11 residents in the client groups of irreversible dementia/Alzheimer's disease and advanced age. On 01/24/2024, the resident census was 5.

On 11/17/2023, the Department received a complaint alleging staffing concerns.

A qualified resident care staff is defined as an employee who has successfully completed all of the applicable training and orientation.

On 01/24/2024 at approximately 11:00 a.m., Surveyor entered the facility. The main door opens to a lounge area that is a common space between the community based residential facility (CBRF) and residential care apartment complex (RCAC). The CBRF is a memory care unit that has a locked door to enter. Caregiver B was working in the CBRF at the time. Surveyor interviewed Caregiver B and asked what the staffing schedule was for the facility. Caregiver B said there was 1 staff in the CBRF on all shifts. S/he explained there was 1 staff in the RCAC

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from 6:00 a.m. - 10:00 p.m. Caregiver B said that if a tenant in the RCAC would need assistance after 10:00 p.m., staff from the CBRF would have to leave and assist in the RCAC, leaving the CBRF with no staff members present.

On 01/24/2024, Surveyor reviewed the residents' face sheets and individual service plans (ISP).

Resident 1's individual service plan (ISP) indicated s/he had an activated power of attorney (POA) and was an elopement risk.

Resident 2's ISP indicated s/he had an activated POA and required 24-hour supervision.

Resident 4's ISP indicated s/he had an activated POA and required 24-hour supervision.

Resident 5 was a new admit. S/he admitted to the facility on 01/16/2024 with a diagnosis of Alzheimer's disease. S/he had an activated POA.

Resident 6's ISP indicated s/he had dementia and would occasionally exit seek. S/he was also an insulin dependent diabetic.

Five of the 5 residents would require at least one resident care staff to be on duty and awake 24 hours.

On 01/24/2024 at approximately 12:55 p.m., Surveyor interviewed Administrator A. Administrator A was also the Regional Director of Operations. Administrator A confirmed to Surveyor there was 1 staff in the CBRF and 1 staff in the RCAC, except on the overnight shift, there were no staff scheduled for the RCAC. Surveyor asked what happened if an RCAC tenant required assistance at night. Administrator

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N 397	Continued From page 22 A told Surveyor the RCAC would ring their pendant, which would go to the CBRF staff. The CBRF staff was to call staff at the neighboring skilled nursing facility (SNF) and have a certified nursing assistant (CNA) from the SNF go to the RCAC to assist the tenant. On 01/24/2024 at 2:10 p.m., Surveyor interviewed Caregiver B. Caregiver B told Surveyor that Caregiver R, who was working in the RCAC, left at around 1:45 p.m., as s/he had to go pick up his/her kids. Surveyor asked if any staff were working in the RCAC. Caregiver B said no. S/he said Caregiver E was coming in to work in the RCAC, but s/he was still at school. On 01/24/2024 at approximately 2:30 p.m., Surveyor interviewed Caregiver E and Caregiver F. Surveyor asked how often between shifts was there only 1 staff for both the CBRF and RCAC. Caregiver E and Caregiver F said it happens more than 50% of the time. Caregiver F told Surveyor that on 01/12/2024, from 6:00 p.m. - 9:00 p.m., s/he was the only staff for both the CBRF and the RCAC. Caregiver F told Surveyor s/he had to leave the CBRF to administer medications to the tenants in the RCAC. At the time of survey, there were 10 tenants in the RCAC. The CBRF was left with no staff while Caregiver F was administering medications in the RCAC. Surveyor asked what would happen if a tenant in the RCAC would need assistance on the overnight shift. Caregiver F said the tenants do not usually ring for help, but if they did, staff from the CBRF would have to leave and assist in the RCAC. Caregiver E told Surveyor s/he was only 17 years old and did not work in the CBRF. Caregiver E said s/he observed Caregiver H sleeping on the floor under the desk when Caregiver H was the only staff working in the	N 397		

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N 397	Continued From page 23 CBRF. Caregiver E told Surveyor s/he reported Caregiver H sleeping on several occasions to Administrator A. On 01/25/2024, Caregiver E emailed Surveyor a picture of a person laying on the floor, under a desk, with a blanket covering them. S/he also emailed Surveyor screenshots of text messages between him/herself and Administrator A informing Administrator A that s/he could not wake Caregiver H. On 01/24/2024 and 01/25/2024, Surveyor reviewed training records for Caregiver B, Caregiver H, and CNA Q, all of which were identified as working alone in the CBRF. The record for Caregiver B did not contain documentation of recognizing and responding to a resident's change in condition, resident rights, client groups, and challenging behavior. The record for Caregiver H did not contain documentation of recognizing and responding to a resident's change in condition, resident rights, client groups, and challenging behavior. The record for CNA Q did not contain documentation of completion of the department-approved fire safety training. Caregiver B, Caregiver H, and CNA Q were not qualified resident care staff as they did not complete all of the required training. The schedule identified Caregiver B worked the following dates alone in the CBRF from 12/01/2023 - 01/24/2024: 12/1, 12/2, 12/3, 12/7, 12/13, 12/17/, 12/20, 12/21, 12/22, 12/23, 12/24, 12/26, 12/27, 12/28,	N 397		

