| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525321 | A. Building<br>B. Wing | 04/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Riverdale Health Care Center | 1000 N Wisconsin Ave<br>Muscoda, WI 53573 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50698<br><br>Based on observation, interview, and record review, the facility did not ensure each resident had the right to a safe, clean, comfortable, and homelike environment for 8 of 14 sampled Residents (R1, R3, R8, R9, R10, R11, R12, R13).<br><br>Surveyor observed in R1's room visibly soiled linens on the bed, dirty towels and washcloths on the floor, food, clothing, and other items scattered on the floor.<br><br>Surveyor observed R3's wheelchair to be dirty. Resident Representative Q voiced concerns of R3's wheelchair being unclean. Surveyor observed dried food particles, a white chalk-like substance, and 2 different colors of dried drips on the seat and arms of R3's wheelchair.<br><br>Surveyor observed a used Kleenex and a piece of gauze on the floor by the head of R8's bed.<br><br>Surveyor observed food, other items, footprints and wheelchair marks on the floor in R9's room.<br><br>Surveyor observed water stains and a cut out square on the ceiling in R10's room.<br><br>Surveyor observed straw wrappers as well as footprints and wheelchair marks on the floor in R11's room.<br><br>Surveyor observed cobwebs in the corner above R12's bed as well as a straw and hair tie on the floor behind the bed.<br><br>Surveyor observed a pile of crumbs at the door entrance of R13's room on the carpet. Surveyor also observed several boxes, plastic tubing and other items on the floor.<br><br>This is evidenced by:<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Facility New Admission Packet dated 1/2023, states in part, on page 70: .(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide - (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. (2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; (3) Clean bed and bath linens that are in good condition .<br><br>Example 1<br><br>R1 was admitted to the facility on [DATE] with diagnoses that include Type 2 diabetes mellitus with foot ulcer, muscle weakness, morbid obesity, dysphagia, pressure ulcer stage 3, nicotine dependence, mild cognitive impairment, and polyneuropathy.<br><br>R1's most recent Minimum Data Set (MDS) dated [DATE] states R1 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R1 is cognitively intact.<br><br>On 4/3/25 at 10:43 AM, Surveyor interviewed R1. Surveyor observed R1's sheets and pillowcase to have yellowish/brown stains on them. Surveyor observed several items on the floor including opened loaf of bread, Ritz cracker packages, air freshener cans, sock, fly swatter, papers, soiled towel and washcloth, blanket, duffle bag, water cup, and Tupperware lids in a bucket. Surveyor asked R1 how often his room gets cleaned and R1 stated once a day but indicated he would like it cleaned better. R1 indicated he wishes staff could get some things off the floor. Surveyor observed R1 transfer himself to the floor and begin to pick things up off the floor and behind a chair.<br><br>On 4/3/25 at 10:45 AM, Surveyor brought NHA A (Nursing Home Administrator), DON B (Director of Nursing), and Housekeeper L over to look at R1's room. Surveyor interviewed NHA A, DON B, and Housekeeper L regarding the cleanliness of R1's room. All indicated the room was unclean and not homelike. DON B stated they would send someone to the room to deep clean right away and change the linens.<br><br>Example 2<br><br>R8 was admitted to the facility on [DATE] with diagnoses that include Sequelae of cerebral infarction (consequence of previous injury of blood flow being blocked to the brain), encephalopathy (brain disease that alters brain function), Chronic Obstructive Pulmonary Disease, asthma, type 2 diabetes mellitus, and dysphagia.<br><br>R8's most recent Minimum Data Set (MDS) dated [DATE] states R8 has a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating R8's cognition is moderately impaired.<br><br>On 4/3/25 at 9:27 AM, during an initial tour of the facility, Surveyor observed a crumpled up used Kleenex and a square piece of gauze on the floor by the head of the bed in R8's room. Resident was not in the room at the time.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/3/25 around 11:10 AM, Surveyor asked NHA A to walk to R8's room with Surveyor and asked NHA A if the floor and room was clean. NHA A indicated those items on the floor by the bed should not be on the floor, should be cleaned, wasn't homelike.<br><br>On 4/3/35 around 11:35 AM, Surveyor asked Housekeeper N to walk to R8's room with Surveyor and asked Housekeeper N if the room was clean. Housekeeper N indicated those items on the floor should have been picked up and it wasn't clean.<br><br>Example 3<br><br>R9 was admitted to the facility on [DATE] with diagnoses that include encounter for orthopedic aftercare following surgical amputation, chronic atrial fibrillation, acute and chronic respiratory failure with hypoxia, muscle wasting and atrophy, and peripheral vascular disease.<br><br>R9's most recent MDS dated [DATE] states R9 has a BIMS score of 15 out of 15, indicating R9 is cognitively intact.<br><br>On 4/3/25 at 9:17 AM, during an initial tour of the facility, Surveyor observed several items on the floor in R9's room including: a cookie, popcorn pieces, empty gift bags, Bears [NAME], clear sandwich bag, and footprints and wheelchair marks on the floor. R9 voiced he wished his room was cleaner.<br><br>On 4/3/25 around 11:10 AM, Surveyor asked NHA A to walk to R9's room with Surveyor and asked NHA A if the floor and room were clean. NHA A indicated the items on the floor should not be there, floor should be cleaned, room wasn't clean and homelike.<br><br>On 4/3/35 around 11:35 AM, Surveyor asked Housekeeper N to walk to R9's room with Surveyor and asked Housekeeper N if the room was clean. Housekeeper N indicated those items on the floor should have been picked up and it wasn't clean.<br><br>Example 4<br><br>R10 was admitted to the facility on [DATE] with diagnoses that include muscle wasting and atrophy, neoplasm related pain (neoplasm is an abnormal growth of tissue that forms a mass or tumor), type 2 diabetes mellitus, morbid obesity, immunodeficiency, chronic respiratory failure, breast and bone cancer, and acute kidney failure.<br><br>R10's most recent MDS dated [DATE] states R10 has a BIMS score of 15 out of 15, indicating R10 is cognitively intact.<br><br>On 4/3/25 at 10:02 AM, Surveyor interviewed R10 about the cleanliness and environment of her room. R10 stated her room gets cleaned daily and mentioned to Surveyor she has a hole in the ceiling that she doesn't like. R10 stated maintenance is aware of the hole and water stains on the ceiling above her bed. Surveyor observed multiple water stains on the ceiling and the cut square on the ceiling, approximately 6in x 6in.