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 02/19/2026

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 02/19/2026, Surveyor conducted a complaint investigation at Rivers Wisconsin (The), a CBRF in Portage. Two deficiencies were identified. One deficiency is a repeat deficiency. See Statement of Deficiency (SOD) 4BTK11, dated 10/03/2025. The complaint was substantiated. Census: 9	N 000		
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 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 ensure the needs, abilities and physical condition were assessed for 2 of 3 residents reviewed when there was a change in needs. Resident 3's needs were not reassessed after sustaining falls.	N 381		

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

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N 381	Continued From page 1 Resident 2's needs related to behaviors were not assessed. Findings include: On 02/19/2026, Surveyor conducted a complaint investigation alleging care concerns at the provider's facility. The following concerns were identified: Example 1 - Resident 3: On 02/19/2026 at approximately 10:35 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 04/11/2024 with diagnoses including diabetes, chronic obstructive pulmonary disease and depression. Resident 3's record included an individual service plan (ISP), dated 10/01/2025, that stated s/he was a high fall risk and often refused to wear shoes. The ISP documented the following: "[Resident 3] is a high fall risk [s/he] often refuses to wear shoes. Staff are to encourage [him/her] to wear shoes indoors and outdoors and ask for assistance when traveling outdoors ... Resident is a fall risk due to falls since admission. Resident will use walker along with having [his/her] call light around [his/her] neck to ensure [s/he] can use it to call for help. Resident has been educated on safe shoes, safe actions, safe transfers. Resident still continues to fall. Resident has signed a risk vs management. Understanding that [s/he] is at risk for falls that can cause harm due to not following interventions." The ISP documented that Resident 3 was independent with transfers and ambulation using a walker. Resident 3's record included a fall assessment, dated 01/20/2026. The record included the following falls sustained after the 01/20/2026 assessment that did not	N 381		

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include a follow up assessment/intervention to prevent further falls:

- 02/02/2026 4:24 p.m. Fall in his/her room while staff and residents were moving resident's television.
- 02/08/2026 3:53 p.m. Fall in dining room.
- 02/14/2026 9:07 p.m. Fall in his/her room.
- 02/19/2026 1:10 a.m. Partial fall in room. Report documented that resident lost his/her footing, but the walker caught resident and kept him/her up, but that resident had to use his/her "bad arm" to catch [him/herself].

On 02/19/2026 at approximately 12:30 p.m., Surveyor reviewed concern with Administrator A, RN B and Assistant Director C that Resident 3 sustained multiple falls since his/her 01/20/2026 assessment and had not been reassessed to determine if his/her needs had changed. RN B stated Resident 3 was difficult because s/he continued to fall regardless of interventions attempted.

Example 2 - Resident 2:

On 02/19/2026 at approximately 10:35 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 06/18/2025. Resident 2's ISP, dated 10/02/2025, did not document any behavioral concerns. Resident 2's record included an assessment, dated 01/15/2026, that did not identify any behavioral concerns. Resident 2's progress notes, dated 09/01/2025 to 02/19/2026:

- 10/27/2025 9:30 p.m. A resident informed staff that Resident 2 stated s/he wanted to hang him/herself. Staff talked with Resident 2 and s/he stated s/he wanted more freedom.

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N 381	Continued From page 3 - 11/24/2025 2:45 p.m. Another resident stated Resident 2 held a fist to him/her. Resident 2 seems irritated and expressed that s/he cannot go anywhere. - 12/17/2025 4:30 a.m. Altercation between Resident 2 and another resident. Staff heard swearing, observed Resident 2 grabbing gloves off the other resident that was holding and pulling them back. Writer separated residents. - 12/18/2025 3:45 p.m. Resident was angry with another resident and stated the resident took items from his/her room a couple days ago. Resident made a fist and was calling the other resident names. The other resident yelled back. - 12/18/2025 4:30 p.m. Resident put hands on another resident. Staff intervened - 01/07/2026 4:15 a.m. Resident discovered feces in his/her trash can. Resident took the feces out and dumped it on top of the resident that had passed the feces into the trash. This caused outbursts from both residents. Staff defused the argument and separated residents. - 02/08/2026 4:15 p.m. Alleged another resident took his/her wallet. *Follow up note documented the wallet was found in Resident 2's room. On 02/19/2026 at approximately 12:30 p.m., Surveyor reviewed concern with Administrator A, RN B and Assistant Director C that Resident 2 exhibited behaviors that were not identified in his/her most recent assessment or ISP. RN B replied, "[S/he] only exhibits behaviors if provoked."	N 381		
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	N 431		

