STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**475 GOLFVIEW AMERY, WI 54001**

(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 06/04/2024, Surveyors conducted a complaint investigation and verification visit for Statement of Deficiency (SOD) V5OS11, dated 01/25/2024 and SOD P9R013, 11/09/2023 at Riverbend. Data was collected through 06/06/2024. Nine citations were corrected. Four violations were identified. Three of 4 violations were repeat deficiencies. See Statement of Deficiencies (SOD) V5OS11, dated 01/25/2024 and SOD P9R013, dated 11/09/2023. Two of 2 complaints were unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 5.	{N 000}		
{N 214}	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on record review and interview, the	{N 214}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**475 GOLFVIEW AMERY, WI 54001**

(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 214}	Continued From page 1 administrator did not supervise the daily operations, including: supervision to ensure residents received proper care and services, that the residents' health and safety were protected and promoted, employee training was completed, and training was completed prior to staff working alone on each shift. This is a repeat deficiency. See Statement of Deficiency (SOD) V5OS11, dated 01/25/2024. Findings include: The provider is licensed to care for up to 11 residents in the client groups of irreversible dementia/Alzheimer's disease, and advanced age. On 06/04/2024, Surveyors conducted a verification visit for Statement of Deficiency (SOD) P9R013, dated 01/19/2024, and SOD V5OS11, dated 03/12/2024.The SODs included the following Special Orders: SOD dated 01/19/2024 read, in part, "..the licensee shall provide employees in sufficient numbers on a 24-hour basis ...facility will develop written procedures to ensure staffing patterns will be sufficient to meet the personal care needs of the residents, to ensure needed supervision... licensee will ensure sufficient, qualified staff members are on duty, present and available to assist residents at all times ...Managers and care staff ...will receive in-service training regarding the provider's written procedures required by Order #1." SOD dated 03/12/2024 read, in part, " ...the licensee shall ensure the administrator supervises the daily operation of the CBRF [community based residential facility] ...The	{N 214}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 214}	Continued From page 2 licensee shall develop corrective measures to resolve each deficiency ...Staffing patterns shall be sufficient to meet the personal care needs of residents, to ensure needed supervision ...All managers and resident care staff will receive in-service training regarding the facility's written procedure required by Order #1." On 04/04/2024 and 06/06/2024, Surveyor reviewed resident records, employee records and staffing schedules. Based on Surveyor's interviews and record reviews, the following deficiencies were identified: 83.20(2)(a)-(d) Department-Approved Training 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake 83.36(1)(a) Adequate Staff To Meet Resident Needs Adequate Staff On 06/04/2024 at approximately 10:00 AM, Surveyors interviewed Administrator A. Administrator A stated the community based residential facility (CBRF) had 1 staff for each shift and that the attached residential care apartment complex (RCAC) did not have staff during the nighttime shift. Nighttime RCAC tenant pages went to the CBRF staff who were to contact the attached licensed nursing home who responded to the RCAC tenant pages. At approximately 12:15 PM, Surveyor interviewed Nursing Home Administrator (NHA) F, who stated that at night, the RCAC tenants page the CBRF staff for assistance. NHA F stated the licensed nursing home did not assist the CBRF with the RCAC tenant pages. On 06/04/2024 at approximately 12:00 PM,	{N 214}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 214}	Continued From page 3 Surveyor interviewed Caregiver D on the phone. Caregiver D told Surveyor s/he worked the overnight shift and left the CBRF every 2 - 2.5 hours to check on the RCAC tenants. On 06/05/2024 at approximately 8:30 AM, Surveyor interviewed Caregiver E on the phone. Caregiver E told Surveyor s/he worked the overnight shift at the CBRF and when a tenant from the RCAC would ring for assistance, s/he checked on the residents at the CBRF, then went to the RCAC to assist with the tenant. Caregiver E told Surveyor s/he left the CBRF 2 - 3 times a night. On 06/06/2024 at approximately 1:00 PM, Surveyor interviewed Administrator A, who stated that as far as s/he knew, the CBRF was not being left without adequate staff. Department-Approved Training On 06/04/2024, Surveyor reviewed staff records and found 3 of 8 staff reviewed did not have completed department approved training. On 06/04/2024 at approximately 11:00 AM, Surveyor interviewed Administrator A, who stated that Department Approved Training is completed by Trainer M, an outside source. Administrator A stated that Registered Nurse (RN) H completed the training components task specific and all employee training. The maintenance director reviewed the doors and alarm system. On 06/06/2024 at approximately 10:00 AM, Surveyor interviewed Registered Nurse (RN) H, who stated Administrator A was responsible to register staff for Department-Approved Training. At approximately 1:00 PM, Administrator A stated s/he was responsible to assign	{N 214}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 214}	Continued From page 4 Department-Approved Training. Qualified Staff In Charge, On Duty And Awake On 06/04/2024, Surveyor reviewed the individual service plans (ISP) for Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5. Five of 5 residents required 24-hour supervision. On 06/04/2024, Surveyors reviewed the training records for 8 staff. Six of the 8 staff reviewed did not have Department-Approved Training and were working alone. Surveyor reviewed the staff schedules from 05/10/2024 through 06/04/2024 and found: -LPN B was hired on 03/23/2023 and worked alone 2 times. -LPN I was hired on 01/01/2024 and worked alone 15 times. -LPN J was hired on 11/14/2023 and worked alone 8 times. -LPN K was hired on 05/07/2024 and worked along 8 times. -LPN L was hired on 05/20/2024 and worked alone 5 times. -Caregiver C was hired on 04/23/2024 and worked alone 1 time. On 06/06/2024, Surveyor asked Administrator A to provide an example of the training requested in the Special Orders. At 4:05 PM, Surveyor received an email communication from Administrator A that included 3 documents. The first document, titled CBRF TRAINING BASED ON SOD V50S11, read, in part, "Adequate Staff ...-Staffing patterns will be sufficient to meet the personal care needs of residents, to ensure needed supervision to provide services ...and to facilitate a safe evacuation ... - NOC (overnight) shift - 24 hour coverage of CBRF	{N 214}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**475 GOLFVIEW AMERY, WI 54001**

