STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019798	A. BUILDING: _____ B. WING _____	C 10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS WISCONSIN (THE)	621 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 09/30/2025 to 10/03/2025, Surveyor conducted a complaint investigation at Rivers Wisconsin (The). Three deficiencies were identified. The complaint was substantiated. Census: 12	N 000		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. Resident 1 refused his/her Trelegy Elipta inhaler on consecutive days during the months of July, August, and September 2025 without notification sent to the	N 410		

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

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N 410	Continued From page 1 prescribing practitioner. Findings include: On 09/30/2025, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 11/01/2024 with a diagnosis of hypertension. Resident 1 is their own decision maker. Resident 1's individual support plan (ISP) dated 12/04/2024, indicated staff administer Resident 1's medications. Resident 1's physician orders included "Trelegy Elipta with instructions to inhale 1 puff by mouth once daily (rinse mouth after each use) *wait 1 minute between puffs*, with a start date of 07/09/2025." Surveyor reviewed Resident 1's July to September 2025 medication administration record (MAR). The MAR included the following dates Resident 1 refused his/her Trelegy inhaler: July: 07/10/2025-07/13/2025, 07/16/2025-07/17/2025, 07/21/2025-07/22/2025, and 07/24/2025-07/31/2025. August: 08/08/2025-08/10/2025, 08/13/2025-08/16/2025, 08/23/2025-08/24/2025, 08/27/2025-08/30/2025. September: 09/02/2025-09/04/2025, 09/06/2025-09/07/2025, 09/10/2025-09/15/2025, 09/20/2025-09/21/2025, 09/23/2025-09/24/2025. Resident 1's progress notes documented: "09/15/2025: staff observed resident having a difficulty breathing, took vitals, talked with AD and [s/he] is [his/her] own person. Asked resident what [s/he] wanted to do and [s/he] said I want to be sent out I am having difficulty breathing." Resident 1's after visit summaries documented:	N 410		

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N 410	Continued From page 2 "09/25/2025 appointment with his/her primary care physician (PCP): Instructions-I am ordering you a new inhaler that is not a powder, called Breztri. Take the Trelegy Elipta until you get the new Breztri inhaler. Use albuterol any time you feel short of breath. You did not take this on the day you felt short of breath and went to the ER on 09/19. Any time you feel short of breath, your assisted living facility should be giving you your albuterol inhaler and measuring your oxygen saturation. For the shortness of breath, leg swelling, and weight fluctuations, and heart murmur, I ordered an echocardiogram to evaluate for heart failure." "-09/19/2025 emergency department: Reason for visit: Illness, Diagnosis: Shortness of breath -09/17/2025 emergency department: Reason for visit: Dyspnea, Diagnosis: Shortness of breath -09/15/2025 emergency department: Reason for visit: Dyspnea, Diagnosis: Shortness of breath." On 09/30/2025 at 1:25 PM, Surveyor interviewed and shared findings with Executive Director A, Nurse B, and Consultant C. The management team acknowledged Resident 1's record did not contain notification to Resident 1's PCP when s/he refused his/her Trelegy inhaler on consecutive days during the months of July to September 2025. Consultant C reported the provider will start sending faxes to the PCP when residents refuse medications on consecutive days.	N 410		
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	N 431		

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N 431	Continued From page 3 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: Based on record review and interview, the provider did not ensure Resident 1 had their health monitored and communication with the resident's physician was documented in the resident's record. Resident 1's blood pressure was not recorded on 10 occurrences over 47 days. Findings include: On 09/16/2025, the Department received a complaint alleging concerns related to a residents hypertension medication.	N 431		

