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 _____	R-C 08/13/2025

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 07/30/2025, Surveyors began a standard survey, verification visit, and complaint investigation at Riverbend. Data was collected through 08/13/2025. One of 2 complaints was substantiated. Two of 4 violations from Statement of Deficiency (SOD) V5OS12 were corrected. Twenty new violations were identified. Five violations were repeat deficiencies. See Statement of Deficiency (SOD) V5OS12, dated 06/06/2024, SOD V5OS11, dated 01/25/2024, SOD P9R012, dated 05/31/2023, and SOD P9R011, dated 03/08/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 8.	{N 000}		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an investigation occurred when a resident had an injury that was not observed and could be adequately explained by	N 161		

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

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N 161	Continued From page 1 the resident. On 04/15/2025, the Department received a complaint regarding resident care. 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 aged. On 07/30/2025, Surveyors reviewed the record of Resident 5, who was admitted on 03/24/2025 and diagnosed with dementia, generalized anxiety disorder, and insomnia. Resident 5 had an activated power of attorney. -A progress note entry, dated 05/06/2025, read, "When staff was changing resident's clothes [sic] staff saw a large bruises [sic] on residents L [left] hip and underneath left arm. Staff asked resident "what happened?" [sic] and resident would not answer ..." On 07/31/2025, from 2:30 PM to 3:45 PM, Surveyors interviewed Administrator A, who stated s/he was unable to provide an investigation into Resident 5's bruising as an investigation had not been completed. Administrator A stated Resident 5 was very active, constantly moving, exit seeking, hitting walls, and aggressive with staff, and the bruising could have occurred during any of these incidents. The provider did not investigate an injury of unknown origin. Cross reference:	N 161		

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N 161	Continued From page 2 N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 161		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's physician was immediately notified when there was an incident or injury to the resident, or a significant change in the resident's physical or mental condition. 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 ages. On 07/31/2025 at 10:35 AM, Surveyors received an email communication from Administrator A that included all the resident incident reports from 01/01/2025 to 07/30/2025. There were 22 incident reports. All the reports indicated the family/legal representative was notified of the	N 169		

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N 169	Continued From page 3 incident. None of the incident reports indicated the resident's physician was notified. On 08/05/2025, from 1:42 PM to 2:02 PM, Surveyor interviewed Assistant Administrator (AA) B, who stated it was the responsibility of staff to complete notifications to the resident's legal representative and medical provider. AA B stated that in October 2024, they held a staff training, but s/he did not think the training included notifying the resident's medical provider. The provider did not notify the resident's medical provider when there was an incident, injury, or significant change in condition. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 169		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure compliance with all laws governing the operation of the program and facility. Findings include: The provider is licensed to care for 11 residents in the client groups advanced aged, and irreversible	N 196		

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N 196	Continued From page 4 dementia/Alzheimer's disease. Between March 2023 and July 2025, the Department investigated 10 complaints; 4 of the 10 complaints were substantiated related to the provider's administration, program services, staff training and staff proficiency, and resident rights. In this same timeframe, the provider received 7 Statements of Deficiencies (SOD) that included violations of 44 regulations (See SOD V5OS13, dated 08/13/2025, SOD V5OS12, dated 06/06/2024, SOD V5OS11, dated 01/25/2024, SOD P9R013, dated 11/09/2023, SOD P9R012, dated 05/31/2023, and SOD P9R011, dated 03/08/2023). Six of the 44 regulations were repeat violations, that included: - DHS 83.17(2)(a) Employees Screened For Communicable Disease - This violation was cited 2 times. See SOD V5OS13, dated 08/13/2025 and SOD P9R011, dated 03/08/2023. - DHS 83.37(1)(e) Medication Regimen, Administration Review - This violation was cited 3 times. See SOD V5OS13, dated 08/13/2025, SOD P9R012, dated 05/31/2023, and SOD P9R011, dated 03/08/2023. - DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs - This violation was cited 2 times. See SOD V5OS12, dated 06/06/2024, and SOD P9R013, dated 11/09/2023. - DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation - This violation was cited 3 times. See SOD V5OS13, dated 08/13/2025, SOD V5OS12, dated 06/06/2024, and SOD V5OS11, dated 01/25/2024 . - DHS 83.19 Orientation - This violation was cited	N 196		