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/3/25 at 11:00 AM, Surveyor asked Maintenance Director M to walk to R10's room with Surveyor and interviewed Maintenance Director M regarding the hole and water stains on the ceiling in R10's room. Maintenance Director M stated he cut the hole in the ceiling on 4/2/25 because he noticed paint peeling in that spot, it was dripping water, wanted to check for mold. Maintenance Director M indicated he's been watching that spot for a while due to the water stains. He indicated he sprayed a bleach solution around the cut-out spot on ceiling to protect it from mold. Maintenance Director M stated R10 was not in the room when he sprayed the bleach solution. He stated the roof has been repaired in the past in that spot and it needs to be repaired again. Maintenance Director M stated NHA A recently got permission from Corporate to fix the roof, unsure when the roof will get fixed.<br><br>On 4/3/25 at 11:05 AM, Surveyor interviewed NHA A regarding the leaking roof and hole in the ceiling in R10's room. NHA A indicated he has seen the hole and water stains on the ceiling. Surveyor asked if he knew when the roof was going to get fixed as R10 doesn't like the hole or water stains on the ceiling. NHA A indicated he wasn't sure when it was going to get fixed. NHA A stated he reached out to someone today, but they couldn't come out and fix it. NHA A stated he will continue to call and keep trying to find someone to fix the roof.<br><br>Example 5<br><br>R11 was admitted to the facility on [DATE] with diagnoses that include hyperlipidemia, nicotine dependence, major depressive disorder, anxiety disorder, and insomnia.<br><br>R11's most recent MDS dated [DATE] states R11 has a BIMS score of 12 out of 15, indicating R11's cognition is moderately impaired.<br><br>On 4/3 25 at 8:45 AM, Surveyor interviewed R11 about the cleanliness of the room and observed straw wrappers on the floor as well as footprints and wheelchair marks on the floor. R11 stated he wished his room was cleaner.<br><br>On 4/3/25 around 11:10 AM, Surveyor asked NHA A to walk to R11's room with Surveyor and asked NHA A if the floor and room were clean. NHA A indicated the items on the floor should not be there, floor should be cleaned, room wasn't clean and homelike.<br><br>On 4/3/35 around 11:35 AM, Surveyor asked Housekeeper N to walk to R11's room with Surveyor and asked Housekeeper N if the room was clean. Housekeeper N indicated those items on the floor should have been picked up and floor wasn't clean.<br><br>Example 6<br><br>R12 was admitted to the facility on [DATE] with diagnoses that include muscle wasting and atrophy, encephalopathy, cirrhosis of liver, type 2 diabetes mellitus, dysphagia, and major depressive disorder.<br><br>R12's most recent MDS dated [DATE] states R12 has a BIMS score of 2 out of 15, indicating R12's cognition is severely impaired.<br><br>On 4/3/25 at 8:52 AM, during an initial tour of the building, Surveyor observed cobwebs above R12's bed in the corner, a straw and hair tie on the floor behind the bed.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/3/25 around 11:10 AM, Surveyor asked NHA A to walk to R12's room with Surveyor and asked NHA A if the floor and room were clean. NHA A indicated the items on the floor and cobwebs should not be there, floor should be cleaned, room wasn't clean and homelike.<br><br>On 4/3/35 around 11:35 AM, Surveyor asked Housekeeper N to walk to R12's room with Surveyor and asked Housekeeper N if the room was clean. Housekeeper N indicated cobwebs shouldn't be there, the items on the floor should have been picked up and floor wasn't clean.<br><br>Example 7<br><br>R13 was admitted to the facility on [DATE] with diagnoses that include muscle wasting and atrophy, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, type 2 diabetes mellitus, sepsis, nicotine dependence, and secondary parkinsonism.<br><br>R13's most recent MDS dated [DATE] states R13 has a BIMS score of 15 out of 15, indicating R13 is cognitively intact.<br><br>On 4/3/25 at 9:05 AM, Surveyor interviewed R13 and observed a pile of crumbs on the carpet at the door entrance of R13's room. Surveyor observed several items on the floor which include: a Kleenex box and plastic tubing on the floor by R13's bed, empty cardboard boxes under the TV as well as another Kleenex box and an empty foam wound dressing box on the floor, a pink piece of paper on the floor, and an opened plastic gallon water jug by the door. R13 stated he would prefer his room to be cleaner.<br><br>On 4/3/25 around 11:10 AM, Surveyor asked NHA A to walk to R13's room with Surveyor and asked NHA A if the floor and room were clean. NHA A indicated the items on the floor shouldn't be there, room wasn't clean and homelike.<br><br>On 4/3/35 around 11:35 AM, Surveyor asked Housekeeper N to walk to R13's room with Surveyor and asked Housekeeper N if the room was clean. Housekeeper N indicated the items on the floor should have been picked up and room wasn't clean.<br><br>38882<br><br>Example 8<br><br>On 4/3/25 at 8:30 AM, Resident Representative Q indicated R3's wheelchair is often observed unclean with food crumbs and dried dripping marks on it. Resident Representative Q indicated she does not think staff have a system in place for upkeeping the cleanliness of the wheelchairs.<br><br>Example 9<br><br>R3 admitted to the facility on [DATE] with diagnoses including Parkinson's Disease with Dyskinesia, Fibromyalgia, spinal stenosis, bipolar disorder, abnormal posture, age-related osteoporosis .Her most recent Minimum Date Set (MDS) with Assessment Reference Date (ARD) of 2/21/25 indicates she is dependent on staff assistance to meet her activities of daily living (ADL) needs.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/3/25 at 10:43 AM, Housekeeper L indicated she is not sure who is responsible for cleaning wheelchairs, but she knows it is not the housekeeping department.<br><br>On 4/3/25 at 2:40 PM CNA/MT E (Certified Nursing Assistant/Medication Technician) indicated he does not think there is a set schedule for wheelchair cleaning, and he is not sure who is responsible for cleaning wheelchairs.<br><br>On 4/3/25 at 2:43 PM CNA F indicated she is not sure how often wheelchairs get cleaned and she is unsure who is responsible for cleaning wheelchairs.<br><br>On 4/3/25 at 2:46 PM CNA G indicated she is not sure how often wheelchairs get cleaned. CNA G indicated a long time ago there was a book with a schedule for wheelchair cleaning, but she does not know what happened to the book.<br><br>On 4/7/25 at 4:52 PM DON B (Director of Nursing) indicated anyone can wash a wheelchair and they should be being washed on the same day as the residents' scheduled bath day. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50698<br><br>Based on interview and record review, the facility did not make prompt efforts to document, investigate, and resolve grievances a resident may have for 1 of 1 resident's reviewed for grievances (R10).<br><br>R10 voiced a grievance to the facility regarding a missing clothing item. The facility did not document the grievance or follow through with their grievance policy.<br><br>This is evidenced by:<br><br>The facility's policy entitled Grievance Policy, dated 3/1/19, states in part .F. Grievances may be given to any staff member who will forward the grievance to the Grievance Official. G. Response Any Employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Official .