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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS-WISCONSIN (THE)	621 LATTON LANE 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 08/08/2023, the Bureau of Assisted Living, Southern Regional Office conducted 3 verification visits at The Rivers-Wisconsin, a CBRF located in Portage, WI. As a result of the survey, 6 violations of Chapter DHS 83 were issued. Twenty-three violations from previous SODs # 744X12, SOD# ZK0812 dated 05/15/2023 and SOD# QDKR13 dated 02/24/2023 were corrected. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed.	N 000		
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 that 1 of 1 employees (Caregiver H) had orientation training prior to performing any job duties which included training	N 230		

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

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N 230	Continued From page 1 in all the required topics. This is a repeat violation from previous statement of deficiency 744X11 dated 03/24/2023. Findings include: On 08/08/2023, Surveyor reviewed employee records and identified the following: Caregiver H was hired 05/04/2023 and his/her record did not include orientation training prior to performing duties. On 08/08/2023 at 11:00 AM, Surveyor interviewed Administrator G. Surveyor asked if the provider had evidence Caregiver H had completed orientation prior to performing job duties. Administrator G stated s/he gave Surveyors all the employee training records s/he could find and Caregiver H, "was hired before I was so I didn't check his/her training."	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	N 239		

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N 239	Continued From page 2	N 239		

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 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 3 employees reviewed obtained all department-approved training as required.

Caregiver H did not have training in fire safety or first aid and choking.

This is a repeat deficiency. See Statement of Deficiency (SOD) ZK0811, dated 12/16/2022, and SOD ZK0812 dated 05/17/2023.

Findings include:

On 08/08/2023, Surveyor conducted a review of 3 employees to verify compliance with department-approved training requirements. Surveyor requested training records from Administrator G for Caregiver H .

Fire Safety:

The record for Caregiver H, hired 05/04/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety. On

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N 239	Continued From page 3 08/08/2023, at approximately 11:00 AM, Surveyor interviewed Administrator G . Administrator G stated that s/he had just discovered that Caregiver H did not complete or meet an exemption for fire safety training. Administrator G confirmed with Surveyor that Caregiver H has been on the schedule and working alone since 05/20/2023. Administrator G acknowledged that Caregiver has been employed longer than 90 days. On 08/08/2023, Surveyor verified Caregiver H was not on the Community-Based Care and Treatment training registry for fire safety. First Aid and Choking: The record for Caregiver H, hired 05/04/2023, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 08/08/2023, at approximately 11:00 AM, Surveyor interviewed Administrator G . Administrator G stated that s/he had just discovered that Caregiver H did not complete or meet an exemption for first aid and choking training. Administrator R confirmed with Surveyor that Caregiver H has been on the schedule and working alone since 05/20/2023. Administrator G acknowledged that Caregiver has been employed longer than 90 days. On 08/08/2023, Surveyor verified Caregiver H was not on the Community-Based Care and Treatment training registry for first aid and choking..	N 239		
N 352	83.32(3)(h) Rights of Residents: Receive medication	N 352		

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N 352	Continued From page 4 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents received all prescribed medications in the dosage and intervals prescribed by the physician. Resident 2 did not receive medications for the months of June 2023, July 2023, and August 2023 as prescribed. This is a repeat violation from previous Statement of Deficiency (SOD) # 2K0811, dated 12/16/2022. Findings include: This facility provide care to the following client groups: irreversible dementia, Alzheimer's, advanced aged, terminally ill, physically disabled, emotionally disturbed and the mentally ill. On 08/08/2023 at 8:30 AM, Surveyors arrived at facility for a verification visit. On 08/08/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/08/2022. Resident 2 is their own legal decision maker. Resident 2's individual service plan (ISP) dated 04/14/2023 documented: "Medication Management: Needs assistance administering medications. To receive assistance from staff administering medications. Diabetic-Blood Sugar Checks: Resident needs	N 352		

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scheduled blood sugar checks. Requires blood sugars to be taken 4x's a day (before meals and at bed time.)"

