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 03/10/2026

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 03/10/2026, Surveyor completed a verification visit and 2 complaint investigations at North Shore House. As a result 10 previous deficiencies were corrected. Three new deficiencies were identified. One complaint was substantiated. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 6	{N 000}		
N 287	83.27(2)(a) Admissions compatible with the license class A CBRF may not admit or retain any of the following persons: A person who has an ambulatory or cognitive status that is not compatible with the license classification under s. DHS 83.04(2). This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 4 residents (Resident 2) were compatible with their license classification. The provider is licensed as a Class CS (Semi-ambulatory) facility. Resident 2 utilized a wheelchair for ambulation. Resident 2 was not compatible with the provider's semi-ambulatory license. Findings include: The provider has a Class CS (semi-ambulatory) (CS) license to care for 8 residents in the client groups emotionally disturbed/mental illness,	N 287		

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

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irreversible dementia/Alzheimer's, advanced aged and developmentally disabled. A CS license means residents may be ambulatory or semi-ambulatory, but one or more may not be physically or mentally capable of responding to a fire alarm by exiting the building without assistance.

Wis. Admin. Code § DHS 83.02(51) states, "'Semi-ambulatory' means a person is able to walk with difficulty or only with the assistance of an aid such as crutches, cane, or a walker."

Wis. Admin. Code § DHS 83.04(e) states, "A class C semi-ambulatory CBRF serves only residents who are ambulatory or semi-ambulatory, but one or more of whom are not physically or mentally capable or responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting."

On 03/10/2026, at approximately 10:05 AM, Surveyor entered the facility and observed Resident 2 in a wheelchair sitting in the living room watching television.

On 03/10/2026, at approximately 10:15 AM, Surveyor interviewed Caregiver G about Resident 2's wheelchair. Caregiver G reported Resident 2 could not walk as s/he required total assistance with ambulation and cares. Caregiver G reported Resident 2 could pivot with the assistance from another person. Caregiver G reported s/he never observed Resident 2 to use a walker and to use a wheelchair since January 2026.

On 03/10/2026, at approximately 10:50 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 03/03/2025. Resident 2 was diagnosed with Huntington's disease,

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hypertension, hyperlipidemia, and dysarthria. Resident 2's preadmission assessment, dated 03/03/2025, indicated Resident 2 used a walker and walked. The assessment indicated Resident 2 needed a wheelchair when going to appointments. Resident 2's Individual Service Plan (ISP), dated 03/07/2025, indicated "S/he needs assistance with walking/and or transferring. S/he used a walker in the house and a wheelchair for long distances/out of the house."

On 03/10/2026, at approximately 10:50 AM, Surveyor reviewed Resident 2's evacuation assessment dated 03/05/2025. The evacuation assessment identified Resident 2 needed full assistance from 2 staff during an evacuation. The assessment did not identify Resident 2 used a wheelchair.

On 03/10/2026, at approximately 12:00 PM, Surveyor observed Caregiver G to transfer Resident 2 from the sofa to his/her wheelchair. Resident 2 struggled to move from a sitting position to a standing position. Surveyor observed Resident 2 to make several attempts to grab the arm of the wheelchair. Resident 2 did not have the ability to grab the wheelchair with his/her arms due to his/her inability to control his/her arms. Surveyor observed Caregiver G to use his/her arms to lift Resident 2 up from the sofa and into the wheelchair.

On 03/10/2026, at approximately 12:34 PM, Surveyor interviewed Licensee F about Resident 2's wheelchair. Licensee F reported Resident 2 was admitted with a walker and had been using a wheelchair due to a change in condition. Licensee F reported the wheelchair was used for doctor's appointments only upon admission. Licensee F reported s/he notified Resident 2's guardian about

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N 287	Continued From page 3 Resident 2's use of the wheelchair. Licensee F reported Resident 2's guardian did not want to relocate him/her. Surveyor asked Licensee F if s/he was aware of the department code for the facility license. Licensee F reported s/he was aware. Surveyor asked Licensee F if s/he had obtained a waiver for Resident 2's use of the wheelchair. Licensee F reported s/he did not apply for a waiver with the Department. Licensee F did not state how long Resident 2 had used a wheelchair in the facility.	N 287		
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, observation, and interview, the provider did not ensure 1 of 4 residents' (Resident 2) Individual Service Plans (ISP) were updated with changes. Resident 2 utilized a wheelchair for ambulation. Resident 2's ISP indicated s/he used a walker for ambulation and a wheelchair for long distances and	N 389		

