STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 07/19/2023 with information gathered through 08/08/2023, Surveyor conducted 2 complaint investigations and a self-report review at Riverview Village Senior Living. Four deficiencies were identified. One of 4 deficiencies was a repeat violation. (See statement of deficiency (SOD) UFF011, dated 12/05/2022.) Both complaints were substantiated. The self-report resulted in no violations. Census: 37	N 000		
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 procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter	N 239		

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
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 1 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 1 employee reviewed had completed training in Department Approved training as required. Caregiver F did not complete Department Approved training within 90 days after starting employment. Findings include: On 08/01/2023, Surveyor conducted a review of employee records to verify compliance with department approved training requirements: First Aid and Choking The record for Caregiver F, hired 03/30/2023, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 08/01/2023, Surveyor verified Caregiver F was not on the CBRF training registry for first aid and choking. On 08/01/2023 at 11:50 AM, Surveyor interviewed Caregiver F. Caregiver F stated s/he was working today. Caregiver F stated s/he had training to be a medical assistant, but was unsure if s/he had ever taken the CBRF training for first aid and choking. On 08/01/2023 at 12:30 PM, Surveyor	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 2 interviewed Administrator A and Nurse B. Administrator A stated s/he was aware that Caregiver F was out of compliance for first aid and choking. Administrator A stated their compliance team flagged Caregiver F and they were trying to get him/her into a class as soon as possible.	N 239		
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 follow the individual service plan (ISP) as written for 1 of 1 resident reviewed. Resident 1 was left on the toilet prior to a fall. This is a repeat violation, see statement of deficiency (SOD) UFF011, dated 12/05/2022. Findings include: On 06/14/2023, the Department received a complaint alleging concerns following a fall. On 07/19/2023, Surveyor conducted a complaint investigation. Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted on 02/24/2023 with diagnosis including type 2 diabetes, dementia, major depressive disorder, and anxiety. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 1's individual service plan (ISP) dated	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 388	Continued From page 3 05/17/2023 identified Resident 1 as a fall risk. Resident 1's ISP documented: "Toileting: Incontinent of bladder requires assist from staff. Incontinent of bowel requires assist from staff. Toileting/Incontinent care: The resident requires 1 assist for toileting/incontinence." A review of the provider's investigation dated 06/11/2023 documented: Timeline: 0710 [Resident 1] was left unattended on the toilet at shift change 0740-0750 [Resident 1] was observed standing at the sink and then fell on the floor 0900-0910 [Resent 1] was transport to the hospital by ambulance where [s/he] was diagnoses with a nondisplaced oblique fracture of [his/her] right distal fibia and right 5th metatarsal. A soft cast was placed up to [Resident 1's] knee. [S/he] is non weight bearing to right extremity and transferred with 2 to 3 assist with a slide board. Conclusion: After all interviews have been completed and an investigation has been concluded; it has been found that no caregiver misconduct has occurred. [Resident 1] is an assisted resident who was left unattended on the toilet through miscommunication during shift change. [Resident 1] has BM on [him/her] and was told [s/he] needed a shower. It is presumed, while [Resident 1] waited for staff to come assist [him/her] that [s/he] got off the toilet and walked along the sink to get into the shower chair. [Resident 1's] situation was observed by the oncoming shift when [s/he] was attempting to get back onto the toilet and then fell resulting in the fractures. Another series of miscommunication occurred when 911 was not immediately called and [Resident 1] remained on the bathroom floor for an hour and 10 minutes.	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 388	Continued From page 4	N 388		

Corrective Actions:
Staff disciplinary actions have taken for not following the care plan and not following the rounding practice.
Falls, emergency situations and care plans have been discussed at Stand-Up meetings daily.
In-services have been completed on how to handle emergencies, how to speak to Dementia Residents, and safe transfers."

