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 02/19/2025

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 02/11/2025 to 02/19/2025, Surveyor conducted a complaint investigation, standard survey, and verification visit at Riverview Village Senior Living. Two deficiencies were identified. One of 2 deficiencies was a repeat violation. See Statement of Deficiency (SOD) XCDZ11, dated 08/08/2023. All previous deficiencies from SOD XCD213, dated 08/22/2024, were substantiatlly corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 34	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.	N 381		

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

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N 381	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the needs, abilities and physical/mental condition were assessed for 1 of 3 residents reviewed when there was a change in needs. Resident 5's physical condition and/or needs were not reassessed after sustaining 8 falls between 08/30/2024-10/16/2024. Resident 5 was not assessed after making suicidal remarks on 09/09/2024. Findings include: On 10/16/2024, the Department received a complaint alleging concerns a resident was having daily falls. On 02/18/2025, Surveyor reviewed Resident 5's record and identified the following; Example 1: Fall risk Resident 5 was admitted to the provider on 04/24/2024 with diagnoses including history of ischemic stroke with residual deficits, borderline personality disorder, and major depressive disorder. Resident 5 had a legal guardian. Resident 5 discharged following a fall with a fracture on 10/16/2024. Resident 5's progress notes and historical incidents, dated 08/30/2024 to 10/16/2024, documented that Resident 5 had sustained 8 falls on the following dates: 08/30/2024, 09/17/2024, 09/23/2024, 10/04/2024, 10/08/2024, 10/12/2024, 10/13/2024, and 10/14/2024. The record did not contain an assessment to determine if Resident 5 had a change in needs due to the falls. Resident 5's most recent individual service plan (ISP) with an unknown date documented:	N 381		

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"Mobility: 5/5/24: resident was encouraged to ask for help and let staff next time if [s/he] does have an unwitnessed fall. 9/24/24: resident is encouraged to wear proper footwear when transferring to avoid tripping and other hazards. 10/4/24: resident was encouraged to use [his/her] wheelchair when [s/he] is weak instead of [his/her] walker. 10/8/24: resident was educated on the importance of keeping [his/her] pathways clear to avoid tripping hazard. 10/15/2024: resident was encouraged to have staff help toilet [him/her] when needed. Unwitnessed fall on 8/30/024: resident to use call light to ask for assistance. Unwitnessed fall on 9/17/2024: Resident will accept staff assistance with transferring and will use [his/her] call light for help. 04/23/2024: Encourage non-slip socks in room. Encourage proper footwear when out of bed. Keep pathways in room clear of clutter."

The ISP listed fall prevention interventions that were the same from previous falls, for example: 04/23/2024: Encourage non-slip socks in room. Encourage proper footwear when out of bed. 09/24/2024: Resident is encouraged to wear proper footwear when transferring to avoid tripping and other hazards.

04/23/2024: Keep pathways in room clear of clutter. 10/08/2024: Resident was educated on the importance of keeping his/her pathways clear to avoid tripping hazards.

05/25/2024: Resident was encouraged to ask for help and let staff know next time if s/he does have an unwitnessed fall. 10/15/2024: Resident was encouraged to have staff help toilet him/her when needed.

08/30/2024: Resident to use call light to ask for

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assistance. 09/17/2024: Resident will accept staff assistance with transferring and will use his/her call light for help.

Surveyor reviewed Resident 5's most recent fall assessment, dated 08/21/2024. The assessment form did not include evaluations to determine if previous interventions were implemented and effective. The form did not assess for the potential need for frequent checks to anticipate needs or for increased supervision to prevent unwitnessed falls. Surveyor noted 8 falls had occurred since Resident 5's fall assessment on 08/21/2024.

Example 2: Suicide risk

Resident 5's progress notes documented: 09/09/2024: "hospice informed facility that resident made a comment about wanting to kill [him/herself] but when asked deeper resident stated that that [s/he] had no plan of action and was simply just frustrated. Guardian updated." The progress notes did not document an assessment of Resident 5's mental health condition after making suicidal remarks or an assessment to determine if Resident 5 had a change in needs due to the suicidal comment. Resident 5's ISP with an unknown date, did not identify him/her as a suicidal risk or include intervention/prevention measures.

On 02/19/2025 at 2:42 PM, Surveyor interviewed and shared findings with Executive Director L and Nurse M. Nurse M acknowledged Resident 5's record did not contain a more recent fall assessment or suicidal risk assessment. Nurse M reported the current management team did not work at the facility when Resident 5 had a high number of falls in September 2024 to October

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N 381	Continued From page 4 2024 or regarding the above comments from 09/09/2024. Surveyor expressed concern that many of Resident 5's fall preventions interventions were repetitive from earlier falls and showed interventions implemented months ago may not be effective or still relevant. Nurse M confirmed that the previous management should have conducted an assessment after the noted pattern of falls to determine the root cause of falls so more effective fall prevention interventions could have been implemented. This would have been the expectation from staff, but if Resident 5 did not have a change in condition, I'm (Nurse M) assuming they did not complete an assessment. Nurse M confirmed s/he was unable to locate any follow up documentation related to Resident 5's suicidal comments on 09/09/2024.	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 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	N 431		

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N 431	Continued From page 5 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 2 of 2 residents reviewed had their health monitored and communication with the resident's physician was documented in the resident's record. Resident 6 experienced a high blood pressure that was not updated to the physician. Resident 7 had 2 occurrences in which his/her blood sugar was over 450, there was no evidence of staff notifying his/her physician. This is a repeat violation. See Statement of Deficiency (SOD XCDZ11, dated 08/08/2023. Findings include: On 02/11/2025, Surveyor reviewed resident records and identified the following: Example 1 - Resident 6 Resident 6 was admitted to the provider on 10/25/2021 with a diagnosis of hypertension. Resident 6's physician orders documented:	N 431		

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N 431	Continued From page 6 "Monitor blood pressure once weekly. Notify MD if SBP is greater than 150." Surveyor reviewed Resident 6's medication administration record (MAR) from 01/01/2025 to 02/10/2025, where staff documented Resident 6's blood pressure. Surveyor observed on 02/10/2025, Resident 6's blood pressure was within the notification parameters, there was no evidence in which Resident 6's medical provider having been notified of the reading: 02/10/2024: Blood pressure documented as 153/81. Example 2 - Resident 7 Resident 7 was admitted to the provider on 03/23/2023 with a diagnosis of type 2 diabetes. Resident 7's individual service plan (ISP) dated 09/18/2024 indicated staff performs medication administration. Resident 7's physician orders documented: "Insulin Lispro Kwikpen with directions: sliding scale: if blood sugar 200-299 add 4 units, blood sugar 300-350 add 6 units, blood sugar over 350 add 8 units. (Call MD if <75 or >450)." Surveyor reviewed Resident 7's MAR from 01/01/2025 to 02/10/2025. Surveyor observed 2 occurrences in which Resident 7's blood sugar was within notification parameters, there was no evidence in which Resident 7's medical provider was notified of the high blood sugar reading. 01/12/2025: Blood sugar documented as 559. 01/14/2025: Blood sugar documented as 494 On 02/19/2025 at 2:42 PM, Surveyor interviewed and shared findings with Executive Director L and Nurse M. Nurse M acknowledged Resident 6's and Resident 7's record did not contain documentation to show their physician was notified regarding the above blood pressure and blood sugar readings. Nurse M reported their	N 431		

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N 431	Continued From page 7 nurse practitioner (NP) had access to their electronic health record, but the system did not notify him/her. Nurse M stated the expectation would be for staff to report high readings to the physician and document in progress notes. Nurse M reported reeducation was needed for some staff.	N 431		