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N 389	Continued From page 4 appointments. Findings include: On 03/10/2026, at approximately 10:05 AM, Surveyor entered the facility and observed Resident 2 in a wheelchair sitting in the living room watching television. On 03/10/2026, at approximately 10:50 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 03/03/2025. Resident 2 was diagnosed with Huntington's disease, hypertension, hyperlipidemia, and dysarthria. Resident 2's preadmission assessment, dated 03/03/2025, indicated Resident 2 used a walker and walked. The assessment indicated Resident 2 needed a wheelchair when going to appointments. Resident 2's Individual Service Plan (ISP), dated 03/07/2025, indicated "S/he needs assistance with walking/and or transferring. S/he used a walker in the house and a wheelchair for long distances/out of the house." On 03/10/2026, at approximately 12:00 PM, Surveyor observed Caregiver G to transfer Resident 2 from the sofa to his/her wheelchair. Resident 2 struggled to move from a sitting position to a standing position. Surveyor observed Resident 2 to make several attempts to grab the arm of the wheelchair. Resident 2 did not have the ability to grab the wheelchair with his/her arms due to his/her inability to control his/her arms. Surveyor observed Caregiver G to use his/her arms to lift Resident 2 up from the sofa and into the wheelchair. On 03/10/2026, at approximately 10:15 AM, Surveyor interviewed Caregiver G about Resident 2's wheelchair. Caregiver G reported Resident 2	N 389		

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N 389	Continued From page 5 could not walk as s/he required total assistance with ambulation and cares. Caregiver G reported Resident 2 could pivot with the assistance from another person. Caregiver G reported s/he never observed Resident 2 to use a walker and to utilize a wheelchair since January 2026. On 03/10/2026, at approximately 12:34 PM, Surveyor interviewed Licensee F about Resident 2's wheelchair. Licensee F reported Resident 2 was admitted with a walker and had been using a wheelchair due to a change in condition. Licensee F reported the wheelchair was used for doctor's appointments only upon admission. Surveyor asked Licensee F if s/he was aware of the department code for updating the ISP to reflect change in conditions. Licensee F reported s/he was aware of the department's code. Resident 2 did not have an updated ISP to reflect his/her change in condition.	N 389		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services to manage behaviors that may be harmful to others for 1 of 4	N 433		

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residents reviewed. The provider did not provide or arrange for services to manage Resident 4's verbally aggressive behavior towards Resident 3.

Findings include:

The provider is licensed to serve 8 residents who are emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, developmentally disabled, and/or publicly funded.

On 02/24/2026, the Department received a complaint alleging a resident was mistreating another resident by name calling.

On 03/10/2026, at approximately 10:50 AM, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 02/13/2025, with diagnoses of schizoaffective disorder, mental, and behavioral disorders. Resident 4's individual service plan (ISP), dated 03/03/2025, reported the following under Attitude/Emotional Behavior, " S/he does not show abnormal behaviors."

On 03/10/2026, at approximately 1:10 PM, Surveyor reviewed the facility communication log for the year 2025 and 2026. On 02/19/2026, Resident 4 was described to call Resident 3 names such as, "you're fat." The comments also indicated Resident 4 made an attempt to take money away from Resident 3. On 10/11/2025, Resident 4 was noted to call Resident 3 disrespectful names and to threaten to hit Resident 3 with a book.

On 03/10/2026, at approximately 10:15 AM, Surveyor interviewed Caregiver G. Caregiver G reported Resident 4 verbally abuses Resident 3. Caregiver G reported Resident 4 called Resident

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N 433	Continued From page 7 3 a "nasty [expletive]" and indicated Resident 4 verbalized s/he would "beat the [expletive] out of Resident 3." Caregiver G reported facility management was aware of Resident 4's behaviors and nothing was done to manage the behaviors. On 03/10/2026, at approximately 12:34 PM, Surveyor interviewed Licensee F about Resident 4's behaviors. Licensee F reported s/he was not aware of any verbal or physical abuse between Resident 4 and Resident 3. Licensee F reported a meeting took place with Resident 4's managed care team and an intervention was not put in place as of yet to address Resident 4's verbal aggression. Licensee F reported Resident 4 had medication changes done approximately 6 months ago and no changes in behavior have been noted. Surveyor requested to see notes from the managed care team meeting, Licensee F did not provide the notes. Licensee F reported Resident 4 had a psychiatric appointment scheduled within the next 3 months. On 03/10/2026, at approximately 12:55 PM, Surveyor interviewed Resident 5. Resident 5 reported s/he witnessed Resident 4 to call Resident 3 "retarded" and to make verbal threats towards Resident 3.	N 433		