A review of Caregiver D's witness statement from June 11th, 2023, documented:
"Punched out at 0731
710 I [Caregiver D] told [Caregiver E] when [s/he] came in that [Resident 1] had an accident. I [Caregiver D] told [him/her] that I [Caregiver D] took [his/her[laundry and started it. I [Caregiver D] told [him/her] that [Resident 1] needed a shower. Then I [Caregiver D] talked outside with [Caregiver E] until 0730.
Follow-up questions:
1. What time did you put [Resident 1] on the toilet? 7:15-7:20. I [Caregiver D] went in and out of [his/her] room putting [his/her] laundry in the washer two times.
2. Why did you leave [him/her] on the toilet? [S/he] needed to use the bathroom. [S/he] needed to use the bathroom. [S/he] is a first shift get-up, I [Caregiver D] didn't want to leave [him/her] in bowel movement.
3. Do you understand [Resident 1's] ISP that if [s/he] is assisted you need to stay with [him/her]? Yes, but I [Caregiver D] had to answer other call lights. Stated, "I was alone, I can't get written up for this."
4. Did you feel that the resident could assist? No, I [Caregiver D] did not expect [him/her] to.
5. What was the plan after reporting off to first shift? I [Caregiver D] expected [Caregiver E] to go into [his/her] room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 388	Continued From page 5 6. What time were you outside with [Caregiver E]? [Caregiver E] and I [Caregiver D] went outside at 7:35, [Caregiver F] came at 7:40-7:45, I [Caregiver D] left, [Caregiver E] and [Caregiver F] went in." On 07/19/2023 at 11:40 AM, Surveyor interviewed Resident 1. Resident 1 confirmed staff let him/her on the toilet after s/he had a bowel movement accident. Resident 1 stated staff told [him/her] that I [Resident 1] needed to take a shower. On 07/19/2023 at 11:45 AM, Surveyor interviewed Nurse B. Nurse B confirmed Caregiver D left Resident 1 on the toilet and went to assist other residents. Nurse B stated Caregiver D told Caregiver E about Resident 1 being left on the toilet full of bowel movement. On 07/19/2023 at 2:06 PM, Surveyor conducted an exit conference and shared findings with Executive Director A, Nurse B, Clinical Marketing Director G and Wellness Director H. Executive Director A and Nurse B confirmed Caregiver D did not follow Resident 1's ISP when s/he was left on the toilet.	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 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	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 389	Continued From page 6 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) for Resident 2 was not updated when there was a change in resident needs and abilities. Resident 2's ISP was not updated when s/he required the use of a sit to stand mechanical lift for all transfers. Findings include: On 06/21/2023, the Department received a complaint alleging concerns with resident cares. On 07/19/2023, Surveyor conducted a complaint investigation. Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted on 04/04/2023 with diagnosis including type 2 diabetes, morbid (severe) obesity, depressive disorder, and anxiety. Resident 2 was their own legal decision maker. Resident 2's progress notes documented: 04/21/2023: "pt for lymphedema assessment and treatment. To add mobility next wk." 05/02/2023: "Pt for lymphedema treatments to [his/her] BLE. Transfers using the sit to stand. Toileting, clean up total assist." 05/15/2023: "Notes from therapy, please use the sit to stand mechanical lift for all transfers."	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 389	Continued From page 7 05/16/2023: "Notes from therapy, OT visit. [Resident 1] reports a fall previous evening using sit to stand with staff. Spoke to [Nurse B], transported [Resident 1] outside for activity." 05/23/2023: "PT: Will Dc from therapy next visit; received therapy for treatment, transfers, and mobility." Resident 2's ISP dated 04/04/2023 documented: "Mobility: Ambulated independently with wheeled walker for short distances. Wheelchair is primary mode of transportation for long distances, needs assist. Transfer: 2 assist in and out of bed, chair." Resident 2's ISP did not document Resident 2 used a sit to stand for all transfers. On 07/19/2023 at 1:15 PM, Surveyor interviewed Caregiver I. Caregiver I stated when Resident 2 first admitted staff were transferring him/her using 2 staff to assist with a pivot transfer. Caregiver I stated Resident 2 was very sensitive to staff assisting him/her, so recently staff had been utilizing a sit to stand. On 07/19/2023 at 2:06 PM, Surveyor conducted an exit conference and shared findings with Executive Director A, Nurse B, Clinical Marketing Director G and Wellness Director H. Surveyor noted Resident 2's ISP did not include the use of a sit to stand. Nurse B and Clinical Marketing Director G looked over Resident 2's ISP and confirmed his/her ISP did not identify the use of a sit to stand. Nurse B stated s/he was responsible for updating ISP's and thought s/he added the sit to stand.	N 389		
N 431	83.38(1)(g) Health monitoring.	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 431	Continued From page 8 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the health of residents were monitored and changes documented in the resident record. Resident 2 experienced	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 431	Continued From page 9	N 431		

substantial weight loss that was not documented in his/her record.

