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RIVERS-WISCONSIN (THE)	621 LATTON LANE PORTAGE, WI 53901

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{N 000}	Initial Comments On 04/24/2024, Surveyors conducted 2 complaint investigations, a self-report review, and a verification visit at Rivers Wisconsin. Three deficiencies were identified. Three of 3 deficiencies were repeat violations. See statement of deficiencies (SOD) 744X11, dated 03/24/2023, SOD ZK0811, dated 12/16/2022, and SOD QDKR13, dated 02/24/2022. Both complaints were substantiated. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed. Census: 11	{N 000}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 9's Individual Service Plan was implemented and followed as written. Resident 9 has behaviors that include verbal/physical aggression towards others and staff did not intervene per Resident 9's ISP when Resident 9 displayed such behaviors. This is a repeat deficiency. See statement of deficiency (SOD) QDKR13, dated 02/24/2022. Findings include:	N 388		

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

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On 03/11/2024, the Department received a complaint that alleged staff do not follow ISPs when residents display aggressive and dangerous behaviors.

On 04/24/2024, Surveyor reviewed Resident 9's medical record. Resident 9 was admitted to the facility on 11/09/2023. Resident 9's initial assessment did not address aggressive behaviors.

On 04/24/2024 at 9:00 AM, Surveyor reviewed facility documentation regarding Resident 9's behavior.

On 02/25/2024, according to facility self-report, Police responded to the facility because Resident 9 was verbally threatening staff and stated s/he had a gun in his room and was going to "take care" of the staff. Police searched the facility and did not find a gun. Police wrote a citation for Resident 9 due to the incident.

On 03/05/2024, Facility issued a 30 day discharge notice to Resident 9 due to unsafe behaviors.

On 04/12/2024, according to facility self-report, Police responded to the facility because Resident 9 physically assaulted Resident 11. According to documentation, Resident 9 pushed Resident 11 resulting in Resident 11 being sent to the Emergency Room (ER) for evaluation.

According to Resident 9's Individual Service Plan (ISP) dated 11/09/2023, staff are supposed to provide supervision and assistance in preventing and redirecting verbal outbursts from Resident 9.

On 04/24/2024 at 9:45 AM, Surveyor interviewed

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Caregiver Q. Caregiver Q stated that there are a few residents that are afraid of Resident 9 due to his/her aggressive behaviors. Caregiver Q stated that a couple weeks ago s/he witnessed Resident 9 shove a dining room table that struck Resident 8. Caregiver Q stated that Resident 8 appeared frightened. Surveyor asked Caregiver Q what staff are supposed to do when Resident 9 is engaging in unsafe and/or aggressive behaviors. Caregiver Q stated that staff are "supposed to tell him/her to walk away or go to his/her room and calm down but that does not always work and most of the time s/he just stands there and yells. Some staff will stand between Resident 9 and the other resident." Surveyor asked Caregiver Q if there were additional prevention/intervention measures put in place to reduce Resident 9's aggressive behaviors. Caregiver Q stated s/he could not think of anything new put in place.

On 04/24/2024 at 10:00 AM, Surveyor interviewed Resident 8. Resident 8 stated s/he is afraid of Resident 9 due to his/her behaviors. "S/he calls me fat." Resident 8 stated that Resident 9 pushed a dining room table at him/her and it, "Hit my stomach pretty hard." Resident 8 stated that if Resident 9 is being aggressive, staff will not always intervene, which, "leaves me on my own."

On 04/24/2024 at 10:30 AM, Surveyor interviewed Resident 10 who stated, "I am afraid of Resident 9, s/he has an attitude and is very explosive. S/he threatens me and other residents all the time. The police have been here a few times because of Resident 9 and his/her behaviors. We have to walk around his/her feelings on our tippy toes. I usually keep to myself now, I don't want to get beat up." Surveyor asked Resident 10 if staff intervene

