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 07/22/2026

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 07/22/2026, Surveyors completed 1 complaint investigation, and a verification visit at North Shore House. As a result, 1 of the previous 3 deficiencies were re-cited with 12 new deficiencies, therefore 13 total deficiencies were identified. One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 5	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the	N 158		

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

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N 158	Continued From page 1	N 158		

provider did not submit a self-report to the licensing agency or document an investigation when they had reasonable cause to suspect caregiver misconduct in 1 of 1 incident.
On 04/29/2026, Caregiver I allegedly threatened to physically harm Resident 4 and called Resident 4 derogatory names. Law enforcement was contacted and responded to the facility.

Findings include:

On 04/28/2026 at approximately 7:00 AM, Surveyor reviewed the department's facility folder and identified no self-reports were submitted in 2026.

On 06/03/2026, the Department received a complaint concerning a caregiver to resident altercation.

On 07/22/2026, at approximately 10:30 AM, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 02/13/2025. Surveyor did not see documentation that indicated an internal investigation was completed related to allegations of staff verbally threatening to physically harm Resident 4 or calling Resident 4 derogatory names.

On 07/22/2026 at approximately 9:30 AM, Surveyor interviewed Operator Management H. Operator Management H reported on 04/29/2026, Resident 4 walked into the facility's garage. Caregiver I followed Resident 4 into the garage as Caregiver I stated Resident 4 had a screwdriver. Per Operator Management H, a verbal altercation occurred between Resident 4 and Caregiver I. For the safety of Resident 4 and Caregiver I, Caregiver I contacted the Fox Point Police Department. Operator Management H

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N 158	Continued From page 2	N 158		

stated he/she received a phone call from the police officer informing him/her of the verbal altercation between Resident 4 and Caregiver I.

Operator Management H disclosed a second incident occurred between Resident 4 and Caregiver I on 04/29/2026. Operator Management H reported he/she received a phone call from Resident 4's family member. The family member allegedly overheard Caregiver I verbally threaten to physically harm Resident 4 and call Resident 4 derogatory names. Operator Management H disclosed Resident 4's family member recorded the interaction between Caregiver I and Resident 4. Operator Management H listened to the recording, and confirmed the voice of the caregiver appeared to belong to Caregiver I. Resident 4's family member informed Operator Management H that the Fox Point Police Department was contacted for the safety of Resident 4.

Operator Management H stated he/she went to the facility. Upon arrival, Operator Management H reported overhearing Caregiver I talk to Resident 4 in a disrespectful manner. Operator Management H reported having a conversation with Caregiver I about their conduct and demeanor towards Resident 4. Caregiver I was relieved of their duties until a full investigation was completed.

Operator Management H confirmed completing the internal investigation, but denied documenting the internal investigation or having a document that included, at minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure the residents' health, safety, and well-being.

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N 158	Continued From page 3 On 07/22/2026 at approximately 12:00 PM, Surveyors interviewed Licensee F and Operator Management H. Licensee E denied submitting a self-report to the department regarding law enforcement contact and the confirmed caregiver misconduct. Licensee E did not provide a reason as to why a self-report was not submitted to the Department. Operator Management H was not aware a self-report needed to be sent when there was reasonable cause to suspect caregiver misconduct as well as law enforcement contact.	N 158		
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 interviews, the provider and its operation did not comply with all laws governing the Community Based Residential Facility (CBRF). The licensee did not ensure compliance with DHS 83 was achieved and maintained. As a result of this verification visit and complaint investigation a total of 13 violations were issued. Two of the 13 violations were repeat deficiencies related to physical environment, training, licensee ensuring facility complies with laws, and administrator supervising daily operations. This is being cited for the 6th time. See Statement of Deficiency(SOD) OJO112, dated 06/10/2021, SOD OJO113, dated 01/11/2022, SOD OJOI14, dated 08/10/2022, SOD OJOI15, dated 11/30/2022, and SOD OJOI16, dated	N 196		