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N 196	Continued From page 5 2 times. See SOD V5OS13, dated 08/13/2025, and SOD V5OS11, dated 01/25/2024. - DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake - This violation was cited 2 times. See SOD V5OS13, dated 08/13/2025, SOD V5OS12, dated 06/06/2024, and SOD V5OS11, dated 01/25/2024. Between 2023 and 2025, the Department issued special order enforcements to the provider that included, among other things: - Orders to achieve and maintain substantial compliance of all regulations within 45 days. (See the Notice and Order letter issued with SOD V5OS12, dated 07/25/2025, SOD V5OS11, dated 03/12/2024, and SOD P9R013, dated 01/19/2024.) - Orders for the licensee to ensure an administrator supervises the daily operation to ensure the provision of services to meet residents' needs. (See the Notice and Order letter issued with SOD V5OS12, dated 07/25/2025, and SOD V5OS11, dated 03/12/2024.) - Orders for the licensee to ensure sufficient, qualified staff members are on duty, present, and available to assist residents at all times. (See the Notice and Order letter issued with SOD V5OS12, dated 07/25/2025, SOD V5OS11, dated 03/12/2024, and SOD P9R013, dated 01/19/2024.) - Orders for the licensee to provide in-service training to managers and care staff regarding the provider's written procedures to address deficiencies within 45 days. This in-service training was to address qualified and adequate	N 196		

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N 196	Continued From page 6 staff, necessary skills and training, staffing patterns, evacuations, and emergency procedures. (See the Notice and Order letter issued with SOD V5OS12, dated 07/25/2024.) The current survey was prompted by a standard licensure survey, 2 complaints, and a verification visit of SOD V5OS12. SOD V5OS12 included 4 violations. The Department found that 2 of the 4 deficiencies were repeat deficiencies. The survey identified 20 additional deficiencies. One complaint was substantiated. Based on the results of the current survey, the provider did not ensure all special orders were followed. The provider has displayed a pattern of ongoing noncompliance and the inability to maintain compliance with the regulations governing the operation. Cross references: N0161 DHS 83.12(3)(a) Investigate Injuries Of Unknown Source N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0230 DHS 83.19 Orientation N0247 DHS 83.22(1)-(4) Task Specific Training N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 196		

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N 196	Continued From page 7 N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0404 DHS 83.37(1)(e) Medication Regimen, Administration Review N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0492 DHS 83.45(1)(a) Exterior Areas N0496 DHS 83.45(1)(e) Electrical, Mechanical, Water Supply N0504 DHS 83.46(1)(c) Heating System Maintenance N0507 DHS 83.46(1)(f) Combustibles N0521 DHS 83.47(1)(c) Safety Requirements: No Safe Evacuation N0523 DHS 83.47(2)(b) Exit Diagram N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills N0617 DHS 3.55(6)(b) Bath And Toilet Areas: Water Temperature	N 196		
{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 observation, interview and record	{N 214}		

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{N 214}	Continued From page 8 review, the provider did not ensure an administrator supervised the daily operation of the facility, programming, and personnel, in a way that ensured proper care and treatment, health and safety were protected, and rights were respected. This is a repeat violation. See Statement of Deficiencies (SOD) V5OS12, dated 06/06/2024, and SOD V5OS11, dated 01/25/2024. Findings include: The provider is licensed to care for 11 residents in the client groups advanced aged, and irreversible dementia/Alzheimer's disease. On 04/15/2025 and 05/08/2025, the Department received complaints regarding resident care. On 07/30/2025, at approximately 9:20 AM, Surveyors conducted an entrance meeting with Administrator A. Surveyors requested multiple records to include: -Resident pre-admission health screen and tuberculosis test results -Employee pre-hire health screen and tuberculosis test results -Furnace inspection -Hot water temperature testing logs -Fire drill documentation from 2023 and 2024 -Other safety drill documentation from 2023 and 2024 -Annual medication regimen reviews for 2023 and 2024 -Employee training records At approximately 9:40 AM, Surveyors interviewed Administrator A and Maintenance C.	{N 214}		

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{N 214}	Continued From page 9 Administrator A stated s/he began employment in July 2024 and was not sure s/he could provide records from 2023 as s/he was not an employee. Maintenance C stated s/he began employment in July 2024 and did not know where any records were kept from before his/her employment. Maintenance C stated s/he did not know s/he should be testing water temperatures at fixtures used by residents, and did not know of any furnace inspection being completed. Maintenance C could only provide fire drills from 3 out of 4 quarters in both 2023 and 2024, and did not provide any documentation of other safety drills for 2024. One of 2 complaints were substantiated, and the following issues were identified during the course of the survey: - Water temperatures at fixtures used by residents exceeded 115 degrees Fahrenheit. - Resident injuries of an unknown source were not investigated. - Required parties were not notified after resident injuries had occurred. - Residents were not screened for communicable diseases, including tuberculosis, prior to admission. - Resident pre-admission assessments were not completed. - Resident service plans were not updated as required. - Resident records were not maintained. - Communicable disease screening for staff was not completed prior to hire. - Change of condition training was not completed by staff upon hire. - Task-specific training was not completed by staff providing personal cares and performing dietary duties.	{N 214}		