(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 214}	Continued From page 5 - Not leaving early/waiting for relief to arrive - DHS 83 Staffing overview." The second and third documents, titled CONTINUING EDUCATION RECORD FOR EMPLOYEE, listed the names of Former Employee (FE) N and FE O and included the following information: Date: 3/29/2024 Topic/Title: Adequate Staffing CBRF Hours: .5 Administrator A did not ensure the residents health and safety were protected by not ensuring there was a qualified care staff present at all times to provide oversight of the residents, and that all staff were properly trained. Administrator A did not ensure implementation of the Special Orders included in SOD P9R013, dated 01/19/2024 and SOD V5OS11, dated 03/12/2024.	{N 214}		
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	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 239	Continued From page 6 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 3 of 8 employees obtained all department approved training as required. Licensed Practical Nurse (LPN) I and J did not have training in fire safety within 90 days after starting employment. Caregiver C, who had responsibilities for medication administration, did not have training in medication administration and management prior to assuming these duties. Findings include: On 06/04/2024, Surveyors conducted a review of 4 employees to verify compliance with department approved training requirements. Surveyor requested of Administrator A, the training records for Licensed Practical Nurse (LPN) B, Caregiver C, D, and E. On 06/06/2024, Surveyors requested training documents for LPN I, J, K and L. Fire Safety	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 239	Continued From page 7 The record for LPN I, hired 01/01/2024, did not contain evidence of training or evidence of meeting an exemption for fire safety. The record for LPN J, hired, 11/14/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 06/10/2024, Surveyor verified LPN I, and J were not on the CBRF training registry for fire safety. On 06/06/2024 at approximately 1:00 PM, Administrator A stated s/he thought they had 90 days to get the fire safety training completed. On 06/06/2024 at approximately 10:00 AM, Surveyor interviewed Registered Nurse (RN) H. RN H stated s/he recalled a conversation with Administrator A about fire safety training and that it did not need to be completed until 90 days after hire. RN H stated Administrator A was responsible to register staff for training. Medication Administration The record for Caregiver C, hired 04/23/2024, did not contain evidence of training or evidence of meeting an exemption for medication administration. On 06/04/2024, at approximately 12:45 p.m., Surveyor interviewed Administrator A. Administrator A confirmed Caregiver C worked alone and was responsible for medication administration duties. Administrator A confirmed the provider did not have evidence Caregiver C completed or met an exemption for medication management training prior to assuming these job duties. Administrator A told Surveyors the prior administrator trained Caregiver C but must not have placed Caregiver C on the registry.	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 239	Continued From page 8 On 06/04/2024, Surveyor verified Caregiver C was not on the Community-Based Care and Treatment training registry for medication administration. An email communication from Administrator A, received 06/04/2024 at 3:23 PM, read, "Regarding [Caregiver C's] department approved training, I am waiting on a call back from UW-GB (University of Wisconsin Green Bay). I have also reached out to [Former Administrator (FA) G] (the former admin who did the trainings) again." Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake	N 239		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure staff in sufficient numbers were available on a 24-hour basis. This is a repeat deficiency. See Statement of Deficiency (SOD) P9R013, dated 11/09/2023. Findings include: The provider is licensed to care for 11 residents in the client groups irreversible dementia/Alzheimer's disease and advanced	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 396	Continued From page 9	N 396		

aged.