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N 196	Continued From page 4 08/15/2025. 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, 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. The census as of 07/22/2026 was 5. On 07/22/2026 at approximately 7:00 AM, Surveyor reviewed the facility's compliance history within the past 6 years. Since 06/10/2021 to date, the department has conducted a total of 7 regulatory visits consisting of 5 complaint investigations, 1 licensing survey, and 7 verification visits. Seven of the 7 visits resulted in deficiencies, substantiated complaints, and/or enforcement actions. The facility's compliance history identified the following: SOD OJO112, dated 06/10/2021, consisted of 1 complaint investigation and verification visit. One complaint was substantiated. N0196 - DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0427- DHS 83.38(1)(c) Leisure Time Activities N0452- DHS 83.41(3)(b) Food Safety N0499 - DHS 83.45(3) Toxic Substances N0507 - DHS 83.46(1)(f) Combustibles N0523- DHS 83.47(2)(b) Exit Diagram N0612- DHS 83.55(3) Bath And Toilet Areas: Handy Drying N0633- DHS 83.59(1)(c) Exit Doors,	N 196		

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N 196	Continued From page 5 Passageways 32 inches Clear SOD OJO113, dated 01/11/2022, consisted of a verification visit. Ten deficiencies were identified. Five of 10 deficiencies were repeat deficiencies. N0196 - DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws - This is a repeat deficiency. N0220- DHS 83.17(2)(a) Employees Screened For Communicable Disease N0389- DHS 83.35(3)(d) Service Plans Updated Annually or on Change N0391- DHS 83.35(3)(f) Staff Access To Assessment And ISP N0491- DHS 83.37(3)(c) Medication Storage Locked Cabinet N0499 - DHS 83.45(3) Toxic Substances- This is a repeat deficiency. N0507 - DHS 83.46(1)(f) Combustibles- This is a repeat deficiency. N0523- DHS 83.47(2)(b) Exit Diagram- This is a repeat deficiency. N0531- DHS 83.47(4)(a) Fire Extinguishers: Type And Inspection N0633- DHS 83.59(1)(c) Exit Doors, Passageways 32 inches clear- This is a repeat deficiency SOD OJOI14, dated 08/10/2022, consisted of a verification visit. Five deficiencies were identified. Three of 5 deficiencies were repeat deficiencies. N0196 - DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws - Cited for a 3rd time. N0499 - DHS 83.45(3) Toxic Substances- Cited for a 3rd time. N0501- DHS 83.45(5) Garbage & Refuse N0633- DHS 83.59(1)(c) Exit Doors,	N 196		

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N 196	Continued From page 6 Passageways 32 inches clear- Cited for a 3rd time. N0702- DHS 83.64(7) Small Cbrf Clear- Width Door Openings SOD OJOI15, dated 11/30/2022, consisted of a verification visit. Three deficiencies were identified. Three of 3 deficiencies were repeat deficiencies. N0196 - DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws - Cited for a 4th time. N0633- DHS 83.59(1)(c) Exit Doors, Passageways 32 inches clear- Cited for a 4th time N0702- DHS 83.64(7) Small Cbrf Clear- Width Door Openings- This is a repeat deficiency. SOD OJOI16, dated 08/15/2025, consisted of 1 complaint investigation and a verification visit. Three of the 3 previous deficiencies were recited with 7 new deficiencies. One complaint was unsubstantiated. N0179- DHS 83.13(1)(g) Maintain Records Of Quarterly Fire Drills N0196- DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws - Cited for a 5th time. N0305- DHS 83.28(6) Resident Rights Grievance Procedure, Rules N0310- DHS 83.29(2) Admission Agreement Include Services, Charges N0386- DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0387- DHS 83.35(3)(b) Service Plan Development: Parties Involved N0526- DHS 83.47(2)(e) Other Evacuation Drills N0531- DHS 83.47(4)(a) Fire Extinguishers:	N 196		