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{N 214}	Continued From page 10 - At least one qualified staff was not in charge or on duty at all times. - Annual medication administration reviews were not completed. - The exterior building was not maintained. - The interior of the building was not clean or in good repair. - The heating system was not maintained or inspected. - Electrical, mechanical, water supply, plumbing, and fire protection systems were not maintained in a safe and functioning condition. - Combustible materials were placed within 3 feet of the furnace. - Emergency exit diagrams were not posted in conspicuous locations. - Quarterly fire drills were not completed as required. - Safety drills (other than fire) were not completed semi-annually as required. -No coordination with local fire department for point of rescue Cross references: N0161 DHS 83.12(3)(a) Investigate Injuries Of Unknown Source N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0230 DHS 83.19 Orientation N0247 DHS 83.22(1)-(4) Task Specific Training N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	{N 214}		

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{N 214}	Continued From page 11 N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0404 DHS 83.37(1)(e) Medication Regimen, Administration Review N0491 DHS 83.44(2)(c) Interior Floors, Walls And Ceilings N0492 DHS 83.45(1)(a) Exterior Areas N0496 DHS 83.45(1)(e) Electrical, Mechanical, Water Supply N0504 DHS 83.46(1)(c) Heating System Maintenance N0507 DHS 83.46(1)(f) Combustibles N0521 DHS 83.47(1)(c) Safety Requirements: No Safe Evacuation N0523 DHS 83.47(2)(b) Exit Diagram N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills N0617 DHS 3.55(6)(b) Bath And Toilet Areas: Water Temperature	{N 214}		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.	N 220		

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N 220	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees reviewed had obtained documentation from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse, indicating they had been screened within 90 days before the start of employment for clinically apparent communicable disease, including tuberculosis (TB). This is a repeat violation. See Statement of Deficiency (SOD) P9R011, dated 03/08/2023. Findings include: The provider is licensed to care for 11 residents in the client groups advanced aged, and irreversible dementia/Alzheimer's disease. On 07/30/2025, Surveyor reviewed the employee records of Caregiver D, hired 02/14/2025, and Caregiver E, hired 02/05/2025. Caregiver D's record did contain documentation of a screen for communicable disease, including TB, dated 03/18/2025, approximately 30 days after hire. Caregiver E's record did contain documentation of a screen for communicable disease, including TB, dated 03/18/2025, approximately 45 days after hire. On 07/31/2025, from 2:30 PM to 3:45 PM, Surveyors interviewed Administrator A, who stated the registered nurse at the attached facility licensed by the same provider typically completed the communicable disease screens, including TB, but there had been a staff shortage, and s/he was unable to get them completed. Administrator A stated s/he knew that the screen and TB test needed to be done at hire, but this just slipped	N 220		

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N 220	Continued From page 13 through the cracks. The provider did not ensure Caregiver D and Caregiver E were screened for communicable disease, including TB, prior to starting employment. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 220		
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 2 of 2 employees reviewed received training in recognizing and responding to resident changes of condition prior to performing their job duties. Findings include:	N 230		

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N 230	Continued From page 14 This is a repeat deficiency. See Statement of Deficiency (SOD) V5OS11, dated 01/25/2024. The provider is licensed to care for up to 11 residents in the client groups of irreversible dementia/Alzheimer's disease, and advanced aged. On 07/30/2025, Surveyor reviewed employee files for Caregiver D and Caregiver E. Caregiver D's date of hire was 02/14/2025. Caregiver E's date of hire was 02/05/2025. Caregiver D and E's training did not include documentation they received training in recognizing and responding to resident changes of condition. At 11:32 AM, Surveyor interviewed Administrator A. Surveyor inquired why there was not a record of Caregiver D and E receiving training in recognizing and responding to changes of condition. Administrator A stated s/he felt they did cover that in orientation training but was unable to find a record. Administrator A stated s/he had been working on streamlining the staff files and may have missed this. The provider did not ensure all staff received training in recognizing and responding to changes of condition prior to performing job duties. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 230		

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N 247	Continued From page 15	N 247		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation.	N 247		

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N 247	Continued From page 16	N 247		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure 1 of 2 employees reviewed, received adequate training for performing personal care and dietary duties.

Caregiver E, who performed dietary duties, did not have training in dietary services within 90 days after assuming these job duties.

Findings include:

The provider is licensed to care for 11 residents in the client groups irreversible dementia/Alzheimer's disease, and advanced age.

On 07/30/2025, Surveyor conducted a review of 2 employees to verify compliance with task-specific training requirements. Surveyor requested training records from Administrator A.

Dietary Training

The record for Caregiver E hired 02/05/2025, did not contain evidence of training, or evidence of meeting an exemption for, dietary training.

On 07/31/2025 at approximately 2:45 PM, Surveyor interviewed Administrator A, who stated the staff did not perform dietary duties. Administrator A stated the resident meals were prepared in the attached building licensed by the same provider and transported to the CBRF (community based residential facility). Administrator A confirmed staff were responsible to serve food.