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N 431	Continued From page 4 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: 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 observation, interview and record review, the provider did not ensure the health was monitored, changes in health were documented and arrangements for physical health were made for 3 of 3 residents reviewed. Resident 1's health wound on his/her buttock was not monitored and changes were not documented in his/her record. Resident 2 did not have a head to toe assessment completed weekly with changes documented in his/her record, resulting in unkept podiatry needs.	N 431		

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Resident 3's physical health was not monitored with changes documented in the record after reporting pain and/or injuries after falls.

This is a repeat deficiency. See Statement of Deficiency (SOD) 4BTK11, dated 10/03/2025.

Findings include:

On 02/19/2026, Surveyor conducted a complaint investigation alleging care concerns at the facility. The following concerns were identified:

Example 1 - Resident 1:

On 02/19/2026 at approximately 10:35 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 01/03/2018 with diagnoses including dementia and diabetes. Resident 1's individual service plan (ISP), dated 10/02/2025, stated "Monitor resident's skin every shift." Resident 1's record documented the following:

- 01/21/2026 7:45 a.m. Progress Note: Resident was covered in bowel movement from his/her waist to his/her feet this morning. Resident said s/he had a bowel movement yesterday, but nobody changed him/her. S/he now has a sore on his/her right buttock.
- 01/22/2026 Skin Evaluation completed by RN B: Resident 1 had moisture-associated skin damage on his/her buttocks. The evaluation stated, "RN received notification regarding sore on resident bottom. RN advised staff to use barrier cream."
- 02/14/2026 3:15 p.m. Progress Note: Staff assisted resident with cleaning up and changing into a clean fresh brief. During the process, both staff observed that the resident's original brief was stained with blood. Writer noticed a large

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open wound on the right side of his/her buttocks, near the anus.
- 02/16/2026 7:45 a.m. Progress Note: Wound on butt looks rough. Writer sent a picture of the wound to RN and executive director.
- 02/16/2026 2:20 p.m. After Visit Summary: Resident 1 was seen for a pressure injury of the sacral region, stage 2 and a home health referral was placed.
- 02/17/2026 1:45 p.m. Progress Note: Residents behind is very red and was bleeding again. Writer put lots of cream on and a clean brief.

Resident 1's physician orders included Boudreaux butt paste (Start Date: 11/03/2025) - Apply topically to skin once daily as directed to buttocks as needed. The Medication Administration Record (MAR), dated 01/21/2026 to 02/19/2026, documented 0 administrations of Boudreaux butt paste.

On 02/19/2026 at approximately 12:30 p.m., Surveyor reviewed concern with Administrator A, RN B and Assistant Director C that Resident 1 had a sore on his/her bottom identified on 01/21/2026 and the record did not document treatment or monitoring from 01/22/2026 to 02/14/2026. RN B stated staff were applying Boudreaux butt paste but did not document the administration. RN B stated s/he did not have documentation to provide of the monitoring of the wound. RN B stated s/he had observed the wound on 02/18/2026 and had previously seen the wound approximately 1 week prior to 02/18/2026. RN B stated, "[Resident 1] is tricky. [S/he] refuses care."

Example 2 - Resident 2:

On 02/19/2026 at approximately 8:20 a.m.,

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N 431	Continued From page 7 Surveyor interviewed Resident 2 regarding his/her care at the facility. Resident 2 stated, "I'm finally getting my feet taken care of. I used to get them ground down monthly, but haven't since being here." On 02/19/2026 at approximately 10:35 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 06/18/2025. Resident 2's ISP, dated 10/02/2025, indicated s/he was not diabetic and required head to toe skin assessments every Thursday. A progress note, dated 01/23/2026, stated, "[Resident 2] needs toenails clipped and has edema in [his/her] ankles and feet. RN stated [s/he] will be in facility Tuesday to clip the nails and is sending a request to DR for the edema and [blood pressure] history." Resident 2's record included skin evaluations, dated 10/29/2025 and 01/31/2026, that did not identify any skin concerns. On 02/19/2026 at approximately 11:00 a.m., Surveyor reviewed the provider's record of podiatry visits from the past year provided by Administrator A. Records indicated Resident 2 had not been seen by the provider's podiatry services. On 02/19/2026 at approximately 11:30 a.m., Surveyor observed Resident 2's feet. Surveyor observed Resident 2's left foot was swollen; toenails were thick and 3 of 5 toenails were grown beyond the toes. Surveyor observed 2 of the 5 toenails were growing sideways. Surveyor observed the toenails on Resident 2's right foot were thick, 1 of 5 toenails was grown approximately ¼ inch beyond the toe and a large callus had grown on the bottom of the foot. Resident 2 stated it was painful to walk due to the	N 431		

