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	0019799	A. BUILDING: _____ B. WING _____	C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS BARABOO (THE)	601 LATTON LN PORTAGE, WI 53901

(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 06/24/2025, with information obtained through 07/08/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a probationary licensing survey and complaint investigation at Rivers Baraboo (The). As a result of the survey, 10 deficiencies were identified. The complaint was substantiated. Census: 11	N 000		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to	N 383		

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

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N 383	Continued From page 1 make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure a safety assessment was completed for Resident 1 for the use of a bed rail. Findings include: On 06/24/2025, Surveyors conducted a complaint investigation and standard survey. Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the facility on 06/03/2025. At 5:42 p.m., Surveyor interviewed Resident 1 in his/her bedroom. Surveyor observed a half rail on Resident 1's bed and asked what s/he used it for. Resident 1 stated the bed rails were not for him/her, "I guess they didn't want to take it off when I moved in." Surveyor asked Resident 1 if anyone has assessed his/her safety with the rail on the bed. Resident 1 stated no, there isn't anyone at the facility that would assess him/her anyway. Surveyor reviewed Resident 1's admission assessment/temporary service plan, dated 06/03/2025. The assessment stated, "Mobility & Transferring, Resident has a history of falls,	N 383		

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N 383	Continued From page 2 leading to hospitalization and rehab stay. Resident can ambulate short distances with assist of one and four wheeled walker but uses wheelchair for longer distances." The admission assessment/temporary service plan did not have an assessment or documentation of a side rail. There was no documentation of Resident 1 having a side rail or a safety assessment in Resident 1's record for the use of the side rail. The Department of Health Services DQA Memo 13-014 identifies the risk of "Serious injury or death which can occur when a resident or patient becomes caught (entrapped) between a bed rail and mattress or within the rail, or from injuries sustained as an individual attempts to climb over the bed rail...The use of bed rails is always accompanied by risk, regardless of their purpose." On 07/08/2025 at approximately 3:00 p.m., Surveyor interviewed Regional Director of Operations C, Health and Wellness Director G, and Vice President of Clinical Services M. All acknowledged the concern of Resident 1 not having had an assessment for his/her bed rail, but did not comment as to why Resident 1 had rails on his/her bed if s/he did not need them.	N 383		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If	N 387		

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N 387	Continued From page 3 a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the initial comprehensive individual service plan (ISP) for Resident 7 was signed by his/her legal representative acknowledging his/her involvement in, understanding of, and agreement with the plan. Findings include: On 06/24/2025, Surveyor reviewed an ISP for Resident 7, which was in a binder for ISPs that staff utilized to reference residents' care needs. The ISP was dated 04/26/2025. There were no signatures observed on the ISP. On 06/24/2025, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 04/16/2025. Resident 7 was documented as having a legal guardian. Surveyor reviewed Resident 7's ISP, dated 06/23/2025 and signed by his/her guardian on 06/24/2025 (day of the survey). At approximately 7:15 p.m., Surveyor requested from Executive Director A the signed initial 30-day	N 387		

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N 387	Continued From page 4 comprehensive ISP for Resident 7. Surveyor gave a deadline of 06/25/2025 at 12:00 p.m. to receive the ISP. On 06/25/2025, Surveyor reviewed the ISP provided, which was sent electronically by Health and Wellness Director G. The ISP was dated 06/14/2025 and was signed by Resident 7, but not his/her legal guardian. On 07/08/2025 at approximately 3:00 p.m., Surveyor interviewed Regional Director of Operations C, Health and Wellness Director G, and Vice President of Clinical Services M. Health and Wellness Director G confirmed that Resident 7 was admitted with his/her legal guardianship in place. Health and Wellness Director G confirmed that there was no evidence of Resident 7's guardian reviewing or signing his/her ISP earlier than 06/24/2025 and that it must have been an oversight.	N 387		
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.	N 389		

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N 389	Continued From page 5	N 389		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that Resident 7's individual service plan (ISP) was updated to include his/her needs related to his/her fall risk.