<br><br>The facility's new admission packet, dated 1/2023, states in part, page 52 .Storage options for Resident's Personal Belongings .Policy Explanation and Compliance Guidelines: .6. The facility will ensure Resident belongings are kept in a neat and orderly fashion and maintained in each Resident's room. 7. The facility will exercise reasonable care for the protection of the Resident's property from loss or theft .<br><br>Surveyor requested a specific policy for lost or missing resident items, facility did not provide one.<br><br>R10 was admitted to the facility on [DATE] with diagnoses that include muscle wasting and atrophy, neoplasm related pain (neoplasm is an abnormal growth of tissue that forms a mass or tumor), type 2 diabetes mellitus, morbid obesity, immunodeficiency, chronic respiratory failure, breast and bone cancer, and acute kidney failure.<br><br>R10's most recent Minimum Data Set (MDS) dated [DATE] states R10 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R10 is cognitively intact.<br><br>On 4/3/25 at 10:02 AM, Surveyor interviewed R10. R10 stated she has been missing a gray scrub top for about two months now and indicated she was frustrated about it. Surveyor asked R10 if she told anyone and remembered who she reported this to. R10 indicated she reported this to laundry staff a couple months ago, doesn't remember a name, and scrub top is still missing.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/3/25 at 10:50 AM, Surveyor interviewed LA O (Laundry Aide)about R10's missing scrub top. LA O stated R10 did tell her about the missing gray scrub top a couple months ago. Surveyor asked LA O if she documented this anywhere, kept a record of when R10 told her about the missing top, or reported this to anyone else. LA O indicated she did not report this to anyone else or write it down anywhere. LA O stated they don't have a log of lost or missing items. LA O stated she tries to remember when a resident says they are missing something and keeps looking for it. LA O indicated they haven't found the missing top yet for R10, stated it could be in someone else's closet. LA O stated she hasn't had time to go in all the resident closets and look for the gray top. Surveyor asked what the process is if a resident's clothing item isn't found, and LA O stated she doesn't know what the process is.<br><br>It's important to note LA O knew of the missing gray scrub top for about 2 months and did not tell anyone else or report it to the supervisor until recently.<br><br>On 4/7/25 at 10:30 AM, Surveyor interviewed HKL P (Housekeeping/Laundry Manager) regarding R10's missing gray scrub top. HKL P indicated she first heard about R10's missing top from LA O last week. Surveyor asked what the process is for lost or missing items. HKL P stated they go around and search, if they can't find it, the facility replaces it. Surveyor asked how long they wait before telling someone else about the missing item and HKL P stated about 2 weeks. HKL P stated they will let medical records know after a couple weeks so the facility can replace the item.<br><br>Of note, neither staff stated they would document the incident, file a grievance or report the missing item to the Grievance Official.<br><br>On 4/7/25 at 2:40 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked what the expectation is for staff if a resident says they're missing a clothing item. NHA A indicated he would expect staff to tell the Social Worker to report it, search for the item, look throughout the building, ask staff to help look for the item, fill out a grievance, and the facility will replace it if not found. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882<br><br>Based on interview and record review, the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 3 out of 18 sampled residents (R2, R16, and R18.)<br><br>R2 reported to staff that she swallowed a toy stress ball. Staff did not call poison control to gain information on the toxicity of the contents within the ball. Staff did not complete a Registered Nurse assessment that included respiratory assessment, abdominal assessment, or pain assessment. Without having the ball back in possession, staff reported to R2's Nurse Practitioner (NP) that the ball was retrieved. R2 reported she asked to go to the hospital and laid in bed worrying about the ball overnight while staff did not make arrangements for R2 to go to the hospital until the next morning. Staff did not follow orders given by R2's NP to monitor R2 closely. The facility failed to update R2's Comprehensive Care Plan to prevent further occurrences. R2 was found to have a high-grade small bowel obstruction that required surgical intervention, necessitating a 6 day hospitalization .<br><br>R16 went to the emergency room for abdominal pain and was noted to have cellulitis to R16's right third toe. R16 was ordered an antibiotic. The facility did not start the antibiotic timely. The facility did not monitor, assess, or document on R16's cellulitis on his right third toe. R16 was then seen by podiatry who noted R16 had wet and dry gangrenous changes with malodor to his right third toe. Podiatry ordered an x-ray which revealed possible acute osteomyelitis involving the right third toe, correlating with site of wound. Podiatry had ordered wound care for the right third toe. The facility did not complete wound care, did not measure, and did not assess R16's right third toe wound. R16 had all 5 toes from his right foot amputated. R16's care plan was not updated and did not reflect the infection, wound, or amputations.<br><br>R18 developed a vascular ulcer on the right lateral leg. Staff failed to transcribe wound orders to the February TAR (Treatment Administration Record), failed to complete multiple treatments in February, March, and April, did not complete weekly wound assessments and measurements, failed to transcribe new antibiotic orders to the TAR, which delayed antibiotic administration for four days, and failed to develop a person-centered care plan for R18's vascular leg ulcer. R18's VLU (vascular leg ulcer) deteriorated and became infected. R18 was hospitalized for cellulitis requiring intravenous antibiotics.<br><br>The facility's failure to provide care consistent with standards of practice for R2, R16, and R18 by not completing an RN assessment with a change of condition, not following orders, not completing diabetic foot checks, wound assessments, transcribing wound treatments and medication orders into the TAR (Treatment Administration Record) and MAR (Medication Administration Record), not completing weekly comprehensive wound assessments, not completing wound treatments or initiating antibiotics timely, and failing to send residents to the hospital timely created a finding of immediate jeopardy that began on [DATE]. Surveyor notified Nursing Home Administrator (NHA A) and Director of Nursing (DON B) of the immediate jeopardy on [DATE] at 4:52 PM. The immediate jeopardy was removed on [DATE], however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.