STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012761	A. BUILDING: _____ B. WING _____	R-C 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH SHORE HOUSE	6807 SANTA MONICA BLVD FOX POINT, WI 53217

(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 08/15/2025, Surveyor completed a standard survey, 1 complaint investigation, and a verification visit at North Shore House. As result, 3 of the previous 3 deficiencies were re-cited with 7 new deficiencies; therefore, 10 total deficiencies were identified. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 5	{N 000}		
N 179	83.13(1)(g) Maintain records of quarterly fire drills. The CBRF shall maintain documentation of all of the following: Dates, times and total evacuation times of quarterly fire drills as required under s. DHS 83.47 (2)(d). This Rule is not met as evidenced by: Based on record review and interview the provider did not maintain documentation of quarterly fire drills including dates, times, and total evacuation times for the years of 2023 and 2024. Findings include: On 08/15/2025, at approximately 11:30 AM, Surveyor requested documentation of fire drills for the years of 2023 and 2024. The documentation given to Surveyor did not have any recorded fire drills for 2023 and 2024. The facility provided documentation for the year of 2025.	N 179		

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

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N 179	Continued From page 1 On 08/15/2025, at approximately 1:30 PM, Surveyor interviewed Manager E and Licensee F. Licensee F could not provide an explanation as to where the documentation was for quarterly fire drills completed for the years of 2023 and 2024. Licensee F was given till 5:00 PM on 08/15/2025, to provide the documentation via e-mail. Surveyor did not receive any documentation of as of 5:00 PM, on 08/26/2025.	N 179		
{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 provider did not comply with all laws governing the Community Based Residential Facility (CBRF), as evidenced by 10 deficient practices of which 5 were repeat violations. This is being cited for a 6th time. See Statement of Deficiency (SOD) OJOI11, dated 01/24/2020, SOD OJOI12, dated 06/10/2021, SOD OJOI13, dated 01/11/2022, SOD OJOI14, dated 08/10/2022, SOD OJOI15 dated 11/30/2022. Findings include: On 07/01/2009, the provider was issued a probationary license as a class CNA (non-ambulatory) facility to serve up to 8 residents with primary diagnoses of, developmentally disabled, emotionally disturbed/mental illness, advanced aged, and	{N 196}		

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{N 196}	Continued From page 2 irreversible dementia/Alzheimer's residents. On 08/15/2025, at approximately 10:30 AM, Surveyor completed a standard survey, 1 complaint investigation and a verification visit for North Shore House. Surveyor conducted interviews with administration and made observations of the general environment and resident safety factors (emergency exits). Surveyor identified 10 deficiencies and 5 were repeat deficiencies: N0179 83.13 (1)(f) Maintain Records of Quarterly Fire Drills N0196 83.14(2)(a) Licensee Ensures Facility Complies with Laws (repeat) N0305 83.28(6) Resident Rights, Grievance Procedure, Rules N0310 83.29(2) Admission Agreement Include Service Plan N0386 83.35(3)(a) Comprehensive Individualized Service Plan (repeat) N0387 83.35(3)(b) Service Plain Development Parties Involved N0526 83.47(2)(e) Other Evacuation Drills N0531 83.47(4)(a) Fire Extinguisher Type And Inspection (repeat) N0633 83.59(1)(c) Exit Doors Passageways 32 inches Clear (repeat) N0702 83.64(7) Small CBRF; Clear Width Door Openings (repeat) On 08/15/2025, at approximately 1:30 PM, Surveyor interviewed Licensee F. Licensee F reported s/he was not aware of the processed SOD OJOI15, dated 03/13/2023. Licensee F reported s/he was not working at the facility during the year of 2023, and no one informed him/her of the corrections needed.	{N 196}		

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N 305	83.28(6) Resident rights, grievance procedure, rules Resident rights, grievance procedure, and house rules. Before or at the time of admission, the CBRF shall provide and explain resident rights, the house rules of the CBRF as required under s. DHS 83.32 (2), and the grievance procedure, including written information regarding the names, addresses and telephone numbers of all resident advocacy groups serving the client groups in the facility, including the long term care ombudsman program and the protection and advocacy services of Disability Rights Wisconsin, Inc. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 2) were provided and explained the resident rights, house rules and grievance procedure at the time of admission. Findings include: On 08/15/2025, at approximately 12:40 PM, Surveyor reviewed Resident 1's and Resident 2's records provided by House Manager E. Resident 1 was admitted to the facility on 05/01/2025. Resident 1 had an activated power of attorney. Resident 1 had a managed care organization. Resident 1's record did not contain evidence of resident rights, house rules, and grievance procedures. Resident 2 was admitted to the facility on 03/03/2025. Resident 2 had a guardian. Resident	N 305		