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N 388	Continued From page 3 when Resident 9 makes threats to him/her. Resident 10 stated, "No, they just let it happen, Resident 9 just yells and threatens until s/he is done. That's why I'm afraid, I don't have any help in that matter." On 04/24/2024 at 11:15 AM, Surveyor interviewed Home Health Nurse R (HHN-R). HHN-R stated that s/he had been caring for residents three times a week for the past month. HHN-R stated that s/he has witnessed Resident 9 engaging in aggressive behavior towards other residents. HHN-R stated s/he has heard Resident 9 yell, "I am going to beat you up!" Surveyor asked HHN-R if staff intervene when this happens. HHN-R stated s/he did not see staff intervene even though they are in the room. "They just let him/her yell and eventually s/he stops and walks away. They seem afraid of what will happen next if they intervene." On 04/24/2024 at 12:00 PM, Surveyor discussed the above concern with Administrator M. Administrator M acknowledged that Resident 9's ISP directs staff to intervene when s/he is engaging in aggressive behaviors. Administrator M acknowledged that Resident 9 has engaged in aggressive behaviors numerous times since admitted. Administrator M stated s/he did not know that staff were not intervening as directed by Resident 9's ISP but would address with staff as soon as possible.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual	N 389		

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service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review, and interview, the individual service plan (ISP) was not updated for 1 of 1 resident reviewed when there was a change in resident needs and abilities.

Resident 8's ISP was not updated to include interventions for refusing cares and new interventions for urinating on items and placing them into dresser drawers.

This is a repeat deficiency. See statement of deficiency (SOD) ZK0811, dated 12/16/2022.

Findings include:

On 02/02/2024, the Department received a complaint alleging concerns how a resident was dressed to a doctor's appointment and incontinence issues.

On 04/24/2024, Surveyor reviewed Resident 8's record and identified the following:

Resident 8 was admitted to the facility on 12/08/2023 with diagnosis including anxiety, obstructive/reflux uropathy, benign prostatic

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hyperplasia, and problems related to living in residential institution. Resident 8 is their own legal decision maker.

Resident 8's ISP with an unknown date documented:
"Dressing: Resident will be able to pick out clothing before [s/he] gets assistance with dressing in the morning and before bed. Residents needs full assistance with getting dressed and undressed each morning and before bed.

Toileting: Resident will have times of incontinence. Resident needs to have assistance on and off the toilet. Resident is able to tell when [s/he] is incontinent. When [s/he] is incontinent, [s/he] will need assistance changing [his/her] depends and washing up.

Refusing Cares: Resident has a history of refusing cares, including showers, turns, wound cares, incontinence cleaning, and changing clothes."

Resident 8's progress notes documented:

"01/01/2024: Staff went into resident's room to get clean brief and when staff opened resident's drawers where [s/he] has [his/her] briefs, staff found that the resident had peed on the brief and put it back into [his/her] drawer. Staff had to throw away numerous brief that had pee on them and also a pair of fuzzy socks that was soaked in pee.

01/13/2024: ...Resident was also caught urinating into depends and shoving them back into [his/her] drawers.

01/15/2024: Staff found that the resident urinated

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on multiple items ([his/her] own long sleeve button up shirt, shorts, a couple unused briefs, and [his/her] old call light) and put them in [his/her] top drawer. The items were so soaked that the bottom of [his/her] drawer was wet as well.

01/16/2024: ...Staff found urine-soaked clothes in [his/her] dresser drawer. When staff asked [him/her] why they are there, resident states "it's not [him/her] doing it, or [s/he] does not know where they came from].'

01/21/2024: Resident was caught by staff stuffing paper towel into [his/her] depend.

01/22/2024: ...Staff found soaked depends in [his/her] drawers again this morning.

02/09/2024: Resident has taken [his/her] clothes and has urinated on them. Resident then hangs the clothes up in [his/her] closet. Staff has reported to writer multiple times they have caught [him/her] throwing [his/her] clothes on the floor in [his/her] closet or opens [his/her[dresser drawer.

02/12/2024: ...Staff heard a bang from [his/her] closet door and went to check on resident. Resident was peeing in [his/her] closet.

02/15/2024: Resident is still urinating on [his/her] clothes and bedding. Staff caught [him/her] once urinating on [his/her] sweater, then hanging back up in [his/her] closet, also found urinated socks rolled up in [his/her] garbage .....Reached out to Aspirus updated on [Resident 8's] issued that need to be addressed. Discussed that facility is unable to accommodate a condom catheter, wound care was set up, urinating all over (nurse at clinic stated [s/he] did that in the clinic as well).