The main door of the facility opens into a lounge area that is common space between the community based residential facility (CBRF) and the residential care apartment complex (RCAC). A licensed nursing home is also attached. The CBRF is a memory care unit with a locked entry door.

On 06/04/2024 at approximately 10:00 AM, Surveyors interviewed Administrator A. Administrator A confirmed only 1 staff was scheduled for each shift in the CBRF. Administrator A stated there were not staff scheduled in the RCAC during the overnight (NOC) shift and if a resident pages, it goes to the CBRF staff who in turn contact the nursing home for assistance.

At approximately 10:56 AM, Administrator A stated there were no residents that required a 2-person assist, residents were not on 2-hour checks, and there were no current elopement risks.

At approximately 12:00 PM, Surveyors reviewed the staff schedule dated 05/10/2024 to 06/09/2024. The schedule listed the following:
Day CBRF: 1 staff scheduled; Day RCAC: 1 staff scheduled.
PM CBRF: 1 staff scheduled; PM RCAC: 1 staff scheduled.
NOC: 1 staff assigned. The RCAC did not have anyone scheduled during the NOC shift.

On 06/04/2024, Surveyor reviewed the individual service plans (ISP) for Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5. Resident 1's ISP, dated 05/04/2023, indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 396	Continued From page 10	N 396		

s/he required supervision and was an elopement risk.
Resident 2's ISP, dated 08/20/2023, indicated s/he required 24-hour supervision, wandered in the CBRF, and required total assist for cares.
Resident 3's ISP, dated 03/20/2024, indicated s/he required 24-hour supervision.
Resident 4's ISP, dated 04/17/2024, indicated s/he required 24-hour supervision and wandered around the unit.
Resident 5's ISP, dated 01/11/2024, indicated s/he required 24-hour supervision, could not make his/her needs known, and wandered in the CBRF.

On 06/04/2024 at approximately 12:00 PM, Surveyor interviewed Caregiver D on the phone. Caregiver D told Surveyor that s/he worked the overnight shift. S/he told Surveyor s/he left the CBRF every 2 - 2.5 hours to check on the RCAC tenants. This left the CBRF with no staff present.

At approximately 12:05 PM, Surveyors interviewed Nursing Home Administrator (NHA) F. NHA F stated s/he believed that when the RCAC needed assistance at night, they rang the CBRF. NHA F stated the nursing home did not assist the RCAC.

On 06/05/2024 at approximately 8:30 AM, Surveyor interviewed Caregiver E on the phone. Caregiver E told Surveyor s/he worked the overnight shift at the CBRF. S/he said that when a tenant from the RCAC would ring for assistance, s/he checked on the residents at the CBRF, then went to the RCAC to assist with the tenant. Surveyor asked Caregiver E if s/he called the nursing home to have staff come over to assist. Caregiver E said s/he also worked the overnight shift in the nursing home and that was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 396	Continued From page 11	N 396		

not something s/he was ever told to do. Caregiver E told Surveyor a tenant in the RCAC required assistance with transferring to the bathroom. S/he said staff left the CBRF 2-3 times a night to assist this tenant with using the bathroom. This would leave the CBRF with no staff present.

On 06/06/2024 from 9:58 AM to 10:16 AM, Surveyor interviewed Registered Nurse (RN) H. RN H stated that in the CBRF, there was only 1 staff scheduled for each shift and the CBRF staff cover the RCAC during the night shift as there is no staff scheduled in the RCAC. RN H stated the CBRF staff responded to the resident emergency call lights but was not sure how often that happened, but at least 1-2 times a night. RN H stated the page goes to the CBRF staff who are supposed to contact the nursing home and then nursing home staff cover the CBRF while the CBRF staff assist the RCAC. RN H stated the CBRF resident behaviors included wandering, elopement risk, and limited mobility. No resident required a 2-person transfer. Surveyor inquired when the CBRF resident laundry was done. RN H stated the CBRF resident laundry was done at different times during the day. RN H confirmed the washer and dryer the CBRF staff utilized was in the RCAC.