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N 431	Continued From page 4 On 09/30/2025, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 11/01/2024 with a diagnosis of hypertension. Resident 1 is their own decision maker. Resident 1's individual support plan (ISP) dated 12/04/2024, indicated staff administer Resident 1's medications. Resident 1's physician orders included "Lisinopril 10mg with instructions to take 1 tablet by mouth daily, with a start date of 04/01/2025 and end date of 05/15/2025." Resident 1's after visit summary with his/her primary care physician dated 04/01/2025 documented: "Instructions: ....I increased your BP medication (lisinopril) to 10mg. Take this daily and measure your BP one hour after." Surveyor reviewed Resident 1's medication administration record (MAR) from 04/01/2025 to 05/19/2025, where staff documented Resident 1's blood pressure. Surveyor observed on the following dates, Resident 1's blood pressure was never recorded after Lisinopril was administered: -04/04/2025: Lisinopril (8am) documented as administered, blood pressure not recorded. -04/12/2025: Lisinopril (8am) documented as administered, blood pressure not recorded. -04/13/2025: Lisinopril (8am) documented as administered, blood pressure not recorded. -04/15/2025: Lisinopril (8am) documented as administered, blood pressure not recorded. -04/18/2025: Lisinopril (8am) documented as administered, blood pressure not recorded. -04/25/2025: Lisinopril (8am) documented as administered, blood pressure not recorded. -04/26/2025: Lisinopril (8am) documented as	N 431		

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N 431	Continued From page 5 administered, blood pressure not recorded. -05/02/2025: Lisinopril (8am) documented as administered, blood pressure not recorded. -05/10/2025: Lisinopril (8am) documented as administered, blood pressure not recorded. -05/11/2025: Lisinopril (8am) documented as administered, blood pressure not recorded. On 09/30/2025 at 1:25 PM, Surveyor interviewed and shared findings with Executive Director A, Nurse B, and Consultant C. The management team acknowledged Resident 1's record did not contain blood pressure values in April and May 2025. Nurse B noted these concerns occurred before s/he started. Consultant C stated the provider would make changes within their electronic health record that would require staff to record blood pressures before going to the next task.	N 431		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medication administration	N 432		

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services to meet the needs of Resident 1. Resident 1 missed 11 days of medications that assist in managing his/her diabetes type 2, deep vein thrombosis (DVT), chronic obstructive pulmonary disease (COPD), hyperlipidemia (HLD), depression, hypertension (HTN), GERD, and vascular dementia.

Findings include:

On 09/16/2025, the Department received a complaint alleging concerns with medication administration.

On 09/30/2025, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the facility on 11/01/2024 with a diagnoses of diabetes type 2, DVT, COPD, HLD, depression, HTN, GERD, and vascular dementia. Resident 1 is their own decision maker. Resident 1's individual support plan (ISP) dated 12/04/2024, documented:
-"Bill Paying: Resident has rep payee that helps with [his/her] bills. [His/her] rep payee will send [him/her] a card along with [his/her] check for spending money to the facility. This will allow the resident to use the money as [s/he] needs to.
-Medication Management: Staff will administer medications as prescribed. Resident will get their medications as ordered by the physician."

Resident 1's physician orders included:
"-Aspirin 81 mg, with instructions to chew and swallow 1 tablet by mouth once daily in the morning, with a start date of 08/25/2025.
-Citalopram 20 mg, with instructions to take 1 tablet by mouth once daily for mood, with a start date of 08/25/2025.
-Multivitamin, with instructions to take 1 tablet by

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mouth once daily, with a start date of 08/25/2025.
-Vitamin D3, with instructions to take 1 capsule by mouth once daily, with a start date of 08/25/2025.
-Vitamin B-12, with instructions to take 1 tablet by mouth once daily, with a start date of 08/25/2025.
-Atorvastatin 20 mg, with instructions to take 1 tablet by mouth once daily for hyperlipidemia, with a start date of 08/25/2025.
-Jardiance 25 mg, with instructions to take 1 tablet by mouth once daily for diabetes mellitus with hyperglycemia, with a start date of 08/25/2025.
-Eliquis 5 mg, with instructions to take 1 tablet by mouth twice daily, with a start date of 08/25/2025.
-Chlorthalidone 25 mg, with instructions to take 1 tablet by mouth once daily, with a start date of 08/25/2025."

Surveyor reviewed Resident 1's September 2025 medication administration record (MAR). The following codes were documented for all 9 scheduled medications Resident 1 was prescribed.