Findings include:

On 06/24/2025, at approximately 12:19 p.m., Surveyor observed Resident 7 eating lunch. Surveyor observed significant dark purple bruising surrounding Resident 7's right eye. When Surveyor asked Resident 7 about the bruising, Resident 7 replied that it occurred because of a recent fall s/he had. Resident 7 reported s/he experienced about 3 falls around the same recent time period and that one of them was outside on pavement.

On 06/24/2025, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 04/16/2025. Resident 7 was documented as having a legal guardian. Surveyor reviewed Resident 7's current ISP, which was signed as reviewed by his/her guardian that same day (06/24/2025). Resident 7's ISP documented that s/he was independent with transfers and mobility. Resident 7's ISP documented that Resident 7 either used a quad cane or wheelchair which s/he self-propelled for ambulation. The only information related to his/her falls was under the "Risk - Fall" heading, and documented, "Resident is a moderate risk for falls ...Resident has been identified as a fall risk ...Desired Goals & Outcome: To be free of falls."

Surveyor reviewed an active cares record for Resident 7, which also documented Resident 7

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as having a "moderate risk for falls." The start date of this "care" was documented as 04/18/2025 (shortly after Resident 7's admission), but there was no evidence of staff's responsibilities for addressing his/her fall risk. Surveyor noted that this was similar information as to his/her current ISP.

Surveyor reviewed Resident 7's observation notes from 05/01/2025 - 06/24/2025 and observed the following 2 falls documented:

- 06/06/2025 (3:30 a.m.): "Resident called staff into [his/her] room. Staff saw resident on the ground, resident told staff that [s/he] slipped out of bed. Resident was helped up, two person assist, into [his/her] chair by [his/her] bed. No injuries found on resident. Director was notified."

- 06/08/2025 (6:30 a.m.): "resident fell hit [his/her] head and [assistant director]] called 911 and took [blood pressure] but couldn't leave resident to grab anything else for any other vitals."

Surveyor reviewed an after-visit summary record dated 06/09/2025, which documented that Resident 7 was evaluated at a local emergency department after a fall. The summary documented, " ...Your [computed tomography (CT)] scan showed a hematoma of the back of your head which is a collection of blood under your skin. Your CT scans showed no brain bleed or broken bones."

In reviewing Resident 7's record, Surveyor noted that the information regarding his/her fall risk remained unchanged from 04/18/2025 (2 days after his/her admission) to the survey day and that his/her ISP did not include any interventions in place to mitigate his/her fall risk.

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N 389	Continued From page 7 On 07/08/2025 at approximately 3:00 p.m., Surveyor interviewed Regional Director of Operations C, Health and Wellness Director G, and Vice President of Clinical Services M. Health and Wellness Director G reported that s/he believed Resident 7's fall risk was possibly influenced by his/her substance use, which was an issue that staff were working on with Resident 7's guardian and care team. All acknowledged Surveyor's concern that it wasn't clear from Resident 7's ISP what interventions staff were implementing to mitigate Resident 7's fall risk.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.	N 408		

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N 408	Continued From page 8	N 408		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the administrator or qualified designees monitored at least monthly for the inappropriate use of Resident 2's as needed (PRN) psychotropic medication.

Findings include:

On 06/24/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/22/2024 with diagnoses including unspecified dementia with anxiety, major depressive disorder, panic disorder, and anxiety disorder. Resident 2's prescriptions included alprazolam 0.5 mg tablets with instructions to, "Take 1 tablet by mouth three times daily as needed for anxiety."

At approximately 12:34 p.m., Surveyor requested from Executive Director A all applicable psychotropic reviews completed for Resident 2 since November 2024 (when the provider's change of ownership took place).

In reviewing the record provided, Surveyor observed 1 psychotropic review of Resident 2's PRN alprazolam, dated 06/24/2025 (day of the survey).

At approximately 7:15 p.m., Surveyor requested from Executive Director A evidence of any other PRN psychotropic medication reviews that were completed for Resident 2. Surveyor gave a deadline of 06/25/2025 at 12:00 p.m. to receive additional records.