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N 247	Continued From page 17 On 07/30/2025 at approximately 12:00 PM, Surveyor observed Caregiver E in the kitchen performing dietary duties such as handling food to be served to residents. Administrator A was given the opportunity to submit any additional evidence of training by 08/04/2025 but none was provided. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake	N 247		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by:	N 302		

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N 302	Continued From page 18 Based on record review and interview, the provider did not ensure 3 of 3 residents sampled had been screened for communicable diseases, including tuberculosis (TB), within 90 days before or 7 days after admission. Findings include: The provider is licensed to care for 11 residents in the client groups irreversible dementia/Alzheimer's disease, and advanced age. On 07/30/2025, Surveyor reviewed records for Resident 1, Resident 3, and Resident 4. Documentation of communicable disease screening and TB testing was missing from 3 of 3 resident records. On 07/31/2025, at approximately 2:30 PM, Surveyors interviewed Administrator A, who stated s/he did not have records of communicable disease screens or TB screen documentation for Resident 1, Resident 3, or Resident 4. The provider did not ensure that residents were screened for communicable disease, including TB. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 302		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s	N 381		

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N 381	Continued From page 19 needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents sampled had a completed pre-admission assessment. Findings include: The provider is licensed to care for 11 residents in the client groups irreversible dementia/Alzheimer's disease, and advanced age. On 07/30/2025 at approximately 9:40 AM, Surveyor reviewed the records for Resident 1, admitted 12/01/2024, Resident 3, admitted 05/04/2023, and Resident 4, admitted 05/23/2025. Two out of 3 of the residents' records did not contain a completed pre-admission assessment. On 07/31/2025 at approximately 2:30 PM, Surveyors interviewed Administrator A, who stated that it was either Assistant Administrator (AA) B or him/herself who was responsible for completing resident pre-admission assessments. Administrator A stated that s/he was not sure if	N 381		

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N 381	Continued From page 20 they had pre-admission assessments on file for Resident 1 and Resident 3. Administrator A stated that if pre-admission assessments had been completed, the records might have been stored in a bin somewhere but did not know where. The provider did not ensure that a pre-admission assessment of each resident's needs, abilities, and physical and mental condition was completed before admission. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 381		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not review and revise the individual service plan (ISP) when there was a change in	N 389		

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N 389	Continued From page 21 resident needs, abilities, or physical or mental condition. Findings include: On 04/15/2025, the Department received a complaint regarding resident care. The provider is licensed to care for 11 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. On 07/31/2025 from 2:30 PM to 3:45 PM, Surveyors interviewed Administrator A, who stated s/he was responsible for updating ISPs and s/he did not update the ISPs when falls occurred. Surveyor inquired how staff were informed of changes with residents. Administrator A stated the information was added to the medication administration record (MAR). On 08/05/2025, Surveyor reviewed the records of Residents 1, 3, 4, and 5. Resident 1 was admitted on 12/01/2024. Resident 1's Incident reports included: -"01/16/2025: unwitnessed fall...Additional Care Plan/Nurse Aide Assignment Updates...increased [sic] in frequency of overnight checks; -01/22/2025: unwitnessed fall...Additional Care Plan/Nurse Aide Assignment Updates...remind resident to ask for help...frequent checks; -04/02/2025: unwitnessed fall...Additional Care Plan/Nurse Aid Assignment Updates...do regular resident checks; -04/05/2025: unwitnessed fall...Additional Care Plan/Nurse Aid Assignment Updates...started regular checks and a toileting schedule; -04/07/2025: unwitnessed fall...Additional Care	N 389		

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N 389	Continued From page 22	N 389		

Plan/Nurse Aid Assignment Updates...hourly checks and tracking of frequency of toileting;
-04/29/2025: unwitnessed fall...Conclusion: educate staff on the importance of resident nightly checks...Additional Care Plan/Nurse Aid Assignment Updates...frequent resident checks, regular toileting;
-05/03/2025: unwitnessed fall ...Additional Care Plan/Nurse Aid Assignment Updates: [Hospice] suggests trying to prevent anxiety;
-06/24/2025: unwitnessed fall...Additional Care Plan/Nurse Aid Assignment Updates...hourly checks, make sure legs are in bed;
-06/24/2025: assisted to floor by staff during shower...Additional Care Plan/Nurse Aid Assignment Updates: bed baths should be completed on resident. Resident is not strong enough to endour [sic] a regular shower."

Resident 1's ISP was last updated 03/01/2025 and included:
-"Eye Sight [sic]...Blind
-Physical Disabilities ...Stand beside walking ...Weakness inhibiting walking ability..."

Resident 1's ISP did not include that s/he was a fall risk. Resident 1 had 9 falls since January 2025. The ISP did not include any fall interventions.

Resident 5 was admitted on 03/24/2025 and discharged in May 2025.