Resident 2's physician orders documented: "Insulin Lispro 100U/ML Kwikpen with instructions to inject separate baseline dosages at breakfast, lunch, and dinner, in addition to the following sliding scale: 70-140- 0 units, 141-180=2 units, 181-220=4 units, 221-260=6 units, 261-300=8 units, 301-350=10 units, >350=12 units call PCP if BS is over 350."

A review of Resident 2's medication administration record (MAR) from 06/19/2023-08/07/2023, Surveyor observed the following discrepancies:

-06/24/2023 (breakfast insulin administration): Blood sugar documented as 245 (within the parameters for 6 units), 8 units administered documented

-06/27/2023 (lunch insulin administration): Blood sugar documented as 226 (within the parameters for 6 units), 4 units administered documented

-06/30/2023 (breakfast insulin administration): Blood sugar documented as 154 (within the parameters for 2 units), 4 units administered documented

-07/01/2023 (lunch insulin administration): Blood sugar documented as 271 (within the parameters for 8 units), 2 units administered documented

-07/07/2023 (dinner insulin administration): Blood sugar documented as 181 (within the parameters for 4 units), 2 units administered documented

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N 352	Continued From page 6 -07/09/2023 (breakfast insulin administration): Blood sugar documented as 185 (within the parameters for 4 units), 2 units administered documented -07/09/2023 (lunch insulin administration): Blood sugar documented as 259 (within the parameters for 6 units), 5 units administered documented -07/11/2023 (lunch insulin administration): Blood sugar documented as 118 (within the parameters for 0 units), 4 units administered documented -07/13/2023 (breakfast insulin administration): Blood sugar documented as 212 (within the parameters for 4 units), 2 units administered documented -07/28/2023 (lunch insulin administration): Blood sugar documented as 158 (within the parameters for 2 units), 4 units administered documented -08/02/2023 (breakfast insulin administration): Blood sugar documented as 252 (within the parameters for 6 units), 8 units administered documented -08/03/2023 (breakfast insulin administration): Blood sugar documented as 179 (within the parameters for 2 units), 4 units administered documented -08/03/2023 (dinner insulin administration): Blood sugar documented as 294 (within the parameters for 8 units), 10 units administered documented -08/05/2023 (dinner insulin administration): Blood sugar documented as 218 (within the parameters for 4 units), 2 units administered documented	N 352		

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N 352	Continued From page 7 -08/06/2023 (dinner insulin administration): Blood sugar documented as 216 (within the parameters for 4 units), 2 units administered documented On 08/08/2023 at 1:15 PM, Surveyor discussed the above concern with Administrator G. Administrator G acknowledged staff did not administer Resident 2's sliding scale insulin as prescribed. Administrator G stated staff would be retrained.	N 352		
{N 383}	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal	{N 383}		

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relationships, communication skills, leisure time activities, family and community contacts and vocational needs.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure the resident assessment, at a minimum included all of the areas applicable to the resident risks, including, choking, falling, and the use of adaptive equipment.

This is a repeat violation from statement of deficiency (SOD) 744X11, dated 03/24/2023, SOD QDKR11 dated 03/30/2022 and QDKR12 dated 09/20/2022.

FINDINGS:

This facility provides care to the following client groups: irreversible dementia, Alzheimer's, advanced aged, terminally ill, physically disabled, emotionally disturbed and the mentally ill.

On 08/08/2023, Surveyors conducted a verification visit and observed the following:

At 1:16 PM, Surveyor observed Resident 2 had 2 quarter bedrails in the up position.

Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/08/2022. Resident 2 is their own legal decision maker.

Resident 2's assessment dated 04/07/2023 documented:
"Mobility and Transferring: Requires monitoring

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and cuing with all walking needs. Issuance of verbal prompting and physical assistance as needed. Service Provider Responsibilities: Resident/Staff." The assessment did not include information related to Resident 2's use of a bedrail.

Resident 2's individual service plan (ISP) dated 04/14/2023 did not include information related to Resident 2's use of a bedrail.

Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings:

"Individualized Patient Assessment Any decision regarding bed rail use or removal from use should be made within the framework of an individual patient assessment. If a bed rail has been determined to be necessary, steps should be taken to reduce the known risks associated with its use.

Sleeping environment assessment This assessment includes elements or conditions that may affect the patient's ability to sleep and may be considered in evaluating areas to address in a patient's care plan.

Treatment Programs/Care Plans
-Address diagnoses, symptoms, conditions, and/or behavioral symptoms for which the use of a bed rail is being considered.
-Identify nursing/medical and environmental interventions (e.g., for a patient with a life-long habit of staying up at night, provide nighttime activity).
-If clinical and environmental interventions have proven to be unsuccessful in meeting the patient's assessed needs or a determination has

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{N 383}	Continued From page 10 been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used. Documentation of the risk-benefit assessment should be in the patient's medical chart. -The team should review the treatment program and determine its effects on the patient through an ongoing cycle of evaluation that includes assessment of outcomes and adverse effects. -When planning care for the patient for whom a low bed is selected, consideration should be given to potential effects on the patient such as restraining desired voluntary movement or creating an unwanted psychological effect by being placed close to the floor. The individualized care plan and risk benefit considerations should address these issues and the plan modified accordingly." (Source: Restraints- Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings., 2003, https://www.dhs.wisconsin.gov/regulations/assisted-living/standards.htm (retrieval date- August 15th, 2023).) On 08/08/2023 at 1:15 PM, Surveyor discussed the above concern with Administrator G. Administrator G acknowledged after looking over Resident 2's most recent assessment and ISP, that it did not include information related to Resident 2's usage of a bedrail. Administrator G stated s/he will work on assessing Resident 2's use of a bedrail.	{N 383}		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents '	N 404		

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medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 residents received all prescribed medications in the dosage and intervals prescribed by the physician. Resident 5 did not receive medications for the months of June 2023, July 2023, and August 2023 as prescribed.

Findings include:

On 08/08/2023, Surveyor reviewed Resident 5's medical record. Resident 5 was admitted 01/03/2022 with diagnoses that include but are not limited to: morbid obesity, depression, seasonal affective disorder, primary open angle glaucoma of both eyes, dry eye syndrome of both

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eyes, environmental allergies, ocular hypertension bilateral.

According to Resident 5's physician's orders, Resident 5 is prescribed the following:

Lubricating eye drops .4-.3%. Instill in both eyes twice daily for dry eyes.
Latanoprost .005% solution. Instill 1 drop in both eyes at bedtime for glaucoma.
Florigen 390mg, take 1 capsule daily for constipation
Fluoxetine, 40 mg cap, take 2 caps at bedtime for depression.

On 08/08/2023 at 10:30 AM, Surveyor reviewed Resident 5's Medication Administration Record (MAR) for the months of July 2023 and August 2023.

The following dates in Resident 5's MAR for the month of July 2023, Resident 5 was not administered the following medications:

07/01/2023- Lubricating eye drop .4-.3%
Reason: No med to match order
07/02/2023- Lubricating eye drop .4-.3%
Reason: Waiting on delivery from pharmacy
07/03/2023-Floragen
Reason: Waiting on delivery from pharmacy
07/05/2023- Lubricating eye drop .4-.3%
Reason: Waiting on delivery from pharmacy
07/06/2023-Floragen
Reason: Waiting on delivery from pharmacy
07/07/2023-Floragen
Reason: Waiting on delivery from pharmacy
07/08/2023-Floragen
Reason: Waiting on delivery from pharmacy
07/12/2023-Latanoprost .005% Sol
Reason: Waiting on delivery from pharmacy

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N 404	Continued From page 13 07/13/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/14/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/15/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/16/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/17/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/18/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/19/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/20/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/21/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/22/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/23/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/24/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/25/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/26/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/27/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/28/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 07/31/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy The following dates in Resident 5's MAR for the month of August 2023, Resident 5 was not administered the following medications: 08/01/2023-Latanoprost .005% Sol	N 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018327	A. BUILDING: _____ B. WING _____	R-C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS-WISCONSIN (THE)	621 LATTON LANE PORTAGE, WI 53901