<br><br>Evidenced by:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Facility policy titled Notification of Changes, implemented [DATE], includes: It is the policy of this facility that changes in condition are immediately shared with the resident and the resident representative, according to their authority, and reported to attending physician or delegate . The resident and/or their representative will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff . requirements for notification of resident the resident representative and their physician: an accident involving the resident, which results in injury and has potential for requiring physician intervention .<br><br>According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process:<br><br>(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.<br><br>(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis.<br><br>(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants.<br><br>(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.<br><br>According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider .<br><br>(b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient .<br><br>(e) Perform the following other acts when applicable:<br><br>1. Assist with the collection of data .<br><br>Example 1<br><br>R2 admitted to the facility on [DATE] with diagnoses including, but not limited to, dysphagia (difficulty swallowing), respiratory failure, and disorder of psychological development.<br><br>R2's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of [DATE] indicates R2's cognition is intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 8:37 AM, Surveyor observed R2 coughing while eating her breakfast meal. R2 indicated she has trouble swallowing and in [DATE] she choked on and swallowed a stress ball that was given to her by staff.<br><br>On [DATE] at 12:35 PM during an interview, R2 indicated she begged the facility to send her to the hospital and she laid awake all night worrying about the ball exploding in her stomach. R2 stated, I could have died . I almost had it stuck in my throat, but then it went down to my stomach. I kept telling them they should get me to the hospital. R2 indicated this event scared her and has caused her a lot of grief, including the need for surgical intervention and six days in the hospital. R2 indicated she was unsure why she put the stress ball in her mouth, but she supposed it was soothing on her gums. R14 was eating at the table with R2 during this interaction and she joined the interview. R14 stated, She is telling the truth. I am an eyewitness. They told her no in front of me. She wanted to go to the hospital. R2 then stated, I wanted to go. They wouldn't let me. I was begging.<br><br>(Of note: R14 admitted to the facility on [DATE]. Her most recent MDS with ARD of [DATE] indicates R14's cognition is intact with a BIMS score of 15 out of 15.)<br><br>(Of note, per R2 and R14, R2 was not sent to the hospital on [DATE] per her request.)<br><br>R2's Medical Record contained the following:<br><br>Face sheet: indicates R2 is her own responsible party/own decision maker.<br><br>Nurse Practitioner Note, created on [DATE], effective date [DATE] at 5:24 PM, includes: late entry . Reason for call - paged by nursing to discuss an incident of the resident reportedly swallowing a stress ball. The patient accidentally swallowed a stress ball while playing with it in her mouth. The stress ball was retrieved without apparent damage. The patient denies swallowing any other objects. She admits to swallowing one stress ball in clear encasing with white and blue beads in it. The patient denies any signs or symptoms of distress. Vitals remain stable. Plan: Continue to monitor the patient closely for any changes in signs or symptoms. Nursing given orders to page immediately with changes in patient vital signs or condition .<br><br>(Of note, this note indicates the stress ball was retrieved without apparent damage, when the stress ball was not retrieved by staff. There is no indication if R2 was offered to go to the hospital or if R2 requested to go to the hospital.)<br><br>On [DATE] at 1:08 PM, NP J (Nurse Practitioner) indicated on [DATE] she was paged by the facility regarding R2 swallowing a stress ball. NP J indicated staff reported to her that they retrieved the ball after R2 swallowed it. NP J indicated she was under the assumption that R2 no longer had the ball inside of her and gave orders for monitoring R2. NP J indicated her expectations for monitoring are the staff complete respiratory and abdominal assessments as well as check resident vitals every 30 minutes to one hour. Then once these are normal 2 times, staff will complete respiratory and abdominal assessments and check vitals every 2 hours. Once these are normal 2 times, staff can do abdominal assessments, respiratory assessments, and check vitals every 4 hours. NP J indicated on [DATE] around 10:00 AM she was paged again regarding R2 having pain in her stomach and at this time she still believed staff retrieved the ball but gave orders to send R2 to the emergency room due to her high pain rating. NP J stated, I thought she did not swallow the ball. I was surprised she had to go out and then surprised she needed surgery.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Change In Condition form, dated [DATE] at 2:41 AM, includes: . Blood pressure: ,d+[DATE] recorded on [DATE] at 8:30 PM in lying position . Pulse: 66 recorded on [DATE] at 8:49PM . Respirations: 20 recorded at 8:49 PM . Temperature: 97 degrees Fahrenheit . route forehead recorded [DATE] at 8:50 PM . Weight: 169.7 pounds recorded on [DATE] at 12:59 PM . Pulse oximetry: 98% recorded on [DATE] at 8:51 PM . Code Status: Full code . Behavioral Status Evaluation (blank) . Respiratory Status Evaluation: (blank) . Abdominal Status Evaluation: (blank) . Pain Status Evaluation/Does the resident have pain: (blank) . Nursing observations, evaluation, and recommendations are: Resident informed myself and another resident of swallowing an object. No respiratory distress noted at this time and during the shift. Resident also stated that she is well aware of the object and states, I was just playing around and put it in my mouth, chewed it, and it was stuck in my throat. I drank pop and it went down into my stomach. Resident asleep and provider, DON B, and family notified. Recommendations: (blank) . New Testing Orders: (blank) . New Intervention Orders: (blank) .<br><br>(It is important to note this assessment is incomplete as it does not contain orders given by R2's Nurse Practitioner, and is signed by a Licensed Practical Nurse (LPN), not a Registered Nurse (RN). There is no indication an RN assessed R2. There is no indication if R2 was offered to go to the hospital. There is no evidence poison control was contacted.)<br><br>Nurses Note, dated [DATE] at 3:56 AM, includes: Resident no apparent respiratory distress at this time and no signs of discomfort. Resident asleep and vitals to monitor signs and symptoms after incident are taken every 2 hours as directed<br><br>(It is important to note the facility failed to provide evidence of R2's vitals being monitored. R2's medical record did not contain documentation of vitals being taken every 2 hours.)