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 11/09/2023

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 10/31/2023. Surveyor conducted a verification visit and complaint investigation at Riverbend. Data was collected though 11/09/2023. One of 3 complaints was substantiated. Two violations were identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 5.	{N 000}		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure staff in sufficient numbers were available on a 24-hour basis to meet the needs of the residents. Findings include: The provider is licensed to care for 11 residents in the client groups: advanced aged and irreversible dementia/Alzheimer's disease. On 10/31/2023 at approximately 10:00 AM, Surveyor interviewed Administrator A. Administrator A stated s/he and Lead Assistant (LA) C were required to work the floor when they were short staffed. Administrator A stated the schedule should have 2 staff on the AM and 2 on PM shift but they did not have enough staff, and	N 396		

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

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N 396	Continued From page 1 this had been the case for many months. Administrator A stated the current scheduling was: -6:00 AM to 2:00 PM, 1 staff -2:00 PM to 10:00 PM, 1 staff -10:00 PM to 6:00 AM, 1 staff Administrator A had been informed by their corporate office that a second staff on nights was not necessary and were directed to contact the nursing home, located next to their building, and licensed by the same licensee, for assistance. Administrator A stated this did not work because s/he knew there were incidents where 2 staff needed to be working in the community based residential facility (CBRF) at night and when assistance was required the nursing home would refuse to assist because they were also short staffed. Administrator A stated that even if there were nursing home staff available to assist, they needed to be CBRF trained. Administrator A stated s/he and LA C worked on the floor so often that both were unable to complete their regular job duties. Administrator A stated the residential care apartment complex (RCAC) attached to the CBRF and licensed by the same licensee, did not have any staff scheduled at night and there were residents that required checks; the checks were completed by CBRF staff. The CBRF staff were also responding to RCAC tenants that pushed their call pendants and that left the CBRF without staff. From 11:25 AM to 11:57 AM, Surveyor interviewed LA C. LA C stated the CBRF responded to nighttime alarmed call pendants in the attached RCAC. LA C stated s/he worked many overnight shifts and responded to Tenant 2's call light a couple times a week that required him/her to be out of the CBRF for approximately 10 minutes for each call.	N 396		

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N 396	Continued From page 2 On 11/02/2023, from 3:28 PM to 3:49 PM, Surveyor interviewed Caregiver B. Caregiver B stated there were 2 residents admitted to the CBRF with elopement history. Caregiver B stated Tenant 3, who resided in the attached RCAC, had been on 2-hour checks and was to be checked 1 time during the night. Caregiver B recalled coming into work for a 6:00 AM shift and Caregiver D stated Tenant 2, who resided in the attached RCAC, had pushed his/her pendant 5 times that night causing Caregiver D to be out of the CBRF for 10-15 minutes each time. Caregiver B stated Resident 4, who resided in the CBRF, was a 2-person transfer and if staff needed help at night, they were directed to call the nursing home. Caregiver B stated s/he knew the CBRF was not to be left without staff at any time. On 10/31/2023 at approximately 12:30 PM, Surveyor interviewed Administrator A. Administrator A provided a document titled NOVEMBER 2023 ATTENDANT SCHEDULE. Administrator A stated the highlighted shifts were the open shifts for the month and totaled approximately 90 shifts. On 11/06/2023, from 8:45 AM to 8:55 AM, Surveyor interviewed LA C. LA C stated they were unable to generate a report from the call/pendant system on how many times the RCAC call pendants were alarmed at night. On 11/09/2023, from 11:06 AM to 11:17 AM, Surveyor interviewed Caregiver E. Caregiver E stated RCAC call pendants were alarmed anywhere from 1 to 5 times a night. Caregiver E stated s/he had to leave the CBRF for 5 or more minutes for each call. Caregiver E stated they did not document tenant checks.	N 396		

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N 396	Continued From page 3 The provider did not ensure adequate staff when staff were responding to call lights and completing tenant safety checks in the RCAC, leaving the CBRF without staff. The provider did not assure adequate staff for Resident 4 who required 2-person assist or provide supervision for 2 residents who were elopement risks.	N 396		
N 650	83.59(4)(b) Delayed egress: locking device sign posted Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: A sign shall be posted adjacent to the locking device indicating how the door may be opened. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the delayed egress door locks had signs posted adjacent to the locking device that indicated how the door may be opened. Findings include: The provider is licensed to care for 11 residents in the client groups: advanced aged and irreversible dementia/Alzheimer's disease. On 10/31/2023. Surveyor observed that the 5 delayed egress doors did not have signage posted that indicated how the door may be opened. Surveyor observed 2 of the 5 egress	N 650		

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N 650	Continued From page 4 doors did have a red stop sign printed on a 9-inch by 11-inch sheet of paper and taped to the door. At approximately 12:00 PM, Surveyor interviewed Administrator A. Administrator A stated s/he thought the paper stop sign posted did indicate delayed egress. On 11/02/2023, from 3:28 PM to 3:49 PM, Surveyor interviewed Caregiver B. Caregiver B stated that s/he had not seen any signs on the delayed egress doors other than the paper stop signs located on 2 exit doors. Caregiver B stated the paper stop signs were on the doors because Resident 1 was eloped. The provider did not ensure the delayed egress door locks had signs posted that indicated how the door may be opened.	N 650		