On 06/25/2025, Surveyor reviewed the additional records provided, which included psychotropic reviews dated 09/30/2024 (before the change of

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N 408	Continued From page 9 ownership took place), 04/01/2025, and 05/01/2025. On 06/27/2025, at approximately 10:05 a.m., Surveyor interviewed Pharmacy Manager N. Pharmacy Manager N reported that the start date of Resident 2's PRN alprazolam was 07/22/2024 but that the medication wasn't actually dispensed until October 2024. Pharmacy Manager N reported that 90 tablets of Resident 2's PRN alprazolam were dispensed in November 2024, January 2025, February 2025, April 2025, and May 2025. Surveyor again reviewed the PRN psychotropic reviews provided for Resident 2 but found no evidence of reviews having been completed for December 2024, January 2025, February 2025, or March 2025. On 07/08/2025 at approximately 3:00 p.m., Surveyor interviewed Regional Director of Operations C, Health and Wellness Director G, and Vice President of Clinical Services M. Health and Wellness Director G confirmed s/he noticed psychotropic reviews had been missing when s/he was sending them to Surveyor but that the missing reviews were prior to him/her working with the provider.	N 408		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the	N 425		

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N 425	Continued From page 10 residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that personal care services were provided adequate to the showering needs of Residents 6 or Resident 1. Findings include: Example 1 - Resident 6 On 06/24/2025, at approximately 11:35 a.m., Surveyor interviewed Resident 6. Resident 6 reported that s/he had only recently that month moved into the facility. Resident 6 reported s/he required staff assistance in the form of supervision for showering. Resident 6 reported that s/he received a shower on Wednesday after s/he moved in but had not been offered any showers since then. On 06/24/2025, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 06/07/2025. There were no diagnoses documented in Resident 6's record. An assessment completed for Resident 6 upon his/her admission (06/07/2025) documented that Resident 6 required "as needed assistance" with a frequency of "daily as needed." The	N 425		

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assessment also documented: "One staff should remain in room when showering for safety and assistance. Uses shower chair/bench. Encourage resident to help as much as possible with washing and drying."

Surveyor reviewed an active cares record for Resident 6, which also documented that Resident 6 required "as needed assistance" with bathing but did not include a frequency.

Surveyor reviewed an individual service plan (ISP) for Resident 6, which was located in a binder for ISPs that staff utilized to reference residents' care needs. The ISP was dated 06/19/2025 and documented the same assistance level as above regarding Resident 6's bathing needs. The schedule for Resident 6's bathing was documented as "Daily as needed."

At approximately 5:47 p.m., Surveyor interviewed Executive Director A. Executive Director A reported that staff were expected to document when resident showers were provided and that they documented showers in residents' electronic records. Surveyor then requested the shower documentation for Resident 6 since his/her admission from Executive Director A.

Surveyor reviewed the record provided, which was a task administration record (TAR) for the month of June 2025. Within the TAR, an entry for bathing was observed among other cares. While some of Resident 6's other care needs were recorded with times for the cares to be done, Resident 6's bathing time was recorded as "as needed." The daily bathing entries from 06/07/2025 (Resident 6's admission) through 06/08/2025 appeared to be grayed out. The daily bathing entries from 06/09/2025 through

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06/23/2025 were blank.

At approximately 6:02 p.m., Surveyor interviewed Caregiver D. Caregiver D confirmed Resident 6 was a reliable historian. When asked if s/he was aware that Resident 6 was reporting s/he only had received one shower since his/her admission, Caregiver D replied that s/he believed that wasn't true. Caregiver D reported that s/he was told by Caregiver E sometime last week that s/he gave Resident 6 a shower. Caregiver D reported that Caregiver E worked third (NOC) shifts. Caregiver D reported s/he could not recall when s/he was told this. Surveyor then observed Caregiver D approach the computer located on the medication cart and look up Resident 6's electronic record. Caregiver D reported that Caregiver E should have documented a shower for Resident 6 but confirmed s/he could not find evidence of one being documented.