Resident 5's documentation included the following:
-"On 04/23/2025: No sleep, yelling at staff, hitting staff, banging on others [sic] doors, exit seeking, looking for [significant other]...
-04/23/2025: trying to get in cars in parking

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lot...redirection unsuccessful...playing in toilet...attempted to bite staff ...taking pictures off walls...
-04/24/2025: very agitated...family left...resident became agitated...
-04/25/2025:...screaming...threatening...I spent time with [him/her] but as soon as I would get up to help others...[s/he] would go right back at it...taking things...trying to eat gloves...
-04/26/2025:...hit attendant in neck...
-04/27/2025: exit seeking, banging on windows & doors, screaming, crying, combative with throwing items...hitting attendant...knocking over chairs...
-04/28/2025:...said someone was trying to kill [him/her]...weepy...screaming ...
-04/29/2025:...yelling at staff...upset and looking for [significant other]...
-04/30/2025:...refusing to leave another residents [sic] room who was sick and scared...said staff were stealing...poisoning [him/her]...hit staff 3 x in front of other resident...pulling on all doors...exit seeking...pinned staff in another resident doorway with a cart, hit staff 4 times...screaming...
-05/01/2025: ...pulled bathroom alarm ...
-05/02/2025: ...started screaming...yelling at staff + other residents...looking for food...wandering around without pants...
-05/03/2025: ...sitting in dining room w/o pants...crying...came out of room without pants...got out exit, I could not redirect [him/her]...
-05/05/2025:...agitated...pulling on other residents [sic] doors...crying...came out of room w/o pants on + wet underwear...hitting & kicking staff...screaming, yelling, exit seeking...crying ...
-05/06/2025:...yelling, hitting the wall, got in courtyard, stripping out of [his/her] clothes...staff saw large bruises on resident L [left] hip and underneath left arm...
-05/07/2025:...exit seeking and looking for

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N 389	Continued From page 24 [significant other]... -05/08/2025:...woke up soiled. Refused changing...screaming at top of lungs & hitting staff...Resident mood would change from crying to talking to laughing to yelling very quickly...refused to use silverware...swearing at staff & residents...refused to change dirty clothes...setting off door alarms... -05/10/2025:...exit seeking...punching staff...throwing self on floor...combative....hallucinations-eating/drinking (trying) things that are not in [his/her] hands..." Resident 5's ISP, dated 03/24/2025 included: -"Destruction of Property or Self, Physically or Mentally Abusive:...slams doors and throws items within reach... -Interaction with Others: occasionally aggressive." Resident 5's ISP did not include information and interventions to address elopement/exit seeking, erratic sleep patterns, screaming/yelling, heightened anxiety, continued aggression to staff, wandering without clothing, refusal of assistance to change soiled clothing, hallucinations, and becoming upset when staff were assisting other residents. The provider did not update Resident 1 and Resident 5's ISP with interventions when changes occurred. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 389		
{N 397}	83.36(1)(b) Qualified staff in charge, on duty and awake.	{N 397}		

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{N 397}	Continued From page 25 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, observation, and interview, the provider did not ensure at least one qualified resident care staff was present, when at least one resident was in need of supervision, intervention, or services on a 24-hour basis. This is a repeat violation. See Statement of Deficiencies (SOD) V5OS12, dated 06/06/2024 and SOD V5OS11, dated 01/25/2024 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.	{N 397}		

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{N 397}	Continued From page 26 A qualified resident care staff is defined as an employee who has successfully completed all of the applicable training and orientation. On 07/30/2025, Surveyors reviewed training records for Caregiver D and Caregiver E, and the staffing schedules for June 2025 and July 2025. On 07/30/2025 at approximately 12:00 PM, Surveyors observed that Caregiver E was the only care staff working in the community-based residential facility (CBRF). Surveyors observed Caregiver E preparing food for residents. -Caregiver D was hired on 02/14/25. Caregiver D's record did not include documentation of recognizing and responding to changes in condition, personal care, or dietary training. -Caregiver E was hired on 02/05/2025. Caregiver E's record did not include documentation of recognizing and responding to changes in condition, or dietary. The 2025 staff schedules indicated that Caregiver E had worked at least 2 hours of his/her shift without supervision or other trained staff in the area for 17 days in June and 19 days in July. Additionally, the staff schedule indicated that Caregiver E had been the only one working the AM shift on 5 weekend days in June and 3 weekend days in July. At approximately 9:30 AM, Surveyors interviewed Administrator A, who stated 1 caregiver was always scheduled to work in the CBRF on each shift. At approximately 9:45 AM, Surveyor interviewed Caregiver E who stated there was only 1 staff scheduled for the AM shift, the PM shift, and the	{N 397}		