<br><br>Nurse Practitioner Note, created [DATE], effective date [DATE] at 10:00 AM, includes: Late entry . I was paged by nursing regarding R2 who is experiencing stomach pain. Stomach pain rated 9 out of 10. Patient consumed a stress ball yesterday. Patient believes the entirety of the stress ball was retrieved and denies swallowing anything other than the stress ball. No further complications reported initially. Vitals have been stable. Next steps or changes to the plan: Send R2 directly to emergency room due to consumption of a foreign object and current stomach pain.<br><br>Nurses Note, dated [DATE] at 10:45 AM, includes: resident swallowed a stress ball on [DATE] during supper time. Resident denied emergency room visit. Nurse Practitioner ordered to monitor. [DATE] at approximately 10:00 AM resident complained of severe abdominal pain verbally rating 9 on pain scale zero to ten. Placed resident on toilet. Defecated without object present. Notified Nurse Practitioner. Ordered to send out. Telephoned emergency medical services. Called report to emergency department's registered nurse . Resident is own person. DON B notified . At time of departure resident was alert and oriented times 3. Respirations were even and nonlabored. Continues to rate abdominal pain 9 out of 10. Vitals: ,d+[DATE], 82, 97%, 18 .<br><br>Change In Condition form, dated [DATE] at 10:45 AM, includes: . Blood pressure-,d+[DATE] . position lying . recorded on [DATE] at 10:51 AM, Pulse- 82 recorded on [DATE] at 10:52 AM, oxygen saturation- 98% recorded on [DATE] at 8:51 PM, respirations- 20 recorded on [DATE] at 8:49 PM . Temperature- 97.0 recorded on [DATE] at 8:50 PM . Route- forehead . Code Status: Full code . Respiratory Status Evaluation: (blanks) . Abdominal Status Evaluation: (blank) . Pain Status Evaluation/ Does the resident have pain: Abdominal pain . Recommendations: Send to emergency room .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | (It is important to note this assessment is incomplete and does not contain an abdominal assessment with bowel sounds or a description of any distention. The assessment also does not contain a respiratory assessment. The vitals on this assessment were recorded approximately 14 hours prior to this evaluation and the assessment is signed by an LPN and not an RN.)<br><br>Emergency Department Note, dated [DATE], includes: date of service [DATE] . Stated complaint: Abdominal pain status post eating a stress ball on [DATE] . History of diabetes, hypertension, hyperthyroidism presenting for evaluation of foreign body ingestion. Patient reports earlier this morning she swallowed a . stress ball. Patient reports she is having abdominal pain and feeling nauseous. Patient denies episodes of emesis. Patient is not forthcoming on why she ate the stress ball. Active problems: foreign body in small intestine, complete small bowel obstruction . A complete review of 10 systems was performed including: . respiratory . GI . Physical exam: . Abdomen- Soft periumbilical tenderness with slight distension . Radiology: X-ray abdominal series impression: . single segment of dilated small bowel of concern for developing obstruction given the clinical context provided . Emergency Department Course and Medical Decision Making: . patient is with periumbilical abdominal pain as well as slight distension. Abdominal series X-ray revealed evidence of possible developing bowel obstruction. CT abdomen pelvis was obtained which revealed evidence of a high grade small bowel obstruction. General surgery evaluated patient. Emergency Department recommended NG tube placement as well as emergent operative management. Impression: high grade small bowel obstruction secondary to foreign object .<br><br>Medical Imaging Note, dated [DATE] includes: Provided indication: foreign body ingestion of a stress ball . Findings: . a single segment of small bowel distension is seen within the leftward abdomen crossing to the right of midline measuring up to 4.6 centimeters in caliber. No radio opaque foreign body detected. The bowel gas pattern is non obstructive. Stool burden is normal . Comparison Abdominal X-ray from earlier same day. Indication: patient ingested a whole stress ball and abdominal X-ray with concern for developing small bowel obstruction. Technique: CT was obtained through the abdomen and pelvis without contrast in the axial plane, reconstructed using bone and soft tissue algorithms and reformatted in coronal and sagittal planes. Findings: Bowel and Peritoneal Cavity: there is an acute high grade small bowel obstruction due to a 3.5 x 4.8 x 5.0 centimeter ball shaped foreign body, which contains air and multiple small radiopaque beads . located in the jejunum in the left abdomen. The distal small bowel is decompressed. No bowel perforation. Impression: acute high grade small bowel obstruction due to a 5 centimeter ball shaped foreign body in the jejunum in the left abdomen, consistent with the clinical history of swallowed stress ball. No bowel perforation.<br><br>Hospital Note, dated [DATE], includes: . Female presents for evaluation who presents for evaluation of abdominal pain. Patient ate a stress ball today. She is unable to explain to me why she ate the stress ball. CT shows acute high grade small bowel obstruction. Surgery found the patient to have a laparostomy with lysis of adhesions and enterotomy with removal obstruction foreign body consistent with a stress ball. Patient admitted to Intensive Care Unit for further recovery . Patient presents . is admitted for small bowel obstruction after ingesting a stress ball that had to be surgically removed. Currently NPO (nothing by mouth) with NG (nasal gastric) tube. General Surgeon is on consult monitoring for possible resection if bowel health does not improve .<br><br>Hospital Note, dated [DATE], includes: Assessment: Small bowel obstruction due to foreign body- status post laparostomy with lysis of adhesions and enterotomy with removal of obstructing foreign body. Blood loss anemia- hemoglobin down trending today to 7.8 from 8.7. Has now received a total of 2 units of packed red blood cells . Patient is feeling much better .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Hospital Note, dated [DATE], includes: discharge date [DATE] .<br><br>R2's Comprehensive Care Plan, reviewed [DATE] and initiated on [DATE], does not include a focus, goals, or interventions related to placing objects in her mouth or swallowing a foreign object.<br><br>(It is important to note the facility did not update R2's care plan to include interventions related to monitoring for R2 putting other things in her mouth after this event or a goal related to preventing future occurrences.)<br><br>On [DATE] at 9:00 AM R2 stated, I got the stress ball from the activity department. It was at least 2 inches in diameter. Maybe bigger. I couldn't believe it went down my throat.<br><br>On [DATE] at 10:15 AM, CNA H (Certified Nursing Assistant) indicated she worked the morning shift after R2 swallowed the stress ball. CNA H indicated she was made aware of R2 swallowing the stress ball at the start of her shift in morning report. CNA H indicated after breakfast R2 complained of having a lot of pain in her stomach. CNA H indicated she assisted R2 on the toilet where R2 had a large bowel movement that did not contain any fragments of the stress ball. CNA H indicated after having the bowel movement R2 was still reporting a lot of pain. CNA H indicated other residents also won stress balls at an activity group and she was unsure if staff collected them after the incident.