-Aspirin 81 mg, Citalopram 20 mg, Multivitamin, Vitamin D3, Vitamin B-12, Atorvastatin 20 mg, Jardiance 25 mg, Eliquis 5 mg, Chlorthalidone 25 mg:

The provider documented:
"-09/04/2025: "1"=Pending POA
-09/05/2025: "WMDO"=Waiting on MD refill.
-09/06/2025: "WMDO"=Waiting on MD refill.
-09/07/2025: "WMDO"=Waiting on MD refill.
-09/08/2025: "WMDO"=Waiting on MD refill.
-09/10/2025: "WMDO"=Waiting on MD refill.
-09/11/2025: "WMDO"=Waiting on MD refill.
-09/12/2025: "WMDO"=Waiting on MD refill.
-09/13/2025: "WMDO"=Waiting on MD refill.
-09/14/2025: "WMDO"=Waiting on MD refill.

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N 432	Continued From page 8 -09/15/2025: "WMDO"=Waiting on MD refill." Resident 1's progress notes documented: "-05/15/2025: resident is at the er [his/her] pcp sent [him/her] over due to a blockage that was found in [his/her] leg during [his/her] ultrasound. -09/09/2025 at 7:30 AM: resident went to [his/her] lab appointment for [his/her] pcp appointment next week. At 10:45 AM: RN notified that resident had lab drawn at Aspirus this morning and returned to facility. Shortly after resident returned, resident's doctor called facility to have resident sent to ER due to critically low potassium levels. Resident sent to ER via non-emergent ambulance. -09/15/2025: at 3:45 AM: staff observed resident having a difficulty breathing, took vitals, talked with AD and [s/he] is [his/her] own person. Asked resident what [s/he] wanted to do and [s/he] said I want to be sent out I am having difficulty breathing. At 4:00 PM: writer called pharmacy to see when they are sending [his/her] meds, they said they have not received payment, yet they said as soon as they get payment, they will be sending [his/her] meds. At 5:30 PM: Catholic Charities sent the check out on 9/8 this is what writer got when checking on payment with care team. -09/17/2025 at 4:15 AM: resident can't transfer without assistance, [s/he] can't get [him/herself] around the house in [his/her] wheelchair, [s/he] has hot sweats, [s/he] is pale and calmy [sic], [s/he] is weak in [his/her] legs. Resident yelled at staff when [s/he] was asked to be quiet and swore at staff." Surveyor reviewed a memo from Resident 1's pharmacy dated 8/6/2025. The following was documented: "This is to summarize my phone conversation with D.C regarding [Resident 1]. As	N 432		

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N 432	Continued From page 9 of today, 8/6/25, [s/he] has been placed on pick up only. [S/he] has an outstanding balance of $117.01 that needs to be resolved for deliveries to resume." Surveyor reviewed Resident 1's medical visit summaries on the following dates: "-05/15/2025: Hospital Emergency Department, Reason for visit Edema, Diagnosis-blood clot in vein. -05/15/2025 appointment with his/her primary care physician (PCP) at 2:00 PM: Instructions: Please ensure you have restarted your aspirin and Jardiance since after your cataract surgery. I increased your chlorthalidone (water pill) from 12.5mg to 25mg which will one full tablet daily. Continue to monitor blood pressures. F/U with Nephrology as scheduled. Ultrasound of your right leg today to rule out a clot-you will get these results before leaving today. -06/05/2025 appointment with his/her primary care physician (PCP) at 7:40 AM-Instructions: Continue intermittent walks throughout the day to help with circulation and prevention of future clots. Make sure to be stretching your legs throughout the day as well. Continue Eliquis 5mg, 1 tablet twice daily. For your diabetes, increasing Insulin Glargine to 32 units nightly. Continue working on decreased sugar and fast food intake. Follow -up in 3 months with Hgb A1C and fasting BMP prior. Fast 8 hours prior to lab. -09/15/2025: Hospital Emergency Department, Reason for visit-Abnormal Lab, Diagnosis-Low blood potassium. Instructions: Take the potassium supplement and follow up with your doctor for rechecked. -09/16/2025 appointment with his/her primary	N 432		

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care physician (PCP) at 7:40 AM-Instructions: Restart all medications as soon as possible. If you experience any shortness of breath, chest pain, palpitations, increased leg pain with swelling, go to ER. Without your medications, you are high risk for things like blood clots, heart attack, stroke.
Increase insulin to 36 units daily. Ultrasound of legs today. Once you do receive medications again, start citalopram with half tablet daily for 5 days, then increase to 1 tablet daily.