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N 404	Continued From page 14 Reason: Waiting on delivery from pharmacy 08/02/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 08/04/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 08/05/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy 08/06/2023-Latanoprost .005% Sol Reason: Waiting on delivery from pharmacy On 08/08/2023 at 1:15 PM, Surveyor discussed the above concern with Administrator G. Administrator G acknowledged that residents must be administered medications as prescribed by their Primary Physician. Administrator G acknowledged that Resident 5 was not administered all medications as prescribed by his/her Primary Physician due to miscommunication with the Pharmacy resulting in the facility not receiving Resident 5's medication in a timely manner.	N 404		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents.	N 427		

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N 427	Continued From page 15	N 427		

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure leisure activities appropriate to resident needs. There was no activity schedule posted, and no activities were observed on day of survey.

This is a repeat violation from previous statement of deficiency (SOD) 744X11 dated 03/24/2023.

Findings include:

On 08/08/2023 at 8:30 AM, Surveyor observed the physical environment. There was no documented calendar for leisure activities for residents.

On 08/08/2023 at 9:00 AM, No resident activities were observed.

On 08/08/2023 at 10:30 AM, No resident activities were observed.

On 08/08/2023 at 10:45 AM, Surveyor interviewed Caregiver H. Caregiver H stated, "I have been here a few months, but have never seen an activity calendar, most of them just go outside." Surveyor asked if there were any structured resident activities. Caregiver H stated, "No not really, we have stuff for them to do if they want, but we don't get together and play bingo or anything."

On 08/08/2023 at 11:15 AM, Surveyor interviewed Resident 5. Resident 5 stated, "They don't offer activities unless you can go outside. There are things to do, but you have to find them yourself." Surveyor asked if there was a calendar indicating

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N 427	Continued From page 16 any activities were scheduled. Resident 5 stated, "If there is, I have not seen one." On 08/08/2023 at 11:45 AM, No resident activities were observed. On 08/08/2023 at 12:30 PM. Surveyor interviewed Caregiver I. Caregiver I stated, "I haven't seen an activity calendar here since I've been here (3 months). Residents don't do many activities other than go outside on nice days to watch the animals." On 08/08/2023 at 1:15 PM, Surveyor discussed the above concern with Administrator G. Administrator G stated that leisure time activities are one of the many things that were being worked on. Administrator G stated that although sometimes difficult, leisure activities need to be scheduled and offered to residents.	N 427		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe, clean and homelike environment appropriate for residents. The front entry door was damaged and there were scuff marks from wheelchairs on several walls in the facility.	N 481		

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N 481	Continued From page 17 This is a repeat violation from previous Statement of Deficiency (SOD)# 744X11 dated 03/24/2023, SOD# QDKR13 dated 02/24/2023, SOD# 2K0811 dated 12/16/2022 and SOD# TBCF11 dated 09/09/2021. Findings include: On 08/08/2023, Surveyor toured the physical environment. OBSERVATIONS: The front entry door was damaged. There were scratches and dents on the bottom 1/4 of the door due to being struck by wheelchairs. There were scuff marks on the kitchen cabinet facing the dining room on the upper 1/4 and lower 1/4 running the entire length of the cabinets (5 feet) due to being struck by wheelchairs. There were scuff marks on the paneling at the rear of the facility on the upper 1/4 and lower 1/4 of the paneling running the entire length of the hallway (10+ feet) due to being struck by wheelchairs. There was a very dirty, corroded sprinkler at the rear of the facility that seemed to be actively leaking. There was a very dirty/dusty sprinkler in the laundry room. There was a missing smoke detector in a storage room. There was a very dusty heating vent in the	N 481		

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N 481	Continued From page 18 laundry room. On 08/08/2023 at 1:15 PM, Surveyor discussed the above concern with Administrator G. Administrator G acknowledged that the facility needs some improvement and the concerns would be fixed as soon as possible.	N 481		