<br><br>On [DATE] at 10:30 AM, DON B (Director of Nursing) indicated she was not present in the building on [DATE] when R2 swallowed the stress ball. DON B indicated it is her expectation that staff would follow R2's Medical Doctor's or Nurse Practitioner's recommendations/orders. DON B indicated it was about 8:30 PM when she was made aware of the incident. DON B indicated there was an LPN (Licensed Practical Nurse) working and she completed an assessment on R2. DON B and Surveyor reviewed R2's Change in Condition Assessment form dated [DATE] at 2:41 AM. DON B indicated the form does not contain a respiratory assessment, a pain rating, an abdominal assessment, or Nurse Practitioner recommendations. DON B indicated the form is incomplete. DON B also indicated LPNs can collect data, but they cannot assess residents. DON B and Surveyor reviewed NP J's (Nurse Practitioner) note. DON B indicated staff should not have reported the ball was retrieved without having some or all of its contents in hand. DON B indicated this was inaccurate information. DON B indicated Activity Director K did call the company where the product was purchased to obtain toxicity information on the contents of the stress ball, but not the night R2 swallowed it.<br><br>On [DATE] at 10:45 AM, Activity Director K indicated she had a few days off and when she came back to work she was told about R2 swallowing the stress ball and needing surgical intervention to remove the ball. Activity Director K indicated this is when she called the company she purchased the balls from to inquire more about the contents of the ball and toxicity information. Activity Director K indicated staff should have called poison control the night R2 ingested the ball to find out if the liquid or the tiny balls inside the encasing of the stress ball were toxic, but no one did this.<br><br>On [DATE] at 10:55 AM, DON B indicated staff should have inquired about the toxicity of the stress ball the night they became aware R2 ingested the stress ball. DON B and Surveyor reviewed R2's medical record, noting only 2 sets of vitals are recorded for R2 on [DATE] and [DATE]. DON B indicated staff should have followed NP J's recommendations for close monitoring for R2. DON B indicated this means staff should have been checking vitals every 2 hours and they should have completed abdominal and respiratory assessments. Surveyor and DON B reviewed R2's Comprehensive Care Plan. DON B stated, I should have updated R2's care plan after the incident. I will do it right now in front of you.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 12:35 PM, LPN I (Licensed Practical Nurse) indicated if a resident reported they swallowed a foreign object she would check the resident's airway, listen to lung sounds, palpate the resident's abdomen for pain and for distention/swelling, listen for bowel sounds, and ask the resident to rate their pain. LPN I indicated she would check the resident's vital signs and report the findings to an RN. LPN I indicated LPNs are not able to assess, but they can collect data. LPN I indicated if an NP gave her orders or recommendations over the phone she would type the order/recommendations into the resident's medical record and she would follow them.<br><br>The facility failed to ensure staff followed standards of practice resulting in staff assuming R2 did not swallow a stress ball without having the ball or pieces of the ball in hand. Staff reported inaccurate information to NP J. R2 indicated she wanted to go to the emergency room and staff did not send her upon her request. Assessments were incomplete and assessments were signed off by an LPN and not an RN, staff did not call poison control to inquire about the stress ball's contents and its toxicity. Staff did not follow NP J's orders for close monitoring. R2's care plan was not updated with new interventions to prevent future occurrences, and staff were not provided education regarding these deficient practices.<br><br>49436<br><br>Example 2<br><br>The facility's policy titled Wound Management, undated, states in part: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidenced-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. Dressing changes may be provided outside the frequency parameters in certain situations: feces has seeped underneath the dressing, the dressing has dislodged, the dressing is soiled otherwise or is wet. Treatment decisions will be based on: a. etiology of the wound: i. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage. ii. Surgical. iii. Incidental (i.e. Skin tear, medical adhesive related skin injury). iv. Atypical (i.e. dermatological or cancerous lesion, pyoderma, calciphylaxis). b. Characteristics of the wound: i. Pressure injury stage. ii. Size - including shape, depth, and presence of tunneling and/or undermining. iii. Volume and characteristics of exudate. iv. Presence of pain. v. Presence of infection or need to address bacterial bioburden. vi. Condition of the tissue in the wound bed. vii. Condition of peri-wound skin. c. Location of the wound. d. Goals and preferences of the resident/representative. Treatments will be documented on the Treatment Administration Record. The effectiveness of treatments will be monitored through ongoing assessment of the wound.<br><br>R16 admitted to the facility on [DATE] with diagnoses including diabetes type 2, closed fracture of the right tibia, fibula, and medial malleolus, (a serious ankle fracture,) and dementia.<br><br>R16's comprehensive care plan printed on [DATE] does not contain a focus, goals, or interventions related to actual skin infection, wounds, or amputation.<br><br>R16's Physician orders include diabetic foot check nightly at bedtime for diabetes. Start date [DATE].<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R16's Treatment Administration Record (TAR) indicates diabetic foot check nightly at bedtime for diabetes. Diabetic foot checks were not completed on the following days based on R16's TARs:<br><br>R16's [DATE] TAR indicated on [DATE], and 18, R16's diabetic foot checks were not completed.<br><br>R16's February 2025 TAR indicated on February 7, 8, 9, 10, 24, and 27, R16's diabetic foot checks were not completed.<br><br>R16's [DATE] TAR indicated on [DATE], 12, and 13, R16's diabetic foot checks were not completed.<br><br>On [DATE] at 3:15 PM, Surveyor interviewed LPN W (Licensed Practical Nurse) regarding diabetic foot checks. LPN W indicated if the order was on the TAR she would have completed a diabetic foot check. Surveyor asked LPN W if she had completed a diabetic foot check for R16, and LPN W indicated she had completed diabetic foot checks for R16. LPN W indicated she could not recall anything in particular with R16's foot checks. When asked if LPN W could recall wounds or open areas to R16's feet, LPN W could not recall. LPN W indicated R16 would become agitated if staff approached him when he was in bed, so many times the diabetic foot check would be rushed and not as thorough as it should be.