At approximately 6:55 p.m., Surveyor interviewed Executive Director A, Chief Clinical Officer B, and Regional Director of Operations C. When sharing the concern that it did not seem Resident 6's shower schedule was established or that s/he was receiving opportunities to shower outside of 1 occasion since his/her admission, Executive Director A and Chief Clinical Officer B agreed with Surveyor's concern but said nothing further.

Example 2 - Resident 1

At 5:45 p.m., Surveyor interviewed Resident 1 in his/her bedroom. Surveyor also observed soiled markings on Resident 1's bed, including 2 blood spots. Resident 1 stated nothing gets cleaned and his/her bedding has not been changed since s/he moved in at the beginning of the month. Resident 1 continued to say that s/he was told

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N 425	Continued From page 13 that the bedding will be changed on bath days, but that s/he has only had one bath since s/he moved in. Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the facility on 06/03/2025. Surveyor reviewed Resident 1's progress notes which document on 06/05/2025, "Resident would like a whirlpool bath today and prefers 3pm for a time." Surveyor reviewed Resident 1's task administration record (TAR) which documented that Resident 1 need assistance with bathing/showering and showers should be completed on Wednesday evening with skin assessment. The TAR documented that Resident 1 had received 1 shower in June 2025 on 06/06/2025. At approximately 6:55 p.m., Surveyor interviewed Executive Director A, Chief Clinical Officer B, and Regional Director of Operations C. When sharing the concern that it did not seem Resident 1 was receiving opportunities to shower outside of 1 occasion since his/her admission, Executive Director A and Chief Clinical Officer B agreed with Surveyor's concern but said nothing further.	N 425		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily	N 427		

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activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents.

Findings include:

On 06/24/2025, at approximately 10:04 a.m., Surveyors arrived onsite. At approximately 10:12 a.m., Surveyor observed the posted activity schedule, which read as follows for that day and the previous day (06/23/2025):

- 06/23/2025: Morning - exercise, Afternoon - board games/cards, "PM" - craft/coloring

- 06/24/2025: Morning - coffee clutch, Afternoon - bingo/ "socolize [sic]", "PM" - craft/coloring

At approximately 10:40 a.m., Surveyor interviewed Resident 2. Resident 2 reported that when s/he first moved in activities were offered for residents but there hadn't been anything for the last several months. Resident 2 reported that s/he loved bingo and would like to see bingo offered. Resident 2 stated, "They need to get activities back." Surveyor reviewed the activity schedule of the previous day (06/23/2025) with Resident 2. Resident 2 reported that none of the listed activities took place and that there were no activities that day. When asked if coffee clutch

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(the listed activity for that morning) or any other activity took place the morning of the survey, Resident 2 replied that there was no activity.

At approximately 11:15 a.m., Surveyor interviewed Caregiver F about activity programming. Caregiver F confirmed that caregiving staff didn't typically offer activities and that there was no activity that morning. Caregiver F reported there was 1 staff that worked each shift, and that between having to do some cleanup, caring for 11 residents, passing medications, and assisting in heating up and serving meals, there was no time for the care staff to conduct activities. Caregiver F reported a few months ago there used to be a hired staff member who conducted activities for residents, but s/he left for a different job.

At approximately 11:35 a.m., Surveyor interviewed Resident 6. Resident 6 reported that s/he had only recently that month moved into the facility. Resident 6 reported s/he had never seen activities take place nor had been informed of any activities taking place. Resident 6 reported that s/he would like to see games offered to residents.

At approximately 6:29 p.m., Surveyor observed Caregiver D invite residents to a "community walk" with him/her. Surveyor then observed Caregiver D with 2 residents walking outside around the block before returning to the facility.

Throughout the rest of the time Surveyors were on site, from approximately 10:04 a.m. until 12:34 p.m. and approximately 2:00 p.m. until 7:15 p.m., Surveyors did not observe any other activity take place.