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condition of his/her feet.

On 02/19/2026 at approximately 12:30 p.m., Surveyor reviewed concern with Administrator A, RN B and Assistant Director C that Resident 2's record did not indicate a head-to-toe skin assessment was completed weekly and that his/her toes appeared unkept and were causing pain. RN B confirmed s/he did not have additional assessments to provide. RN B stated podiatry services should occurr quarterly and s/he was unsure why Resident 2 had not been seen since admission. RN B stated Resident 2 was supposed to be seen by podiatry on 01/23/2026, but the appointment was cancelled due to weather. RN B stated Resident 2 was then supposed to be seen earlier in the week of Surveyor's visit but was somehow missed by the podiatrist. RN B stated s/he planned to complete cares to Resident 2's feet on 02/20/2026.

Example 3 - Resident 3:

On 02/19/2026 at approximately 10:35 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 04/11/2024 with diagnoses including diabetes, chronic obstructive pulmonary disease and depression. Resident 3's record included the following concerns with occurrences of pain or an injury that had limited to no follow up monitoring:

- 01/02/2026 3:30 p.m. Fall in dining room. The report documented pain level of a "9" and stated resident reported pain in his/her arms. Resident 3's record did not include any further monitoring of his/her pain or potential injury to arms.
- 01/03/2026 10:59 p.m. Fall in another resident's room. The report documented pain level of a "2." Resident 3's record did not include any further

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monitoring of his/her pain.
- 01/06/2026 5:40 p.m. Fall outside of resident's room. The report documented pain level of a "9" and stated resident was having pain in his/her left arm. Resident 3's record did not include any further monitoring of his/her pain or potential injury to left arm.
- 01/09/2026 9:27 a.m. Fall in his/her room while changing. The report documented a pain level of a "8" and that resident stated his/her bottom was sore and had a skin tear opened on right upper extremity. Resident 3's record did not include any further monitoring of his/her pain or injuries.
- 01/18/2026 9:16 a.m. Fall while using the bathroom. The report documented pain level of a "6" and complaints of pain in bilateral hips and on head. An After Visit Summary, dated 01/18/2026, documented Resident 3 was diagnosed with hip strain. Resident 3's record did not include any further monitoring of his/her pain or hip strain.
- 02/02/2026 4:24 p.m. Fall in his/her room while staff and resident were moving resident's television. The report documented pain level of "7" and stated resident sustained a laceration on the right kneecap. Resident 3's record did not include any further monitoring of his/her pain or injury.
- 02/08/2026 3:53 p.m. Fall in dining room. The report also stated resident's ankle had some redness around the ankle bone. Resident 3's record did not include any further monitoring of his/her ankle.
- 02/17/2026 12:57 a.m. Fall from bed. The report documented pain level of a "9" and stated resident's left arm was in a sling from prior to fall, but that pain had intensified status post fall. A progress note, dated 02/18/2026, stated Resident 3 was crying loudly, so a PRN Oxycodone order was received and appointment scheduled for 02/24/2026. *An After Visit Summary, dated

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N 431	Continued From page 10 02/15/2026, documented Resident 3 was diagnosed with a left humeral neck fracture. The record did not include any follow up monitoring of Resident 3's left arm following the fall on 02/17/2026. On 02/19/2026 at approximately 12:30 p.m., Surveyor reviewed concern with Administrator A, RN B and Assistant Director C that Resident 3 sustained multiple falls resulting in pain or injury with no documented follow up or monitoring of the reported pain and/or injury. RN B stated Resident 3 had chronic pain. Assistant Director C stated s/he observed Resident 3 daily but would begin documenting follow up after the falls.	N 431		