<br><br>On [DATE] at 10:19 AM, Surveyor interviewed IDON X (Interim Director of Nursing) regarding diabetic foot checks. IDON X indicated she would expect diabetic foot checks to be completed as ordered and to be signed out in the TAR. IDON X indicated if there was an abnormality found or something unusual, there would be a progress note indicating what was found/observed.<br><br>On [DATE] at 12:04 PM, Surveyor interviewed MD V (Physician). MD V indicated he would expect physician orders to be completed and followed and if not, the facility should notify the physician.<br><br>On [DATE], R16 went to the ER (emergency room ). R16's ER report states in part: R16 came in via ambulance from local nursing home with a complaint of right sided .abdominal pain .Right third toe redness and swelling for the last 1 week patient denies any trauma. Currently not on any treatment for the toe. Right third toe redness and swelling with bruising seems early cellulitis to the dorsum (back) of the right foot . Impression: right foot third toe cellulitis. Disposition: Follow-up with podiatrist in 1 week, return if problem worsening or change symptoms, follow-up with primary care doctor in 3 to 5 days for recheck of abdominal pain and right foot. New prescription Keflex (antibiotic) 500 mg capsule 4 times a day for 7 days, quantity 28.<br><br>R16's Physician orders include Cephalexin (antibiotic) 500 mg four times a day for infection for 7 days. Order was entered on [DATE] with a start date of [DATE].<br><br>R16's March Medication Administration Record (MAR) indicates Cephalexin (antibiotic) 500 mg by mouth for times a day for infection for 7 days. Order date on [DATE] at 9:50 AM. First dose of R16's antibiotic was given on [DATE].<br><br>Of note, R16 was seen in theER on [DATE] and was prescribed an antibiotic for cellulitis of his right third toe. The antibiotic was not started until [DATE].<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 10:19 AM, Surveyor interviewed IDON X regarding medication orders and implementing physician orders. IDON X stated any physician order should be processed within 24 hours even though that is not considered very expedient. IDON X indicated new orders are not always seen right away by facility staff.<br><br>On [DATE] at 12:04 PM, Surveyor interviewed MD V regarding antibiotic orders and processing times for new orders. MD V indicated any order placed in the system by 5:00 pm, the pharmacy will have the new order delivered that night, any time after 5:00 pm, the pharmacy would deliver the medication the next day.<br><br>Of note, the facility does not have documented assessments of R16's right third toe or the effectiveness of the antibiotic.<br><br>On [DATE], R16 was seen by podiatry. Podiatrist progress note for services on [DATE] includes the following: Follow-up concern of wound infection right third toe. Unclear duration .initial wound was seen in the emergency room approximately a week ago of concern of cellulitis .no erythema (redness) along the dorsal plantar forefoot there are wet and dry gangrenous (dead tissue) changes with malodor (unpleasant odor) and slight serous drainage (thin watery fluid) to the right third toe. I discussed nature of dry and wet gangrene of how this is a combination I discussed how this may cause problems in the near future. I do not think the toe is salvageable and I do think given the wet gangrene nature of this he would likely benefit from toe amputation however due to his unclear vascular status and stable nature of the condition we will order urgent ABIs (Arterial Brachial Index) and urgent vascular referral .Gangrene associated with type 2 diabetes mellitus .I assessed the site it is currently stable I counseled them and instructed nursing staff what to look for .additional instructions: To the wound base apply (a gauze soaked in betadine wring out any extra betadine and apply especially around the bottom of the toe and secure with roll gauze and tape), change the dressing every day or as needed if it becomes soaked wet or falls off, monitor for infection. If you notice spreading redness, redness that is getting a dark angry red, the site is getting more painful or more swollen, starts to drain more or drain cloudy or bad smelling liquid then call us right away .<br><br>R16's medical imaging report dated [DATE] includes the following: X-ray of frontal, lateral and oblique views of the right third digit (middle toe) .There appears to be an erosion of the cortex of the tuft of the third digit distal phalanx .possible acute osteomyelitis involving the tuft of the third digit. Correlate clinically for site of wound.<br><br>R16's [DATE] TAR includes the following: Monitor for s/s (signs and symptoms) of infection. Report it to the provider. Start [DATE] discontinued on [DATE]. Facility staff signed out as being completed on [DATE] night shift, [DATE] night shift, [DATE] evening shift, [DATE] day, evening and night shifts.<br><br>Of note, monitoring for signs and symptoms of infection was signed out as completed only 6 times out of 14 opportunities between when the order was written on [DATE] and when the resident was admitted to the hospital on [DATE].<br><br>R16's [DATE] TAR includes the following: Wound Care Right foot: Soaked a gauze in Betadine wring out any extras. Apply it especially around the base of the toe. Secure with roll gauze and tape. Every day shift. Start date [DATE].<br><br>(continued on next page) |

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|---|---|---|---|
| | 525321 | A. Building<br>B. Wing | 04/21/2025 |

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| Riverdale Health Care Center | 1000 N Wisconsin Ave<br>Muscoda, WI 53573 |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Of note: Facility staff did not sign out the [TRUNCATED] |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228<br><br>Based on observation, interview, and record review, the facility did not ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, for 1 of 3 sampled residents (R15).<br><br>R15 was hospitalized from 3/31/25 through 4/4/25 and from 4/7/25 through 4/9/25, and did not have a skin assessment completed by the facility upon return from these hospitalization s.<br><br>Evidenced by:<br><br>The facility's Skin Assessment policy, dated 3/1/29, states, in part: It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment. Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, daily for three days, and weekly thereafter.<br><br>R15 was admitted to the facility on [DATE] and has diagnoses that include type 2 diabetes mellitus with diabetic polyneuropathy (a chronic condition characterized by high blood sugar levels which can cause poor circulation leading to slow healing of wounds); pressure ulcer of right heel (localized injury to the skin and underlying tissue caused by prolonged pressure); chronic venous hypertension with ulcer of right lower extremity (a condition where the veins in the legs have consistently high pressure, which can lead to swelling, skin changes and leg ulcers/wounds); varicose veins of unspecified lower extremity with ulcer other part of lower leg (swollen, twisted veins that prevent blood from flowing back to the heart effectively, which can cause swelling and skin discoloration or ulcers/wounds.