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{N 397}	Continued From page 27 NOC shift. Caregiver E stated that on the weekends Administrator A and Assistant Administrator (AA) B were not scheduled. On 07/31/2025, at approximately 2:30 PM, Surveyors interviewed Administrator A. Surveyors inquired about staff serving and handling food without dietary training. Administrator A stated s/he did not know that staff needed dietary training because they do not make food. The provider did not ensure there was a qualified resident care staff present and on duty at all times. Cross references: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0230 DHS 83.19 Orientation N0247 DHS 83.22(1)-(4) Task Specific Training	{N 397}		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and	N 404		

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N 404	Continued From page 28 address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a physician, pharmacist, or registered nurse (RN) conducted an annual onsite review of the provider's medication administration. This is a repeat violation. See Statement of deficiencies (SOD) P9R012, dated 05/31/2023 and SOD P9R011, dated 03/08/2023. Findings include: The provider is licensed to care for 11 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 07/30/2025 at approximately 9:30 AM, Surveyors requested the annual medication regimen reviews for 2023 and 2024 from Administrator A. Administrator A could not provide the records. At approximately 4:00 PM, Surveyors interviewed Assistant Administrator (AA) B, who stated s/he did not know what an annual medication regimen review or pharmacy review was. AA B stated s/he would try to find records to send to Surveyors at a later date.	N 404		

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N 404	Continued From page 29 On 07/31/2025, Surveyors reviewed records provided by Administrator A via email, which included medication storage reviews for 2023 and 2024. There was no record of a medication administration review provided. The provider did not ensure an annual medication administration review was completed. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 404		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the interior floor was clean and in good repair. Findings include: The provider is licensed to care for 11 residents in the client groups advanced age and irreversible dementia/Alzheimer's disease. On 07/30/2025 at approximately 9:30 AM, Surveyors observed the carpeting in the main resident hallway was stained in multiple areas and had a run approximately 2 feet long that was covered with tape. Surveyors observed the carpeting in the resident dining area was heavily stained in multiple spots.	N 491		

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N 491	Continued From page 30 On 07/31/2025 at approximately 2:30 PM, Surveyors interviewed Administrator A, who stated the provider had put in a request to their corporate office to replace the carpeting in the dining area approximately two months prior. Administrator A stated there was no request put in to replace the carpeting in the hallway. The provider did not ensure that the interior floor was clean and in good repair. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 491		
N 492	83.45(1)(a) Exterior areas. Exterior areas. The CBRF shall maintain the yard, any fences, sidewalks, driveways and parking areas of the CBRF in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain the yard and sidewalk area of the community based residential facility (CBRF) in good repair and free of hazards. Findings include: The provider is licensed to care for 11 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. On 07/30/2025, Surveyors observed the exterior of the building and the internal courtyard. The rock landscaping in front of the building was full of weeds and the rug directly outside the front	N 492		

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N 492	Continued From page 31 entrance was covered in debris. The internal courtyard had multiple weeds, a pile of branches, and a portion of the outdoor rug had a large section detached. At approximately 10:40 AM, Surveyors interviewed Assistant Administrator (AA) B, who stated they hade a landscaping company mow the lawn, but it did not appear they completed other outdoor tasks. AA B stated Maintenance C would be responsible for other outdoor tasks and either Maintenance C or Administrator A were responsible for replacing the damaged outdoor rug. The provider did not maintain the exterior yard and sidewalk, and did not ensure an outdoor rug was in good repair. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 492		
N 496	83.45(1)(e) Electrical, mechanical, water supply Systems. The CBRF shall maintain all electrical, mechanical, water supply, plumbing, fire protection and sewage disposal systems in a safe and functioning condition. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain all electrical, mechanical, water supply, plumbing, and fire protection systems in a safe and functioning condition. Findings include:	N 496		

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N 496	Continued From page 32 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 07/30/2025 at approximately 10:30 AM, Assistant Administrator (AA) B unlocked the furnace room. Surveyor observed there was a significant amount of water on the floor. Surveyor observed water was draining from underneath the furnace towards the drain and there was a significant area of water draining from the sprinkler system. Water was covering an area of approximately 2 feet wide and there were water stains on the cement floor. AA B stated there had been repairmen on site for the sprinkler system which was in the same room as the furnace. On 07/31/2025, from 2:30 PM to 3:45 PM, Surveyors interviewed Administrator A who stated Maintenance C was responsible for the furnace and sprinkler room. Administrator A stated there was water on the floor because of the drain. Administrator A stated sprinkler repairs were needed. The provider did not maintain the electrical, mechanical, water supply, plumbing, and fire protection systems in a safe and functioning condition. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 496		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating	N 504		