On 06/06/2024, from 12:45 PM to 1:53 PM, Surveyor interviewed Administrator A, who stated they did implement procedures on NOC coverage for the RCAC but guessed the staff were not following it. Administrator A stated the RCAC nighttime coverage information was appropriately shared at training and with verbal reminders. Administrator A stated s/he believed the CBRF did have adequate staff, and as far as s/he knew, the CBRF was not left without staff. Administrator A confirmed the staff do laundry during the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 396	Continued From page 12 for the CBRF residents and the washer and dryer were in the RCAC. Administrator A stated s/he could see that the CBRF was left unattended, and s/he needed to do a better job with documenting. The provider did not ensure there was 24-hour supervision of the CBRF when staff left the CBRF to respond to RCAC nighttime call lights and to complete resident laundry during daytime hours.	N 396		
{N 397}	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the	{N 397}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 397}	Continued From page 13 provider did not ensure at least one qualified resident care staff was present, on duty and awake, when at least one resident was in need of supervision, intervention, or services on a 24-hour basis. This is a repeat violation. See Statement of Deficiency (SOD) V5OS11, dated 01/25/2024. Findings include: The provider is licensed to care for up to 11 residents in the client groups of irreversible dementia/Alzheimer's disease and advanced age. A qualified resident care staff is defined as an employee who has successfully completed all of the applicable training and orientation. On 06/04/2024 at 10:06 AM, Surveyors interviewed Administrator A, who stated the community based residential facility (CBRF) has 1 staff scheduled for each shift. The shifts are 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM, and 10:00 PM to 6:00 AM. On 06/04/2024, Surveyors reviewed the training records for Licensed Practical Nurse (LPN) B, I, J, K, L, Caregiver C, D, and E. -LPN B was hired on 03/23/2023. LPN B's record did not include documentation of department approved fire safety training. The schedule indicated LPN B worked the following dates alone: 05/12/2024 and 05/20/2024. -LPN I was hired on 01/01/2024. LPN I's record did not include documentation of department approved fire safety training. The schedule indicated that LPN I worked the following dates	{N 397}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	475 GOLFVIEW AMERY, WI 54001

(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 397}	Continued From page 14 alone: 05/10/2024, 05/13/2024 AM and 05/13/2024 PM, 05/20/2024, 05/21/2024, 05/24/2024, 05/26/2024 AM and 05/26/2024 PM, 05/27/2024, 05/30/2024 AM and 05/30/2024 PM, 06/03/2024 AM and 06/03/2024 PM, 06/04/2024 AM and 06/04/2024 PM. -LPN J was hired on 11/14/2023. LPN J's record did not include documentation of department approved fire safety training. The schedule indicated LPN J worked the following dates alone: 05/10/2024, 05/21/2024, 05/24/2024 PM and 05/24/2024 NOC (overnight), 05/25/2024 PM and 05/25/2024 NOC, 05/31/2024 PM and 05/31/2024 NOC. -LPN K was hired on 05/07/2024. LPN K's record did not include documentation of department approved fire safety training. The scheduled indicated LPN K worked the following dates alone: 05/10/2024, 05/14/2024, 05/17/2024, 05/21/2024, 05/22/2024, 05/28/2024, 05/29/2024, and 05/31/2024. -LPN L was hired on 05/20/2024. LPN L's record did not include documentation of department approved fire safety training. The schedule indicated LPN L worked the following dates alone: 05/22/2024, 05/23/2024, 05/28/2024, 05/31/2024, and 06/01/2024. -Caregiver C was hired on 04/23/2024. Caregiver C's record did not include documentation of department approved fire safety training, First Aid and Choking, and Medication Administration. The schedule indicated Caregiver C worked the following date alone: 05/16/2024. On 06/06/2024 from 12:45 PM to 1:53 PM, Surveyor inquired why so many staff were	{N 397}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010999	A. BUILDING: _____ B. WING _____	R-C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	**475 GOLFVIEW AMERY, WI 54001**

(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 397}	Continued From page 15 missing department approved training. Administrator A stated s/he thought they had 90 days to complete Fire Safety Training. Surveyor stated that was true except when the staff were working alone. Administrator A confirmed s/he was responsible for all staff training. Administrator A stated LPN B must have just gotten missed. The provider did not ensure there was a qualified resident care staff present and on duty at all times. Cross Reference: N0239 83.20(2)(a)-(d) Department-Approved Training N0396 83036(1)(a) Adequate Staff To Meet Resident Needs	{N 397}		