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N 389	Continued From page 7 02/17/2024: Staff witness resident urinating on paper towels than putting back into dresser drawer. When staff asked resident about it [s/he] denied it. 02/21/2024: ...Resident is still shoving briefs down [his/her] pants, paper, mail, tissues, paper towel to urinate on instead of using toilet. 03/29/2024: Resident has dried bm on [his/her] behind, staff offered multiple times to bathe resident and get resident properly cleaned up due to resident already having issues with skin breakdown. Resident refused multiple times to shower or be toileted, and instead choose to stuff paper towels down the front of [his/her] pants. 04/02/2024: Resident refused to go to Urology appt. Called RN case manager. 04/23/2024: Staff changed resident and while doing so noticed [s/he] open wounds on [his/her] lower back and the wounds on [his/her] bottom are still open and bleeding. 04/20/2024: Resident go up at 6:15a and went to the bathroom. Staff assisted resident with changing brief and pants. Staff offered resident a shower, and spoke to resident about skin integrity, and importance of it in health. Resident refused shower, and wanted to get back into bed ...Staff offered to take resident to restroom before lunch to get cleaned up, resident refused. 04/17/2024: Resident got up this morning around 6:45 am. Resident used the bathroom and asked to go back to bed. Staff cleaned resident's room and bed before resident got back into it. Resident refused wound care nurse, and multiple attempts	N 389		

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by staff to be toilets and changed into clean dry clothing to help not cause additional skin irritation/skin integrity issues."

Resident 8's home health notes documented: "03/25/2024: Patient was seen today for skilled nursing assessment and wound care. Patient incontinent or urine upon arrival. Writer helped clean up and change patient. New scattered tearing to left buttocks. Most other areas are scabbed. Excoriation is due to sitting in urine Patient has difficulty using urinal due to endurance/functional issues and refuses staff help.

03/22/2024: ...Buttocks and thighs extremely excoriated. Patient incontinent or urine during assessment. Writer assisted patient in cleaning up and changing pants. Staff report they have difficult keeping patient dry because [s/he] refuses toileting.

03/11/2024: ...Patient incontinent upon arrival and resistant to allowing writer to change [him/her] and clean [him/her] up but did eventually allow. Patient has scattered breakdown to buttocks due to urinary incontinence. This was discussed with assisted living staff who states patient refuses to use urinal or toilet due to noncompliance.

03/08/2024: ...Wounds worsened today from last visit with this writer. Serosang/blood drainage noted to buttocks ....Patient continues to have 2 open areas on back of [his/her] thighs.

02/26/2024: ...Pleasant and cooperative with assessment and wound care."

The ISP did not identify interventions or

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N 389	Continued From page 9 approaches for staff to utilize in managing Resident 8's behavior of urinating on items and placing them into dresser drawers. The ISP did not identify interventions or approaches for staff to utilize to mitigate Resident 8 refusing cares. The lack of updated and new interventions led to negative outcome for Resident 8 with ongoing wound care. On 04/24/2024 at 1:00 PM, Surveyors conducted an interview with Regional Director L and Administrator M. Surveyor noted Resident 8's record indicated a behavior of refusing cares and urinating on items and placing them into dresser drawers and both behaviors were not updated to Resident 8's ISP. Regional Director L stated s/he was aware of Resident 8's continued refusals, the other behavior of him/her urinating on items would need to investigated. Surveyor expressed concern Resident 8 would accept care from home health staff, but staff did not have updated interventions to accept incontinent changes. Regional Director L acknowledged if staff were documenting behavior of urinating on items for Resident 8, the staff should have updated management to include updates to the care plan. Regional Director L noted s/he would work with staff to include updated interventions for both above behaviors.	N 389		
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:	N 432		