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N 504	Continued From page 33 system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain the heating system in a safe and properly functioning condition, and did not have the gas furnace serviced at least once every 3 years. Findings include: The provider is licensed to care for 11 residents in the client groups of advanced aged, and irreversible dementia/Alzheimer's disease. On 07/30/2025, at approximately 9:30 AM, Surveyors requested furnace inspection records from Maintenance C. Maintenance C stated s/he was employed by the provider in July of 2024 and did not know where any records were prior to his/her start date. Maintenance C stated s/he routinely inspected the gas furnace and that each resident room had its own individual furnace. Maintenance C was unable to provide records for any furnace inspections while Surveyors were on site. Surveyors requested Assistant Administrator (AA) B send records at a later date.	N 504		

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N 504	Continued From page 34 On 07/31/2025, at approximately 7:30 AM, Administrator A provided a furnace inspection invoice, dated 05/04/2022, via email. The invoice read, in part: "...Furnace 1: CO [carbon monoxide] above 300 ppm [parts per million], heat exchanger plugged ...unit needs to be replaced [sic] Furnace 2: Need [sic]...capacitor for blower ... Furnace 3: ...heat exchanger plugged - recommend unit replacement ... Furnace 4: Need [sic]...capacitor for blower ... Furnace 5: Need [sic]...for blower...heat exchanger plugged. unit [sic] needs to be replaced. Furnace 6: Need [sic] new for blower ... Furnace 7: ...combustion no good [sic]...heat exchanger plugged, new unit needed. Furnace 8: Need [sic]...capacitor for blower ... Furnace 9: Need [sic]...capacitor for blower ... Furnace 10: Need [sic]...cap [sic][capacitor] for blower ... RTU (rooftop unit) 1:...capacitr [sic]...needs [sic] replaced. Visually inspected heat exchanger and found cracks/holes. Need [sic] new heat exchanger or new unit ...is not to be ran for safety purposes. RTU 2: RTU already condemned from earlier visit but visually inspected heat exchanger to verify, and found cracks/holes. Needs new heat exchanger or unit replaced ...is not to be ran [sic] for safety purposes ... ...Realistically Units [sic] should be getting replaced..." At approximately 2:30 PM, Surveyors interviewed Administrator A, who stated maintenance staff was sure the recommended repairs/replacements mentioned on the inspection invoice had been	N 504		

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N 504	Continued From page 35 remedied but was not sure where to find documentation of the repairs/replacements. As of 08/04/2025, Administrator A was unable to provide a current furnace inspection record or documentation that recommended repairs were completed. The provider did not maintain the heating system in a safe and properly functioning condition. The provider did not ensure a gas furnace was serviced once every 3 years. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 504		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did ensure combustible materials were not placed within 3 feet of any furnace, boiler, or water heater. 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 aged. On 07/30/2025 at approximately 10:30 AM, Surveyor toured the facility with Assistant Administrator (AA) B. AA B unlocked the furnace room. Surveyor observed there was a large	N 507		

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N 507	Continued From page 36 plastic tote (no cover) that included 2 rolls of a type of paper item. A large cardboard box with foam packaging was sitting on top of the tote. Surveyor observed these items were located within 3 feet of the furnace. On 07/31/2025 from 2:30 PM to 3:45 PM, Surveyors interviewed Administrator A, who stated Maintenance C was responsible to keep the furnace/sprinkler room clear of debris. The provider did not ensure combustible items were not placed within 3 feet of the furnace. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 507		
N 521	83.47(1)(c) Safety requirements: no safe evacuation If a resident cannot be safely evacuated from their bedroom as determined by the CBRF ' s assessment, the CBRF shall instruct the resident to remain in the resident ' s bedroom and the CBRF shall meet all of the following requirements: 1. Be sprinklered as required under s. HFS 83.48(8). 2. Notify the local fire department and identify the specific residents using point of rescue, and provide an up-to-date floor plan identifying where those resident rooms are located. 3. Have vertical smoke separation between all floors. 4. Have 24 hour awake qualified resident care staff. This Rule is not met as evidenced by: Based on record review and interview, the	N 521		

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N 521	Continued From page 37 provider did not ensure the local fire department was notified of residents using point of rescue (POR), or that there was an up-to-date floor plan identifying where POR rooms were located. 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 aged. On 07/30/2025 at 11:32 AM, Surveyor interviewed Administrator A, who stated the emergency fire evacuation procedures included residents staying in their apartments until the fire department arrived. Surveyor asked if the fire department was aware of their procedures including names/room numbers and current floor map. Administrator A stated s/he did not send a resident list or a current floor map to the fire department. On 07/31/2025 at approximately 3:00 PM, Surveyors interviewed Administrator A, who stated Maintenance C was responsible for fire drills, and that per the corporate policy, residents were to remain in place until someone assisted them out of the building. On 08/04/2025 at 8:00 AM, Surveyors received an email communication that contained the [FACILITY] Fire Procedure, that included: -" ...Wait at the front desk for the fire department, and direct them to the fire when they arrive," and "Every resident should be behind a closed door." The procedure did not include notification to the fire department of residents that required POR. The provider did not ensure the fire department was notified of residents using POR.	N 521		