At approximately 6:55 p.m., Surveyor interviewed

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N 427	Continued From page 16 Executive Director A, Chief Clinical Officer B, and Regional Director of Operations C. Executive Director A reported that s/he thought "some" activities were being completed but was unaware which ones were compared to which ones weren't.	N 427		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by:	N 431		

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Based on record review and interview, the provider did not monitor Resident 1's intake at meals, the use of supplemental drinks, or his/her weight, as stated in the individual service plan (ISP).

Findings include:

On 06/24/2025, Surveyors conducted a complaint investigation and standard survey. The facility is licensed as a class CNA (non-ambulatory) community based residential facility, able to serve up to 14 residents within the client groups of Advanced Age and Irreversible Dementia/Alzheimer's.

On 06/25/2025, Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the facility on 06/03/2025 with diagnoses including COPD, congestive heart failure and hypothyroidism.

Surveyor reviewed Resident 1's admission assessment/temporary service plan, dated 06/03/2025. The assessment stated, "Resident receives chocolate and vanilla Ensure supplemental drinks from MCO to increase caloric intake to reach and maintain healthy weight." The desired goal is to maintain Resident 1's weight of 110 pounds.

Surveyor reviewed Resident 1's medication administration record (MAR) and task administration record (TAR) for June 2025. The TAR documented that Resident 1's vital signs and weight should be documented weekly on Wednesdays. There was no documentation of Resident 1's vital signs or weight throughout June. Neither the MAR or TAR had documentation of whether or no Resident 1 had received any Ensure supplemental drinks since

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N 431	Continued From page 18 admission. At 5:42 p.m., Surveyor interviewed Resident 1 after dinner. Resident 1 stated that the food is disgusting, and s/he can't eat it even if s/he wanted to. Surveyor observed lunch, which was roast beef, Resident 1 opened his/her mouth to show s/he did not have any upper teeth and stated, the food is not cut up or safe to eat for people without teeth, but that the staff do not care. Resident 1 stated s/he feels like s/he is losing weight and is probably less than 96 pounds, "I'm afraid I am going to starve to death." Surveyor asked if the caregivers regularly take Resident 1's weight and monitor it for him/her. Resident 1 stated no, they have not weighed him/her since moving here. S/he stated that the staff don't care whether the residents can eat the food or not and that the food they can eat, isn't great. Resident 1 stated that s/he has been offered mac 'n cheese for the last 3 days. S/he stated that if it wasn't for the Ensure, s/he wouldn't be able to keep what little weight s/he has on. At approximately 7:05 p.m., Surveyors asked Executive Director A if s/he had documentation of Resident 1's weight upon admission or documentation that his/her weight was being monitored. Executive Director A stated no, s/he did not know why staff were not weighing Resident 1. Surveyor asked Executive Director A if staff were documenting Resident 1's intake at meals or the amount of Ensure s/he consumes. Executive Director A stated not that s/he is aware of.	N 431		
N 525	83.47(2)(d) Fire drills.	N 525		

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N 525	Continued From page 19 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 ensure that 2 of 2 fire drills completed included the CBRF's total evacuation time. Findings include: On 06/24/2025, Surveyor reviewed fire drill records to ensure compliance with fire drill requirements. Surveyor requested records of all fire drills completed by staff from Executive Director A. In reviewing the records provided for drills completed after the provider received their probationary license, Surveyor observed that fire drills were completed on 04/18/2025 at 8:16 a.m. and on 06/13/2025 at 12:45 a.m. For both drills,	N 525		

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N 525	Continued From page 20 there was no evidence of the CBRF's evacuation time recorded. On 07/08/2025 at approximately 3:00 p.m., Surveyor interviewed Regional Director of Operations C, Health and Wellness Director G, and Vice President of Clinical Services M. All acknowledged Surveyor's concern that evacuation times were not documented for the provider's fire drills. Nothing further was said.	N 525		
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 observation and interview, the provider did not ensure that the temperature of 3 of 3 tested water fixtures used by residents did not exceed 115° F. Findings include: The provider is licensed to serve up to 14 nonambulatory adults in the client groups of advanced aged and irreversible dementia/Alzheimer's. On 06/24/2025, at approximately 10:55 a.m.,	N 617		

