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 _____	R-C 08/22/2024

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 08/20/2024 - 08/22/2024, Surveyors conducted a verification visit and 2 complaint investigations at Riverview Village Senior Living. Two deficiencies were identified. One of 2 deficiencies is a repeat violation. See statement of deficiency (SOD) 6KFT11, dated 09/21/2022. All deficiencies from SOD XCD212, dated 05/02/2024, were substantially corrected. One complaint was substantiated. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 40	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the	N 164		

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

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N 164	Continued From page 1	N 164		

provider did not send a written report to the Department within 3 working days after law enforcement personnel was called to the facility because of an incident that jeopardizes the health, safety, or welfare of residents or employees.

On 07/06/2024, police responded to the facility due to an incident involving missing medication and suspecting the wrong resident took the medication.

This is a repeat violation. See statement of deficiency (SOD) 6KFT11, dated 09/21/2022.

Findings include:

On 07/12/2024, the Department received a complaint related to an incident on 07/06/2024 that resulted in law enforcement involvement.

On 08/20/2024, Surveyor reviewed Resident 5's record and identified the following:

Resident 5 admitted to the facility on 04/24/2024. His/her diagnosis included but were not limited to major depressive disorder, generalized anxiety disorder, borderline personality disorder, narcissistic personality disorder, histrionic personality disorder, and insomnia.

Surveyor reviewed Resident 5's progress notes and incident reports. The record did not include any details of the incident on 07/06/2024.

On 08/20/2024, Surveyor completed a review of the reports submitted to the Department and did not find evidence of this incident.

On 08/20/2024 at 10:10 AM, Surveyor

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N 164	Continued From page 2 interviewed Resident 5. Surveyor asked if s/he would be able to share more about the incident involving the police on 07/06/2024, but Resident 5 stated they were not comfortable talking about it. On 08/20/2024 at 11:45 AM, Surveyors interviewed Executive Director (ED) A. Surveyors asked for details about the incident on 07/06/2024 that involved law enforcement, but ED A was unable to confirm with any managers that the team was aware of the incident. Staff scheduled on 07/06/2024 did not document the incident in facility records and did not provide verbal report to any management. Surveyors and ED A discussed reviewing the staff schedule and attempting to retrieve additional information from staff who were scheduled at that time. On 08/20/24 at 2:03 PM, Surveyors discussed the provider's self-reports to the Department with ED A and Wellness Coordinator (WC) K. Through interview and further investigation, it had been discovered the provider was accidentally submitting reports to the Southeastern Regional Office instead of the Southern Regional Office at times. Submittals were reviewed but ED A confirmed this incident on 07/06/2024 was not submitted to either office. WC K also had retrieved additional information from staff about the incident on 07/06/2024 and the provider was then able to document details into their own records.	N 164		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed	N 352		

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N 352	Continued From page 3	N 352		

medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 5 received his/her medications in the dosage and intervals prescribed by a practitioner.

Resident 5 missed 6 doses of a scheduled medication between 06/17/2024 and 06/30/2024.

Findings include:

On 08/20/2024 Surveyor reviewed Resident 5's record which documented:

Resident 5 admitted to the facility on 04/24/2024. His/her diagnosis included but were not limited to personal history of transient ischemic attack, cerebral infarction, hypertension, myocardial infarction, and atherosclerotic heart disease.

Resident 5's physician orders documented:
"Atorvastatin 10 mg tablet- Take one tablet by mouth once daily at bedtime for cholesterol."

Resident 5's progress notes for June 2024 documented:
"06/15/2024 20:16- Atorvastatin- not in the cart
06/19/2024 19:52- Atorvastatin- not in cart
06/25/2024 20:48- Atorvastatin- not in cart
06/28/2024 19:55- Atorvastatin- dont (sic) see
06/29/2024 20:12- Atorvastatin- not in cart
06/30/2024 20:29- Atorvastatin- given but not in the bedtime cart so had to use as prn"

On 08/22/2024 at 2:30 PM, Surveyors interviewed

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N 352	Continued From page 4 Executive Director (ED) A and Wellness Coordinator (WC) K during exit conference. Surveyor reviewed the concerns related to Resident 5's atorvastatin which included the missed doses, and inconsistent administration. ED A and WC K acknowledged the concerns regarding Resident 5 not receiving their Atorvastatin as prescribed. Surveyors asked for any documentation of attempts made to address the medication concern with pharmacy. WC K stated his/her communication with pharmacy was usually over the phone so there was no documentation. "Recent research shows that people 75 and older who go off statins have an increased risk of hospitalization because of cardiovascular problems." (Williams, V. Mayo Clinic Minute: Should older people take statins? August 29, 2019. Mayo Clinic Minute: Should older people take statins? - Mayo Clinic News Network (retrieval date- 09/03/2024).)	N 352		