Findings include:

On 06/21/2023, the Department received a complaint alleging concerns with resident cares.

On 07/19/2023, Surveyor conducted a complaint investigation. Surveyor reviewed Resident 2's record and identified the following:

Resident 2 was admitted on 04/04/2023 with diagnosis including type 2 diabetes, morbid (severe) obesity, depressive disorder, and anxiety. Resident 2 was their own legal decision maker. Resident 2 was admitted to the hospital on 06/13/2023 and never returned to the provider.

Resident 2's individual service plan (ISP) dated 04/04/2023 documented:
"Nutrition/Eating: Will maintain adequate nutrition status as evidenced by maintain weight. Provide meal three times daily and snacks."

Resident 2's monthly weight report documented:
April: 259 lbs, May: 252 lbs, June: 211 lbs

Resident 2's progress notes dated 04/17/2023-06/13/2023 did not document any concerns related to weight loss or a change in Resident 2's eating habits.

Resident 2's hospital records dated 06/13/2023-06/29/2023 documented:
"Weight: 06/13/2023-220 lbs, 06/15/2023: 225 lbs, 06/16/2023: 232 lbs, 06/17/2023: 234 lbs, 06/18/2023: 235 lbs, 06/20/2023: 232 lbs. Admitted to ICU for septic shock ....[Resident 2] is primarily wheelchair bound and transfers with sit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 431	Continued From page 10	N 431		

to stand lift. [Resident 2] can ambulate short distances with a walker but will only walk with therapy. [Resident 2] is current with home health for PT/OT and wound care on for coccyx ulcer. Initially wound care was coming 2x/week but since the ulcer "opened up", wound care is now coming 3x/week. [Resident 2] is on a regular diet with thin liquids and can feed [him/her self]. Staff administer [Resident 2's] medications .....Stage 3 pressure injury to right and left buttocks with possible elements of moisture, friction, and shear. Associated Factors for Wound/Skin Impairment: Incontinence of bowel and bladder, Inability to reposition self, Suspected inadequate nutrition, pressure, low braden, and body habitus. Medical Nutrition Therapy: Nutrition Diagnosis-Active inadequate protein-energy intake related to: decreased appetite, early satiety; increased nutrient needs 2/2 wound healing evidenced by: multiple wounds documents; 50% intake x 1 meal; not meeting nutrition needs during admission.
Met with [Resident 2] and [Family Member J]. [Resident 2] reported early satiety and not eating well prior to admission; unsure for how long. [Family Member J] reported [s/he] suspects that [Resident 2] has lost 50 lbs since Thanksgiving 2022; very limited wt history per chart review and Care Everywhere. [Resident 2] reported that [his/her] appetite has improved over the last couple of days."

On 07/19/2023 at 1:45 PM, Surveyor interviewed Caregiver K. Caregiver K stated at the beginning of June the provider had gotten a new scale and many staff were having trouble weighing residents. Surveyor asked Caregiver K if s/he was aware of any weight loss concerns with Resident 2. Caregiver K stated s/he was not aware, but Resident 2 would skip breakfast and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015619	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE SENIOR LIVING	W176 N9430 RIVER CREST DR MENOMONEE FALLS, WI 53051

(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 431	Continued From page 11 only eat lunch and dinner. On 07/19/2023 at 2:06 PM, Surveyor conducted an exit conference and shared findings with Executive Director A, Nurse B, Clinical Marketing Director G and Wellness Director H. Nurse B confirmed the provider received a new scale at the beginning of June and many resident weights were off. Surveyor noted according to their records Resident 2 experienced an approximately 40-pound weight loss from May to June 2023. Nurse B stated s/he was unaware of the weight loss and usually a significant amount like that would be reported to management. Nurse B stated s/he followed with the hospital after Resident 2 was admitted, but s/he was unaware of the weight loss. Surveyor noted Resident 2's record did not include any documentation of Resident 2's weight loss or a change in diet. Executive Director A stated s/he often helped at meals and Resident 2 would eat 100% of his/her meals. There was no further comment on Resident 2's alleged weight loss.	N 431		