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N 617	Continued From page 21 Surveyor tested the water temperature of the sink in Resident 3's bathroom, located within his/her room, which reached 122.9° F. On 06/24/2025, at approximately 10:57 a.m., Surveyor tested the water temperature of the sink in the main resident bathroom located near Resident 4's room, which reached 124.2° F. On 06/24/2025, at approximately 11:00 a.m., Surveyor tested the water temperature of the sink in the main resident bathroom located near Resident 5's room, which reached 123.8° F. According to the Wisconsin Department of Health Services, "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents 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." Sustained contact with water at or above 120° F and 127° F can result in second or third-degree burns in approximately 10 minutes and 1 minute, respectively (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017). At approximately 6:55 p.m., Surveyor interviewed Executive Director A, Chief Clinical Officer B, and Regional Director of Operations C. Upon Surveyor sharing the concern of the above tested sink water temperatures, Regional Director of	N 617		

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N 617	Continued From page 22 Operations C replied that staff would address the concern immediately.	N 617		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all residents were treated with courtesy, respect, and full recognition of their dignity and individuality. People who were not staff or residents were allowed into the facility throughout the survey period to address concerns with caregivers. Findings include: On 06/24/2025, Surveyors conducted a complaint investigation and standard survey. The facility is licensed as a class CNA (non-ambulatory)	Y3234		

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community based residential facility, able to serve up to 14 residents within the client groups of Advanced Age and Irreversible Dementia/Alzheimer's.

At 11:37 a.m., Surveyor was conducting a record review in the facility's dining room when Person H entered the back door of the facility. Person H did not have shoes on and appeared unsteady on his/her feet as s/he wandered around the dining room. Person H attempted to enter the staff office without success and then walked up onto the wheelchair scale where s/he stumbled and braced him/herself against the wall. Person H continued to walk around the facility and left through the back door at 11:44 a.m. Surveyor asked Caregiver F who Person H was and why they were in the facility. Caregiver F identified Person H and stated that s/he comes over to this facility to talk to Caregiver D.

At 5:15 p.m., Surveyor observed all residents sitting down eating dinner. Person I was wheeled into the facility by a caregiver from another facility and stated s/he was there to see Caregiver D. Person I was topless, did not have shoes on and started yelling to Caregiver D, who was serving dinner, "You rented out my room!" Caregiver D attempted to pull up Person I's pants and Person I responded, "Don't pull my [expletive] pants up!" Caregiver D asked Person I if s/he wanted to eat dinner and pulled him/her up to the dining room table between two residents. Person I asked, "Who am I sitting with?" Person I then stated, "I already had dinner so I will just have a Miller Lite, that sounds pretty [expletive] good right now." The caregiver that brought Person I to the facility asked Caregiver D if s/he should come back in 5 minutes to get Person I. Caregiver D responded that s/he will call when s/he needed someone to

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come get Person I. Person I stated, "I don't want to sit in front of these people while they eat." Person I was sitting next to the kitchen and continued to talk to Caregiver D, who was across the dining room at the medication cart, stating, "You gave my room away and I only want to move to room 2."
At 5:20 p.m., Person I asked Resident 3, "What is wrong with your voice?"
At 5:22 p.m., Person I asked, "Where did my ride go? I'm ready to leave."
At 5:24 p.m., Person I wheeled him/herself over to Resident 1's room and stated to Resident 1, "I'm looking for a [significant other], are you available?" Resident 1 stated no and Person I responded that was too bad because s/he sounded pretty.

At 5:27 p.m., Person H entered through the back door of the facility without shoes on, walked directly into the staff office, and then left the facility.

At 5:44 p.m., Surveyor observed Person H enter the back door of the facility. Person H was observed to have a brief conversation with Executive Director A, then started walking down the hallway of resident bedrooms. Person H was then observed to turn back, open the door to Resident 1's room, and peer inside. Surveyor noted that at that time, Resident 1 was being interviewed by a second Surveyor. Person H was observed to briefly look upon the interaction before being acknowledged and redirected by that Surveyor. Person H was then observed to leave the facility.