-09/17/2025: Hospital Emergency Department, Reason for visit-Dyspnea, Diagnosis-Shortness of breath. Instructions: As we discussed, the following describes what we did during your visit today and the plan moving forward:
1. Your evaluation included physical exam, lab testing, EKF, and X-Ray. Your potassium was slightly low. You were given an additional dose of potassium in the ER Your labs, EKG, and chest x-ray were otherwise unremarkable. You are negative for COVID, influenza and RSV. Shortness of breath due to fluid overload.
2. At home, please start taking your prescription medications as prescribed as soon as possible.
3. Follow up with Primary care in 1 week for recheck.

-09/19/2025: Hospital Emergency Department, Reason for visit-Illness, Diagnosis-Shortness of breath. Instructions: 1) Your chest xray was normal 2) Lung sounds are clear and equal bilaterally 3) Lab work is normal 4) EKG is normal 5) Cardiac enzymes are normal 6) Heart failure lab is normal 7) Vital signs are normal 8) Oxygen level is normal 9) Follow up with primary care next week 10) Return to the ER for any new or worsening symptoms.

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-09/25/2025 appointment with his/her primary care physician (PCP): Instructions-I am ordering you a new inhaler that is not a powder, called Breztri. Take the Trelegy Elipta until you get the new Breztri inhaler.
Use albuterol any time you feel short of breath. You did not take this on the day you felt short of breath and went to the ER on 09/19. Any time you feel short of breath, your assisted living facility should be giving you your albuterol inhaler and measuring your oxygen saturation.
For the shortness of breath, leg swelling, and weight fluctuations, and heart murmur, I ordered an echocardiogram to evaluate for heart failure."

Surveyor reviewed emails between Assistant Director D and Case Manager E:
"-08/21/2025-Assistant Director D sent to Case Manager E: Good evening, I was wondering if there is any progress on the rep payee conversation. [Resident 1] has a past due pharmacy bill. I gave [him/her] the fax that we got from the pharmacy and [s/he] said [s/he] would pay it. I will remind [him/her] again closer to the first that [s/he] needs to pay this but I feel like [s/he[would benefit from having one as soon as [his/her] money gets on [his/her] card [s/he] goes out and spends it.
-08/22/2025-Case Manager E replied to Assistant Director D: Good morning, I just received notice yesterday that [Resident 1] was approved for rep payee and Catholic Charities will take over beginning in September. They will be sending [him/her] a debit card in the mail that will have [his/her] monthly spending money on it. Would you be able to send me the bill for the pharmacy and I will forward to Catholic Charities.
-09/12/2025-Assistant Director D sent to Case Manager E: Good Evening, I was wondering if the rep payee started paying anything, yet we

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(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
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received this on the fax.
-09/15/2025-Assistant Director D sent to Case Manager E: Good Morning, [Resident 1] ended up going to the er last night this is [his/her] after visit, [s/he] thought that the er would give [him/her] medicine.
-09/15/2025-Case Manager E replied to Assistant Director D: Good Morning, Catholic Charities sent the check out on 9/8 so the pharmacy should receive it soon."

Interviews:

On 09/30/2025 at 9:00 AM, Surveyor interviewed Caregiver F. Caregiver F reported at the beginning of the month, Resident 1 did not get his/her routine medications due to issues with his/her payee. Caregiver F stated staff reported concerns to management but they were waiting to hear back from the rap payee. Caregiver F noted since 09/18/2025 all of Resident 1's medications were delivered.

On 09/30/2025 at 9:10 AM, Surveyor interviewed Assistant Director D regarding concerns related to Resident 1 missing his/her medications. Assistant Director D confirmed Resident 1 went without his/her medications for a period of time due to non-payment of a bill ordered to the pharmacy. Assistant Director D reported ongoing concerns with trying to get Resident 1 dating back to the spring and just beginning of this month, did his/her rep payee services start. Surveyor asked for evidence of the provider following up with the pharmacy or Resident 1's care team trying to ensure medication administration services were met for Resident 1.