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N 196	Continued From page 7 Type And Inspection- This is a repeat deficiency. N0633- DHS 83.59(1)(c) Exit Doors, Passageways 32 inches clear- Cited for a 5th time. N0702- DHS 83.64(7) Small Cbrf Clear- Width Door Openings- Cited for a 3rd time. SOD OJOI17, dated 03/10/2026, consisted of 2 complaint investigations and 1 verification visit. One complaint was substantiated. A Notice and Order Letter was sent via email. The following deficiencies were identified: N0287- DHS 83.27(2)(a) Admissions Compatible With The License Class N0389- DHS 83.35(3)(d) Service Plans Updated Annually Or on Changes- This is a repeat deficiency. N0433- DHS 83.38(1)(i) Behavior Management The Notice and Order Letter included the following: Special Orders: Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that North Shore House: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall develop and implement corrective measures to resolve the deficiencies in Statement of Deficiency OJOI17. The corrective measures shall include, at a minimum, the development (or review/revision) of written procedures to address: Behavior Management	N 196		

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N 196	Continued From page 8 The procedure shall include, but is not limited to: (a) identifying specific behavior patterns that are or may be harmful to the resident or others, (b) assessing and documenting contributing factors to the behaviors, (c) developing and implementing the Individualized Service Plan (ISP) with specific individualized interventions to reduce incidences of these behaviors, (d) staff response when the identified interventions are not effective, (e) monitoring the effectiveness of any behavioral intervention including the use of PRN psychotropic medications, and (f) notifying the resident's legal representative and physician when there is a significant change in a resident's mental condition. SOD OJOI18, dated 07/22/2026, consisted of a verification visit and 1 complaint investigation. A total of 13 deficiencies were identified. Two of the 13 deficiencies were repeat deficiencies. One complaint was substantiated. N0158- DHS 83.12(2)(a) Caregiver Investigating Abuse and Neglect N0196- DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws - Cited for a 6th time N0200- DHS 83.14(2)(e) Notify Within 7 Days Of Administrator Change N0230- DHS 83.19 Orientation N0239- DHS 83.20(2)(a)-(d) Department Approved Training N0243- DHS 83.21(1)-(3) All Employee Training N0287- DHS 83.27(2)(a) Admissions Compatible with the License Class- This is repeat deficiency. N0302- DHS 83.28(4)(a) Resident Health Screening and Documentation N0348- DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment N0381- DHS 83.35(1)(a) Pre-Admission And	N 196		

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N 196	Continued From page 9 Ongoing Assessments N0387- DHS 83.35(3)(b) Service Plan Development: Parties Involved N0492- DHS 83.45(1)(a) Exterior Areas N0663- DHS 83.59(6)(c) Mounting Height Of Handrails On Ramps On 07/22/2026, at approximately 12:00 PM, Surveyor interviewed Licensee F. Licensee F acknowledged the facility's compliance history. Licensee F acknowledged the deficiencies that were identified on 07/22/2026 while Surveyors were onsite. Licensee F reported s/he would work on correcting the identified deficiencies.	N 196		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the Department within 7 days of administrator change for 1 of 1 administrator (Administrator J). Findings include: On 07/22/2026, at approximately 9:30 AM, Surveyors entered the facility and requested to speak with the administrator to begin the survey entrance conference. Licensee F met with Surveyors. On 07/22/2026, at approximately 12:00 PM, Surveyors interviewed Licensee F and Operator Management H. Licensee F stated s/he had been the provider's administrator "for a while".	N 200		

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N 200	Continued From page 10 Licensee F reported s/he did not report the administrator change to the Department. On 07/22/2026, Surveyor reviewed the Department's facility electronic file and did not locate notification of administrator change. The facility correspondence records indicated Administrator J had been in place since February 13, 2023.	N 200		
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 1 of 1 (Caregiver I) employee reviewed received orientation in the required topics: (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	N 230		

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procedures, (5) Community Based Residential Facility (CBRF) policies and procedures, (6) Recognizing and responding to resident changes of condition.

This is a repeat deficiency. See Statement of Deficiency OJO113, dated 01/11/2022.

Findings include:

The provider is licensed as a Class CS (semi-ambulatory) facility to care for 8 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, developmentally disabled and emotionally disturbed/mental illness. On 07/22/2026, the facility census was 5.

The following definition of Wis. Admin. Code § DHS 83.02 is as follows:

Wis. Admin. Code § DHS 83.02(22) "Employee" means any person who works for a CBRF or for an entity that is affiliated with the CBRF or that is under contract to the CBRF, who is under direct control of the CBRF or corporation affiliated with the CBRF and who receives compensation subject to state and federal employee withholding taxes.