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N 305	Continued From page 4 2 had a managed care organization. Resident 2's record did not contain evidence of resident rights, house rules, and grievance procedures. On 08/15/2025, at approximately 1:30 PM, Surveyor interviewed House Manager E and Licensee F. Surveyor inquired whether s/he had documentation that the resident rights, house rules and grievance procedure had been explained and given to Resident 1 and Resident 2 in writing at the time of admission. House Manager E and Licensee F reported they were not aware resident records needed to have resident rights, grievance procedure and rules upon admission. House Manager E reported s/he would ensure all resident records contained the documents.	N 305		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government	N 310		

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N 310	Continued From page 5	N 310		

correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed had a signed and dated admission agreement. Resident 1 did not have an admission agreement in his/her record.

Findings include:

On 08/15/2025, at approximately 12:40 PM, Surveyor requested the signed admission agreements for Resident 1. Resident 1 was admitted to the facility on 05/01/2025. Resident 1 had an activated healthcare power of attorney. Resident 1 had a managed care organization. Resident 1's record did not contain evidence of an admission agreement.

On 08/15/2025, at approximately 1:30 PM, Surveyor interviewed House Manager E and Licensee F and asked about admission

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N 310	Continued From page 6 agreements. House Manager E reported admission agreements are done at the time of admission. House Manager E could not locate the admission agreement for Resident 1. Licensee F reported s/he had the admission agreement for Resident 1. Licensee F reported s/he could provide a copy of the admission agreement for Resident 1 by 5:00 PM on 08/15/2025. As of 08/26/2025 at 5:00 PM, Surveyor did not receive a copy of the admission agreement.	N 310		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) had a comprehensive individual service plan (ISP) developed. Resident 1's record did not contain a comprehensive individual service plan. Findings include:	N 386		

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N 386	Continued From page 7 On 08/15/2025, at approximately 12:40 PM, Surveyors reviewed Resident 1's record. Resident 1 was admitted on 05/01/2025, with a diagnosis of malignant neoplasm of prostate. Resident 1 had an activated healthcare power of attorney and a managed care organization. Resident 1's record did not contain a comprehensive individualized service plan. On 08/15/2025, at approximately 1:30 PM, Surveyor interviewed House Manager E and Licensee F and asked about comprehensive individualized service plans. House Manager E reported the comprehensive individualized service plan was done at the time of admission. Licensee F and House Manager E reported the resident files were being updated by their nurse. Licensee F reported s/he would email a copy of the comprehensive individualized service plan on 08/15/2025 by 5:00 PM. As of 08/26/2025 at 5:00 PM, Surveyor did not receive any additional information for Resident 1.	N 386		
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 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	N 387		

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N 387	Continued From page 8 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 the resident or the resident's legal representative signed the individual service plan (ISP), acknowledging their involvement in, understanding of, and agreement with the ISP for 1 of 1 residents (Resident 2) reviewed. Findings include: On 08/15/2025, at approximately 12:40 PM, Surveyor reviewed resident records and observed the following: Resident 2 was admitted to the facility on 03/03/2025. Resident 2 had a guardian. Resident 2 had a managed care organization. Resident 2's ISP, dated 03/03/2025, was not signed by all parties involved. Resident 2's ISP was not signed by the guardian or the managed care organization care team. On 08/15/2025, at approximately 1:30 PM, Surveyor interviewed House Manager E and Licensee F regarding the unsigned ISPs. House Manager E and Licensee F could not provide an explanation as to why the individual service plan was not signed by all parties involved.	N 387		

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N 526	Continued From page 9	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 ensure tornado, flooding or other emergency or disaster drills were conducted semi-annually for 2 of 2 years. There were no other emergency or disaster drills conducted in 2023 and 2024. Findings include: On 08/15/2025, at approximately 12:40 AM, Surveyor reviewed safety records and identified there was no evidence of tornado, flooding, or disaster drills in 2023 and 2024. On 08/15/2025, at approximately 1:30 PM, Surveyor interviewed House Manager E and Licensee F regarding the emergency or disaster drills. House Manager E confirmed s/he was aware of the code requirement and did not know where 2023's and 2024's other evacuation drills were as s/he just started working at the facility in February of 2025. Licensee F reported s/he was unaware if the other evacuation drills were completed during the years of 2023 and 2024. House Manager E reported s/he would ensure the emergency or disaster drills are completed.	N 526		
N 531	83.47(4)(a) Fire extinguishers: type and inspection. At least one portable dry chemical fire	N 531		