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N 432	Continued From page 10 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 appropriate to the needs for 1 of 1 resident reviewed. Resident 7 did not receive his/her antibiotics following a UTI on 01/20/2024 which resulted in resident outcome. This is a repeat deficiency. See statement of deficiency (SOD) 744X11, dated 03/24/2023. Findings include: On 02/02/2024, the Department received a self-report noting Resident 7 was prescribed an antibiotic for UTI. The medication was delivered on 01/20/2024 but Resident 7 was not administered antibiotic until 01/29/2024. On 04/24/2024, Surveyor conducted a self-report review and identified the following: Resident 7 was admitted to the facility on 01/06/2022 with diagnoses including dementia, delusional disorders, and chronic kidney disease. Resident 7 had an activated healthcare power of attorney. Resident 7's self-report dated 02/02/2024 documented: "Antibiotic for UTI was delivered for [Resident 7] on 1.20.24 at 10:50pm and it was signed for by [Resident Assistant N]. [Resident Assistant N]	N 432		

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gave medication to [Resident Assistant O]. [Resident Assistant O] pit in bottom drawer of me cart and notified [Executive Director P] that it had been delivered so it could be entered into the MAR next day (1.21.24). Medication was not entered into MAR until 1.27.24."

Resident 7's individual service plan (ISP) dated 04/14/2023 documented:
"Medication Management: Needs assistance administering medications."

Resident 7's progress notes documented:
"01/19/2024 at 8:45 PM: Staff need to prompt resident a few times to eat meals or bring [his/her] plate to their room.

01/19/2024 at 11:45 PM: resident returned from ER. Had the beginning of UTI, given dose of medication and sent RX to Guardian. Resident also has a slow heartbeat per ER nurse.

01/27/2024: Late entry for 01/19/2024: Resident had unwitnessed fall in room. Resident was sent to ER and returned with diagnosis of UTI and new order for Bactrim DS that was sent to Guardian Pharmacy. No injuries noted. All x-rays returned normal.

01/30/2024 at 1:30 PM: Staff noticed resident not acting [him/her] self this afternoon. Resident came down for lunch still in [his/her] PJs and that is out of the norm for resident. Staff asked resident if [s/he] felt alright and resident stated. [S/he] felt fine just really confused of [his/her] surroundings. Resident also had a different posture at lunch (slouched over the table). Staff asked [him/her] if [his/her] back hurt and [s/he] stated 'no", [s/he] just was not hungry and wanted to lay down. Staff assisted [him/her] back to their

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room. Resident is now resting.

01/30/2024 at 8:00 PM: Staff called this RN to state that resident was quite confused and not [him/her] normal self. Upon assessment resident with right sided facial droop Vital signs taken. EMS called and police department arrived for support.

02/01/2024: Writer called Aspirus Med/Sur department to get update on resident's condition. RN taking care of resident stated that [s/he] is doing really well. Still slightly confused however, [s/he] was able to give an update. Resident is standby assist with staff. Hospital may send resident back to facility tomorrow. Resident care team is requesting home health, PT/OT, [s/he] will come with orders to do so."

Resident 7's physician orders documented: "SMZ/TMP Ds 800-160mg tablet, [start 1/20/24-1/27/24] Take 1 Tablet by Mouth Every 12 Hours for 7 Days."

Resident 7's January 2024 Medication Administration Record (MAR) documented:
"01/20/2024-01/26/2024: no entries
01/27/2024: 8am and 8pm: "1, notations-not in cart."
01/28/2024: 8am: "1, notations-out of date."
01/28/2024: 8pm: "Ref, notations-not in cart."
01/29/2024: 8am: "Ref, notations-not in cart."
01/29/2024: 8pm: "Initialed as given"
01/30/2024: 8am: "Initialed as given."
01/30/2024: 8pm: "OUT."

Charting codes: 1=other

On 04/24/2024 at 1:00 PM, Surveyors conducted an interview with Regional Director L and

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 04/24/2024

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 432	Continued From page 13 Administrator M. Regional Director L acknowledged an understanding of the concern and stated staff should have administered Resident 7's antibiotic on 01/20/2024 once delivered from the pharmacy. Regional Director L confirmed Resident 7 experienced negative outcome by staff not administering his/her antibiotic and s/he was hospitalized 2x in 11 days. Regional Director L stated staff was retrained on process of entering medication into MAR and follow up by any/all staff.	N 432		