On 07/22/2026 at approximately 10:00 AM, Surveyor reviewed Caregiver I's record. Caregiver I was hired on 01/28/2026. Caregiver I's record did not contain evidence of having completed orientation in prevention and reporting of resident abuse, neglect, and misappropriation of resident property and recognizing and responding to resident changes of condition.

On 07/22/2026 at approximately 12:00 PM,

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N 230	Continued From page 12 Surveyors interviewed Licensee F and Operator Management H. Operator Management H disclosed management was responsible for ensuring all staff completed orientation as management is the individual who completes orientation with the caregivers. Operator Management H stated a different manager hired Caregiver I. Operator Management H could not state why Caregiver I did not complete orientation in all required topics. Licensee F reported staff files are audited every quarter to ensure compliance. Licensee F acknowledged Caregiver I's record should have been audited at least once this year. When asked why Caregiver I's file was not found to be in compliance, Licensee F did not provide a reason.	N 230		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter	N 239		

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N 239	Continued From page 13 medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 (Caregiver I) employee reviewed obtained all department approved training as required. Caregiver I did not have training in fire safety within 90 days after starting employment. Findings include: On 07/22/2026 at approximately 10:00 AM, Surveyor reviewed Caregiver I's file. Caregiver I was hired on 01/28/2026. Caregiver I's record indicated s/he received training in medication administration, personal care, and first aid/choking. Caregiver I's record did not contain evidence of completed training or evidence of meeting an exemption for fire safety. On 07/22/2026, Surveyor verified Caregiver I was not on the Community-Based Care and Treatment training registry for fire safety. On 07/22/2026 at approximately 12:00 PM, Surveyors interviewed Licensee F and Operator Management H. Operator Management H disclosed management was responsible for ensuring all staff have completed the required training(s). Operator Management H stated a different manager hired Caregiver I and was supposed to ensure Caregiver I completed all	N 239		

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N 239	Continued From page 14 department approved training courses. Operator Management H could not state why Caregiver I did not complete fire safety. Licensee F reported staff files are audited every quarter to ensure compliance. Licensee F acknowledged Caregiver I's record should have been audited at least once this year. When asked why Caregiver I's file was not found to be in compliance, Licensee F did not provide a reason.	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment.	N 243		

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N 243	Continued From page 15 Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 (Caregiver I) employee reviewed, obtained all training as required within 90 days after starting employment. Caregiver I did not have training in resident rights, client groups, and recognizing, preventing, managing, and responding to challenging behaviors within 90 days of starting employment. Findings include: The facility was licensed on 07/01/2010 to provide care and services to residents within the client groups of irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and developmentally disabled. On 07/22/2026 at approximately 10:00 AM, Surveyor reviewed Caregiver I's file. Caregiver I was hired on 01/28/2026. Caregiver I's record	N 243		

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N 243	Continued From page 16 indicated s/he received training in medication administration, personal care, and first aid/choking. Caregiver I's record did not contain evidence of completed training in resident rights, client group, and recognizing, preventing, managing, and responding to challenging behaviors within 90 days of starting employment. In addition, Caregiver I's file did not include evidence of meeting an exemption for any of the required trainings. On 07/22/2026 at approximately 12:00 PM, Surveyors interviewed Licensee F and Operator Management H. Operator Management H disclosed management was responsible for ensuring all staff have completed the required training(s) within the required time frame. Operator Management H stated a different manager hired Caregiver I and provided the required trainings. Operator Management H could not state why Caregiver I had not completed the above required trainings. Licensee F reported staff files are audited every quarter to ensure compliance. Licensee F acknowledged Caregiver I's record should have been audited at least once this year. When asked why Caregiver I's file was not found to be in compliance, Licensee F did not provide a reason.	N 243		
{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).	{N 287}		

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{N 287}	Continued From page 17 This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 5 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. This is a repeat deficiency. See Statement of Deficiency OJOI17, dated 03/10/2026. 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, 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 07/22/2026, at approximately 9:30 AM,	{N 287}		