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N 397	Continued From page 24 12/29, 12/30, 12/31, ½, ¼, 1/5, 1/9, 1/10, 1/12, 1/13, 1/14, 1/18, 1/19, 1/23, and 1/24. The schedule identified Caregiver H worked the following dates alone in the CBRF from 12/01/2023 - 01/24/2024: 12/5, 12/6. 12/9, 12/11, 12/12, 12/19, 12/20, 12/23, 12/26, 1/6, 1/9, 1/10, 1/11, 1/16, 1/18, and 1/20. The schedule identified CNA Q worked the following dates alone in the CBRF from 12/01/2023 - 01/24/2024: 12/29, 12/30, 12/31, ½, 1/3, ¼, 1/5, 1/6, 1/7, 1/8, 1/17, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23, and 1/24. The provider did not ensure there was a qualified resident care staff present, on duty and awake at all times. Cross References: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0230 DHS 83.19 Orientation N0243 DHS 83.21 All Employee Training N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule	N 397		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the	N 399		

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N 399	Continued From page 25 provider did not maintain an accurate staffing schedule. Findings include: The provider is licensed to care for up to 11 residents in the client groups of irreversible dementia/Alzheimer's disease, and advanced age. On 11/17/2023, the Department received a complaint alleging staffing concerns at the facility. On 01/24/2024 at approximately 11:15 a.m., Surveyor conducted an entrance interview with administrator A. Surveyor requested the staff schedule from 11/15/2023 to present. On 01/24/2024 at approximately 2:30 p.m., Surveyor reviewed the employee schedule with Caregiver F. Caregiver F told Surveyor the employee schedule was not accurate. Caregiver F told Surveyor s/he worked on 01/12/2024 and worked alone for both the CBRF (community based residential facility) and RCAC (residential care apartment complex) between the hours of 6:00 p.m. and 9:00 p.m. On 01/24/2024, Surveyor requested Administrator A email Surveyor a sample of timesheets for January 2024. On 01/25/2024, Surveyor compared a sample of employee timesheets to the staff schedule and found the following discrepancies: On 01/10/2024, the schedule indicated Caregiver B worked "6-2" and "8-10" in the CBRF. Caregiver B's timesheet for 01/10/2024 indicated s/he worked 6:26 a.m. - 8:09 p.m. on 01/10/2024.	N 399		

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N 399	Continued From page 26 On 01/12/2024, the staff schedule did not indicate Caregiver F worked. Caregiver F's timesheet indicated s/he worked from 1:43 p.m. - 10:29 p.m. on 01/12/2024. On 01/13/2024, the staff schedule indicated Caregiver B worked "6-2" and "2-10" in the CBRF. Caregiver B's timesheet indicated s/he worked from 6:21 a.m. - 8:05 p.m. on 01/13/2024. The provider did not maintain an accurate staffing schedule.	N 399		
N 480	83.42(3) Access to resident records. The employee in charge on each work shift shall have a means to access resident records. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident records were available to all employees on each shift. Findings include: The provider is licensed to care for 11 residents in the client groups of irreversible dementia/Alzheimer's disease, and advanced aged. On 11/17/2023, the Department received a complaint that resident records were locked in the administrator's office and staff could not access the records. On 01/24/2024 at approximately 11:00 a.m., Surveyor interviewed Caregiver B, who was	N 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**475 GOLFVIEW AMERY, WI 54001**

(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 480	Continued From page 27 working in the facility. Caregiver B told Surveyor the resident records were locked in the office and nobody was currently working in that office. Caregiver B showed Surveyor the records they had access to, which included: resident face sheets, individual service plans, evacuation assessments, medication administration record, and the cleaning schedule. Caregiver B said Caregiver F had a key to the office. Caregiver B said Caregiver F worked as a casual employee and was leaving employment there soon. On 01/24/2024 at approximately 2:15 p.m., Surveyor interviewed Caregiver F. Caregiver F told Surveyor s/he had a key for the office and lived approximately 2 miles away from the provider. Caregiver F said an office person at the skilled nursing facility also had a key to the office. Caregiver F confirmed the resident records were kept in the locked office. Surveyor asked if physician's orders were in the resident records in the office. Caregiver F confirmed they were. The provider did not ensure resident records were available to an employee in charge, each shift. If staff were to administer a medication in the middle of the night and wanted to verify the medication administration record with the physician's orders, they would not have access to do so.	N 480		