At 5:45 p.m., Surveyor asked Resident 1 who had entered his/her room. Resident 1 stated, "I don't know but [s/he] didn't knock, and [s/he] shouldn't

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be in here." Resident 1 stated that Person H always comes over and s/he does not know who s/he is and wants him/her to go away. S/he stated that people s/he does not know will come into the facility at 3 or 4 in the morning, at all points throughout the day, and will sit in the residents' chairs so the people that live there do not have a place to sit. Resident 1 stated, "It makes me feel unsafe." This isn't homelike and that it is not respectful of his/her space, privacy, and personal belongings. S/he continued to say that one of the people that comes over just got out of prison and that s/he knows that because s/he hears all the staff talking, "They talk loudly, and they talk about all of us. I don't want to, but I know what is going on with each resident here, nothing is private." Surveyor observed Resident 1's personal bedroom and saw 2 different oxygen concentrators. Resident 1 stated that only one is for him/her, the other one was supposed to be delivered to a resident at a different facility, but the staff haven't taken the concentrator or 2 oxygen tanks to the correct person and are storing it in Resident 1's room. Surveyor observed a garbage that was full, and laundry basket that was overflowing in Resident 1's bathroom. Resident 1 stated s/he has been asking staff for two days to do his/her laundry and staff tell him/her they will get to it when they can, and then never do. Surveyor also observed soiled markings on Resident 1's bed, including 2 blood spots. Resident 1 stated that nothing gets cleaned and his/her bedding has not been changed since s/he moved in at the beginning of the month. Resident 1 continued to say, "When I ask them to straighten out my [incontinence] pad, they roll their eyes and act like they are being put out. Staff are acting nice to you guys but not to us. They lack human compassion."

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At 6:11 p.m., Surveyor interviewed Resident 2. Resident 2 stated that Person K and Person I come into the facility whenever they want something from staff. S/he stated that Person J and Person H are in the facility all the time talking with staff. Resident 2 stated that sometimes s/he does not feel safe with everyone coming in and out all the time and, "They never lock the doors, not even at night. People are coming in and out at all hours. I even had a window peeper."

At approximately 6:50 p.m., Surveyors conducted an exit conference with Executive Director A and Chief Clinical Officer B.

At 6:55 p.m., Person J walked into the facility and Executive Director A stated that s/he lives next door. Person J walked into the dining room and stated, "I need a new door jam so I can close my [expletive] door." Person J then looked over to the Surveyors and stated, "You must be the [ladies/gentleman] from the State, good."

At 6:59 p.m., Person K walked into the dining room and Executive Director A stated that s/he lives next door as well.

At 7:02 p.m., Surveyors observed 2 young people walk into the facility and over to the water dispenser. Surveyor asked Executive Director A who the 2 people were. Executive Director A stated s/he did not know as the 2 people then turned around and left the facility.

At approximately 7:05 p.m., Surveyors asked Executive Director A why there was so many people coming in and out of the resident's home throughout the day. Executive Director A stated to socialize with the residents. Surveyor stated that s/he did not observe the above listed visitors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019799	A. BUILDING: _____ B. WING _____	C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS BARABOO (THE)	601 LATTON LN PORTAGE, WI 53901

(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
Y3234	Continued From page 27 interacting with the residents at the facility and Executive Director A stated that sometimes the people from next door will come to the facility to speak with staff. Surveyor asked Executive Director A if s/he is aware that guests unknown to the residents coming into the facility makes some of the residents feel unsafe and disrespected in their home. Executive Director A stated no. Surveyor asked Executive Director A if s/he was concerned that non-residents coming into the facility to address concerns with caregivers took time and attention away from current resident's needs and privacy. Executive Director A stated s/he understands that concern. Chief Clinical Officer B. nodded along with the above listed concerns and stated that this issue will be addressed. The provider did not treat each resident of the facility with courtesy, respect, and recognition of the resident's dignity and individuality by allowing non-resident and non-caregivers to come into the facility without permission to discuss concerns with caregivers that are not related to current residents at the facility.	Y3234		