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{N 287}	Continued From page 18 Surveyors entered the facility and observed Resident 2 in a wheelchair sitting in the living room watching television. On 07/22/2026, at approximately 9:50 AM, Surveyors 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 07/22/2026, at approximately 12:15 PM, Surveyors interviewed Licensee F about Resident 2 residing in the facility while using a wheelchair. Surveyor asked Licensee F if s/he received the Statement of Deficiency(SOD) OJOI17 notice, dated 05/13/2026. Licensee F confirmed s/he received the SOD and indicated Resident 2 would be moving to another facility by the end of the week. Licensee F reported Resident 2's family did not want Resident 2 to move. Licensee F confirmed s/he had more than 45 days to move Resident 2 to another facility. Licensee F reported Resident 2 would be moving to another facility owned by Licensee F. Surveyors asked for supporting documentation to ensure Resident 2 was moving at the end of the week. Licensee F was unable to produce documentation reflecting Resident 2 would be moving to another facility by the end of the week.	{N 287}		

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N 302	Continued From page 19	N 302		
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: Based on record review and interview, the provider did not obtain a screening for clinically apparent communicable disease, including tuberculosis (TB), by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before or 7 days after admission for 1of 1 resident reviewed (Resident 6) Findings include: On 07/22/2026, at 10:00 AM, Surveyor reviewed resident records and identified the following: Resident 6 was admitted on 03/09/2026. Resident 6's record contained a TB test document dated 03/05/2026. Resident 6's record	N 302		

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N 302	Continued From page 20 did not contain a communicable disease screening. The results on the document were for the TB test only. On 07/22/2026, at approximately 12:00 PM, Surveyors interviewed Licensee F. Licensee F indicated s/he was aware of residents needing at TB test and communicable disease screening completed. Licensee F indicated the document would normally say "free of all communicable disease." The document viewed by Licensee F and Surveyors did not mention communicable disease screening. Licensee F could not provide an explanation as to why a communicable disease screening was not completed for Resident 6.	N 302		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 1 resident (Resident 4) was free from mistreatment. On 04/29/2026. Caregiver I threatened to physically harm Resident 4 and called Resident 4 derogatory names.	N 348		

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N 348	Continued From page 21 Findings include: The provider is licensed as a Class CS (semi-ambulatory) facility to care for 8 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, developmentally disabled and emotionally disturbed/mental illness. On 07/22/2026, the facility census was 5. On 06/03/2026, the Department received a complaint concerning a caregiver to resident altercation. On 07/22/2026, at approximately 10:30 AM, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 02/13/2025 with diagnoses including schizoaffective disorder. Resident 4's record indicated Resident 4 had a legal guardian. On 07/22/2026, at approximately 10:00 AM, Surveyor reviewed Caregiver I's record. Caregiver I was hired on 01/28/2026. Caregiver I was terminated on 05/19/2026 due to misconduct towards Resident 4. On 07/22/2026 at approximately 9:30 AM, Surveyor interviewed Operator Management H. Operator Management H disclosed on 04/29/2026, Resident 4 went into the garage. Caregiver I followed Resident 4 into the garage as Caregiver I stated Resident 4 had a screwdriver. Per Operator Management H, a verbal altercation occurred between Resident 4 and Caregiver I. For the safety of Resident 4 and Caregiver I, Caregiver I contacted the Fox Point Police Department. Operator Management H stated he/she received a phone call from the police officer informing him/her of the verbal	N 348		

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N 348	Continued From page 22 altercation between Resident 4 and Caregiver I. Operator Management H reported on the same day as the above incident; Operator Management H received a phone call from Resident 4's family member. The family member allegedly overheard Caregiver I threaten to physically harm Resident 4 and calling Resident 4 derogatory names. Operator Management H disclosed Resident 4's family member recorded the interaction between Caregiver I and Resident 4. Operator Management H listened to the recording, and confirmed the voice of the caregiver appeared to belong to Caregiver I. Resident 4's family member informed Operator Management H that Fox Point Police Department was contacted for the safety of Resident 4. Operator Management H stated he/she immediately went to the facility. Upon arrival, Operator Management H reported overhearing Caregiver I talk to Resident 4 in a disrespectful manner. Operator Management H reported having a conversation with Caregiver I about their conduct and demeanor towards Resident 4. Caregiver I was relieved until a full investigation could be completed. On 07/22/2026 at approximately 12:00 PM, Surveyors interviewed Licensee F and Operator Management H. Operator Management H stated Caregiver I and Resident 4 never got a long since Caregiver I was hired.	N 348		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental	N 381		