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N 531	Continued From page 10	N 531		

extinguisher with a minimum 2A, 10-B-C rating shall be provided on each floor of the CBRF. All fire extinguishers shall be maintained in readily usable condition. Inspections of the fire extinguisher shall be done by a qualified professional one year after initial purchase and annually thereafter. Each fire extinguisher shall be provided with a tag documenting the date of inspection.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 2 of 2 fire extinguishers were maintained in readily usable condition and inspected by a qualified professional annually in 2025. The fire extinguishers were due for inspection by 04/2025.

This is a repeat deficiency. See Statement of Deficiency (SOD) OJOI13, dated 01/11/2022.

Findings include:

On 08/15/2025, at approximately 10:30 AM, Surveyor toured the facility. Surveyor observed 2 fire extinguishers located throughout the facility.

-The fire extinguisher in the kitchen had an inspection tag that read 04/2024.

-The fire extinguisher in the basement had an inspection tag that read 04/2024.

On 08/15/2025 at approximately 1:30 PM, Surveyor interviewed Licensee F about the expired fire extinguisher tags. Licensee F reported the fire extinguishers were updated and provided Surveyor with a document dated April 2024 from Blair Fire Protection. Licensee was informed of the expired fire extinguishers and the

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N 531	Continued From page 11 date on the document provided. Licensee E reported s/he would have the fire extinguishers serviced and retagged.	N 531		
{N 633}	83.59(1)(c) Exit doors, passageways 32 inches clear All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exit doors and doors in exit passageways shall have a clear opening of at least 32 inches in width and 76 inches in height. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 3 exits doors had a clear opening of at least 32 inches. The kitchen door, which led to the garage, had a clear opening of 29.5 inches. This is being cited for the fifth time. See Statement of Deficiency (SOD) OJOI12, dated 06/10/2021, SOD OJOI13, dated 01/11/2022, SOD OJOI14, dated 08/10/2022, and SOD OJO115, dated 11/30/2022. Findings include: The facility is licensed as a Class CS (semi-ambulatory) to serve 8 residents with advanced age, irreversible dementia/Alzheimer's disease, developmentally disabled, and emotionally disturbed/mental illness.	{N 633}		

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{N 633}	Continued From page 12 On 08/15/2025, at approximately 10:30 AM, Surveyor toured the facility and reviewed the facility's emergency exits diagram. The emergency exits diagram indicated the kitchen door leading to the garage, was an emergency exit for the facility. Surveyor measured the kitchen door leading to the garage and the door had a clear opening of 29.5 inches. On 08/15/2025, at approximately 1:30 PM, Surveyor interviewed Licensee F about the exit door passageways. Licensee F reported s/he was not aware of the clear opening requirement, and s/he was not aware of the SODs issued regarding the clear passageways. Licensee F reported s/he would have the door corrected.	{N 633}		
{N 702}	83.64(7) Small CBRF: clear-width door openings All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms in small CBRFs shall have a clear-width opening of at least 32 inches. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all interior doors serving common living areas, all bathrooms, and bedrooms, had a clear width opening of at least 32 inches. Four of 4 bedroom doors had a clear-width opening of 29.5 inches and 3 of 3 bathroom doors had clear-width opening of 30 inches. This is a repeat deficiency. See Statement of Deficiency (SOD) OJOI14, dated 08/10/2022, and SOD OJOI15, dated 11/30/2022. Findings include:	{N 702}		

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{N 702}	Continued From page 13 The facility is licensed as a Class CS (Semi-ambulatory) to serve 8 residents with advanced age, irreversible dementia/Alzheimer's disease, developmentally disabled, and emotionally disturbed/mental illness. On 08/15/2025, at approximately 10:35 AM, Surveyor, accompanied by House Manager E, toured the facility and measured the clear width opening of the interior doors in the facility. - Four of 4 resident bedroom doors had a clear-width opening of 29.5 inches. -Three of 3-bathroom doors had a clear-width opening of 30 inches. On 08/15/2025, at approximately 1:30 PM, Surveyor interviewed Licensee F about the clear width door openings. Licensee F reported s/he was not aware of the requirement, and s/he was not aware of the SOD's issued regarding the interior door clear width opening requirement of 32 inches. Licensee F reported s/he would have the doors corrected.	{N 702}		