On 09/30/2025 at 9:25 AM, Surveyor interviewed Executive Director A regarding the above

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	0019798	A. BUILDING: _____ B. WING _____	C 10/03/2025

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concerns. Executive Director A confirmed Resident 1 went without his/her medications for a time. Executive Director A reported s/he was not 100% sure what RN B and Assistant Director D did on Resident 1's behalf when s/he was out of medications. Executive Director A stated Resident 1 went to the ER at least once while s/he was out of medications. Executive Director A reported Resident 1 went to an appointment with his/her PCP, and s/he was upset Resident 1 hadn't been taking his/her medications.

On 09/30/2025 at 9:40 AM, Surveyor interviewed Resident 1 in his/her room. Resident 1 reported s/he had been living at the facility for approximately a year and never had any issues with medications until the beginning of September. Resident 1 stated s/he had an outstanding bill due at the pharmacy and s/he showed the Surveyor the memo dated 08/06/2025. Surveyor noted that deliveries were only suspended. Surveyor asked if the provider called the pharmacy about having Resident 1's medications picked up. Resident 1 stated s/he did not know. Resident 1 reported s/he went to an appointment with his/her PCP a few week ago and shared concerns about missing medications and s/he was pissed. Resident 1 reported s/he went to the ER several times while out of medications.

On 09/30/2025 at 1:25 PM, Surveyor interviewed and shared findings with Executive Director A, Nurse B, and Consultant C. The management team acknowledged Resident 1 did not get his/her medications for several days this month. Nurse B reported the pharmacy would not budge about the past due payment Resident 1 owed. Surveyor showed Consultant C the memo dated 08/06/2025 from the pharmacy regarding

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Resident 1's balance s/he owed and how only deliveries were suspended. The management team stated they have never seen this memo and the provider does not get involved with resident funds. Surveyor asked if the provider followed up with the pharmacy about having Resident 1's medications picked up or trouble shooting the issue to find a reasonable solution. The management team was unable to provide evidence the provider followed up with the pharmacy. Surveyor asked if another pharmacy was explored. The management team stated "no." Consultant C stated s/he would work with the owners to come up with a policy to address this issue.

On 10/03/2025 at 11:52 AM, Surveyor interviewed Pharmacy Staff G via phone regarding Resident 1's missed medications. Pharmacy Staff G stated the pharmacy received payment on 09/17/2025 and deliveries resumed on 09/18/2025. Pharmacy Staff G reported we contacted the facility on 08/06/2025 regarding Resident 1's past due balance. Pharmacy Staff G stated the pharmacy received a new order on 09/09/2025 for potassium, but that was not delivered but could have been picked up. Pharmacy Staff G reported usually if deliveries are suspended, medications can still be picked up at the pharmacy. Pharmacy Staff G reported s/he could not find any communication from the facility in their system from 09/04/2025 to 09/17/2025. Pharmacy Staff G stated if the facility would have called the pharmacy we could have troubleshoot the issue. Pharmacy Staff G stated s/he was going to have his/her manager call the Surveyor back after reviewing Resident 1's account.

On 10/03/2025 at 2:03 PM, Surveyor interviewed Pharmacy Staff H via phone. Pharmacy Staff H

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N 432	Continued From page 15 reported Resident 1's automatic refills that s/he received via delivery were suspended at the beginning of September because s/he had a past due bill. Pharmacy Staff H stated if someone from the facility or associated with the patient would have called the pharmacy, we would have filled the medications, and someone could have picked them up. Pharmacy Staff H stated the facility receives medications delivered on a 4-week cycle. Pharmacy Staff H reported after reviewing their system, we did not have anyone reach out on Resident 1's behalf regarding the missed medications. Summary: The provider did not ensure residents received medications as appropriate to the residents' needs and as ordered when Resident 1 did not receive his/her scheduled medications for 11 days.	N 432		