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N 381	Continued From page 23 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 assess 1 of 1 resident (Resident 6) after s/he fell on 05/16/2026. Findings include: On 07/22/2026, at approximately 10:00 AM, Surveyor reviewed resident records and identified the following: Resident 6 was admitted to the facility on 03/09/2026. Resident 6 had an activated healthcare power of attorney. Resident 6 had diagnosis of dementia, cerebrovascular accident, stage 3 chronic kidney disease and cardiovascular disease. Resident 6 's incident report, dated 05/16/2026, at 11:17 PM, indicated Resident 6 was found on the floor of his/her bedroom by facility staff. Facility staff assisted Resident 6 back into the bed and no injuries were observed. Resident 6's pre admission assessment identified him/her as a fall risk. A fall risk assessment was completed on 03/11/2026. There was no assessment after Resident 6's fall on 05/16/2026.	N 381		

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N 381	Continued From page 24 On 07/22/2026 at approximately 12:00 PM, Surveyors interviewed Licensee F and Operator Management H. Operator Manager H reported Licensee F was responsible for conducting assessments. Licensee F confirmed Resident 6 was not assessed after his/her fall on 05/16/2026. Licensee F reported s/he did not know why a risk assessment was not completed after Resident 6's fall on 05/16/2026.	N 381		
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 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	N 387		

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N 387	Continued From page 25 with the ISP for 1 of 1 residents (Resident 6) reviewed. This is a repeat deficiency. See Statement of Deficiency OJOI16, dated 08/15/2025. Findings include: On07/22/2026, at approximately 10:00 AM, Surveyors reviewed resident records and observed the following: Resident 6 was admitted to the facility on 03/09/2026. Resident 6 had an activated healthcare power of attorney and a managed care organization (MCO). Resident 6's ISP, dated 03/11/2026 was not signed by all parties involved. Resident 6's ISP was not signed by the guardian or the managed care organization care team. On 07/22/2026 at approximately 12:00 PM, Surveyors interviewed Licensee F and Operator Management H. Operator Manager H and Licensee F indicated they were familiar with the Department's code to have all parties sign ISPs. Operator Management H and Licensee F could not provide an explanation as to why Resident 6's ISP was not signed by all parties.	N 387		
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 ensure the facility was maintained in good	N 492		

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N 492	Continued From page 26 repair. One of 2 exit ramps was in disrepair. The ramp was made of wood and there were several decaying boards which were loose. The guardrails were unstable. Findings include: On 07/22/2026, at approximately 11:45 AM, Surveyors observed the entrance ramp to the facility to be in disrepair. The ramp contained approximately 16 loose and decaying ramp decking boards. The guardrails on both sides of the ramp were unstable. The guardrail located on the right side was leaning towards the ground. On 07/22/2026 at approximately 12:00 PM, Surveyors interviewed Licensee F and Operator Management H. Licensee F confirmed s/he was not aware of the ramp needing repairs. Operator Management H confirmed the ramp had shifted and needed repairs.	N 492		
N 663	83.59(6)(c) Mounting height of handrails on ramps Handrails. 1. Ramps in CBRFs initially licensed on or after January 1, 1997 shall have a handrail on each side which shall be mounted between 34 inches and 38 inches above the ramp surface. CBRFs licensed before January 1, 1997 shall have handrails mounted at least 30 inches above the ramp surface. 2. Handrails on unenclosed ramps shall include an intermediate parallel rail at mid-height. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 exit ramps had handrails.	N 663		

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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 663	Continued From page 27 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, 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 07/22/2026 at approximately 9:35 AM, Surveyors toured the interior and exterior of the home. Surveyors observed 2 of 2 exit ramps did not have handrails. Licensee F stated s/he did not know the ramps were not up to code.	N 663		