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N 521	Continued From page 38 Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 521		
N 523	83.47(2)(b) Exit diagram. Exit diagram. The disaster plan shall have an exit diagram that shall be posted on each floor of the CBRF used by residents in a conspicuous place where it can be seen by the residents. The diagram shall identify the exit routes from the floor, including internal horizontal exits under par. (f) when applicable, smoke compartments or a designated meeting place outside and away from the building when evacuation to the outside is the planned response to a fire alarm. This Rule is not met as evidenced by: Based on observation and interview, the provider did ensure there were exit diagrams posted on each floor of the community based residential facility (CBRF) used by residents in a conspicuous place where it could be seen by the residents. 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 aged. On 07/30/2025 at approximately 10:30 AM, Surveyor toured the building with Assistant Administrator (AA) B. Surveyor asked AA B to point out the posted emergency exit diagrams. AA B was unable to locate any emergency exit	N 523		

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N 523	Continued From page 39 diagrams posted in the CBRF hallway or common areas. AA B stated there were exit diagrams on the back of each resident's door. The provider did not ensure emergency exit diagrams were posted in areas used by the residents. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 523		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct fire evacuation drills at	N 525		

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N 525	Continued From page 40 least quarterly in 2023 or 2024. Findings include: The facility is licensed to provide care to 11 residents from the client groups irreversible dementia/Alzheimer's disease, and advanced aged. On 07/30/2025, Surveyor requested fire drill documentation for 2023 and 2024. At approximately 9:30 AM, Surveyor interviewed Maintenance C, who stated s/he had started employment at the facility in July of 2024, and did not know where any safety drill documentation prior to his/her employment was located. Maintenance C provided fire drill documentation for 2024. Surveyor reviewed the provider's safety drill records. The records indicated fire drills had been conducted on 03/27/2024, 09/17/2024, and 12/13/2024. On 07/31/2025, at approximately 7:33 AM, Administrator A sent additional fire drill documentation for 2023 via email. The records indicated fire drills had been conducted on 04/28/2023 and 11/29/2023. Administrator A sent one fire drill report which was dated 03/30/31. The provider did not conduct fire evacuation drills at least quarterly in 2023 or 2024. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 525		

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N 526	Continued From page 41	N 526		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct an "other" (other than fire) evacuation drill, at least semi-annually. Findings include: The facility is licensed to provide care to 11 residents from the client groups advanced aged, and irreversible dementia/Alzheimer's disease. On 07/30/2025 at approximately 9:30 AM, Surveyors requested documentation of "other" evacuation drills conducted in 2023 and 2024. At approximately 9:30 AM, Surveyor interviewed Maintenance C, who stated s/he had started working at the facility in July of 2024, and did not know where any documentation for safety drills were located that had occurred prior to his/her employment. At approximately 10:59 AM, Surveyor reviewed the provider's safety binder. There were no "other" safety drills documented for 2023 or 2024. The provider did not ensure safety evacuation drills (other than fire) were conducted at least semi-annually. Cross reference:	N 526		

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N 526	Continued From page 42 N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 526		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on interview and observation, the provider did not ensure the temperature of water at fixtures used by residents was automatically regulated by valves and did not exceed 115 degrees Fahrenheit. Findings include: The provider is licensed to care for 11 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. According to his/her face sheet, Resident 1 has a diagnosis of peripheral neuropathy and macular degeneration. On 07/30/2025 at approximately 9:30 AM, Surveyor interviewed Administrator A and Maintenance C and requested documentation of water temperature testing. Maintenance C stated	N 617		

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N 617	Continued From page 43 s/he routinely checked the temperature on the facility water heater to ensure it did not exceed 140 degrees Fahrenheit but was not aware that s/he was required to check fixtures used by residents to ensure they did not exceed 115 degrees Fahrenheit. Maintenance C stated staff would usually test the hot water temperature at fixtures used by residents by feel. Administrator A stated s/he was not aware that the provider was required to test temperatures at water fixtures used by residents. At approximately 4:13 PM, Surveyors observed that hot water temperatures in resident rooms exceeded 115 degrees Fahrenheit. Surveyors tested the hot water temperatures accessible by Resident 1, Resident 2, and Resident 3. Surveyors tested the hot water at sinks in room 108, room 107, and room 103. The kitchen sink in room 108 tested at approximately 137.2 degrees Fahrenheit. The bathroom sink in room 107 tested at approximately 128 degrees Fahrenheit. The bathroom sink in room 103 tested at approximately 121.5 degrees Fahrenheit. Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017).	N 617		

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 _____	R-C 08/13/2025

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 617	Continued From page 44 The provider did not ensure hot water was at or below 115 degrees Fahrenheit at fixtures used by residents. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 617		