<br><br>R15's Minimum Data Set (MDS) with Target Date 4/7/25 states a Brief Interview of Mental Status (BIMS) score of 13 indicating that R15 is cognitively intact.<br><br>R15's Braden Scale (assessment for risk of developing pressure ulcer) is listed as follows:<br><br>*1/30/25 score 12, indicating high risk<br><br>*2/25/25 score 15, indicating mild risk<br><br>*3/18/25 score 15, indicating mild risk<br><br>*4/16/25 score 12, indicating high risk<br><br>R15's Care Plan states, in part: Focus-Pressure ulcer risk due to : diagnosis of diabetes .venous insufficiency, hx (history of) pressure ulcers . Interventions/Tasks .Skin assessment to be completed per Living Center Policy. Date initiated 6/24/24.<br><br>R15's Progress Notes state, in part:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | *3/31/25 11:10 AM .emergency services called resident POA (Power of Attorney) aware resident will be sent to hospital .<br><br>*4/5/25 11:22 AM .returned last evening around 6:30 PM from hospital stay report from hospital includes . coccyx (tailbone) reddened and scrotal area. Will have wound care readdress areas.<br><br>*4/7/25 2:06 PM .son gave consent to go to the emergency department for eval .resident left the building .en route to [Town name].<br><br>*4/9/25 2:21 PM .returned from [Town name] area Hospital .<br><br>R15's Wound Visit Reports state, in part:<br><br>*3/24/25 .Right heel pressure ulcer 0.5x0.5x0.1 (length by width by depth in centimeters) . unstageable<br><br>*3/31/25 .No measurements obtained today for wounds. Patient's wound evaluation was abbreviated due to acute respiratory distress.decision was made to transport the patient to [Emergency department] for further eval<br><br>*4/7/25 .No measurements obtained today for wounds. Patient's wound evaluation was abbreviated due to respiratory distress.<br><br>*4/14/25 .Right heel pressure ulcer 4.5x11.2x0.1 unstageable<br><br>Important to note: there is no documentation of wound assessments for 4/4/25 and/or 4/9/25 when R15 returned from the hospital.<br><br>On 4/17/25 at 8:13 AM, Surveyor interviewed RN BB (Registered Nurse) and asked how often wounds are assessed. RN BB stated weekly by the charge nurse. Surveyor asked about skin protocol when a resident returns from the hospital. RN BB stated there is a skin assessment and wound evaluation completed.<br><br>On 4/17/25 at 8:25 AM, Surveyor interviewed IDON X (Interim Director of Nursing) and asked how often wounds are to be assessed. IDON X stated that the assessments occur weekly with wound consultant and facility nurse. Surveyor asked what happens if a resident is not available/in house when the wound consultant rounds. IDON X stated the care continues as ordered and the consultant will assess the following week. Surveyor asked about skin protocol when a resident returns from the hospital. IDON X stated a skin assessment is completed when the resident returns. Surveyor asked if there was a skin assessment on 4/4/25 and/or 4/9/25 when R15 returned from the hospital. IDON X reviewed the chart and stated that there was no assessment documented. Surveyor asked if staff was expected to perform a skin assessment for R15 when he returned from the hospital. IDON X stated yes.<br><br>On 4/17/25 at 9:16 AM, Surveyor observed R15's right heel with IDON X. Wound bed measured 5 cm (centimeter) length by 2.5 cm width with pale center of wound bed and slough around the edges.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/17/25 at 3:20 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if staff is expected to complete a skin assessment when a resident returns from the hospital. NHA A stated yes. |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228<br><br>Based on interview and record review, the facility did not ensure that residents are provided foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) for 2 of 2 residents (R15 and R16) reviewed for diabetic foot checks.<br><br>R15 was not provided routine diabetic foot checks.<br><br>R16 was not provided routine diabetic foot checks.<br><br>Evidenced by:<br><br>The facility's Skin Integrity-Foot Care policy, dated 10/1/24, states, in part: It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot.2. Assessment of Risk . e. Diabetic foot checks will be performed daily by the licensed nurse.<br><br>Example 1<br><br>R15 was admitted to the facility on [DATE] and has diagnoses that include type 2 diabetes mellitus with diabetic polyneuropathy (a chronic condition characterized by high blood sugar levels which can cause poor circulation leading to slow healing of wounds); pressure ulcer of right heel (localized injury to the skin and underlying tissue caused by prolonged pressure); chronic venous hypertension with ulcer of right lower extremity (a condition where the veins in the legs have consistently high pressure, which can lead to swelling, skin changes and leg ulcers/wounds)<br><br>R15's Care Plan states, in part: Focus-Pressure ulcer risk due to : diagnosis of diabetes .venous insufficiency, hx (history of) pressure ulcers . Interventions/Tasks .Diabetic foot monitoring. Date initiated 5/30/24.<br><br>R15's Physician's Orders state, in part: Diabetic foot check daily at HS (bedtime) Order date 4/4/25<br><br>R15's Treatment Administration Record (TAR) states, in part: Diabetic foot check daily at HS. Order date 4/4/25. Diabetic foot checks on April 8, 9, 10, and 13, 2025 are not signed off as completed.<br><br>On 4/17/25 at 8:13 AM, Surveyor interviewed RN BB (Registered Nurse) and asked if there are skin assessments completed for diabetic residents. RN BB stated yes, foot checks are completed nightly for all diabetic residents.<br><br>(continued on next page) |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/17/25 at 8:25 AM, Surveyor interviewed IDON X (Interim Director of Nursing) and asked if there are skin assessments completed for diabetic residents. IDON X stated that diabetic foot checks are completed nightly and documented on the TAR. Surveyor asked if foot checks were completed for R15 prior to 4/4/25. IDON X stated there is no documentation of foot checks prior to 4/4/24. Surveyor asked if foot checks were completed on April 8, 9, 10, or 13. IDON X stated if it wasn't documented it wasn't done. Surveyor asked if the facility is expected to perform nightly foot checks for R15. IDON X stated yes.<br><br>On 4/17/25 at 3:20 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if staff is expected to perform nightly foot checks for diabetic resident. NHA A stated yes.<br><br>49436<br><br>Example 2<br><br>R16 admitted to the facility on [DATE] with diagnoses including diabetes type 2, closed fracture of the right tibia, fibula, and medial malleolus, (a serious ankle fracture) and dementia.<br><br>R16's 3/24/25 Brief Interview for Mental Status (BIMS) score is a 15, indicating R16 is cognitively intact.<br><br>R16's Physician orders include diabetic foot check nightly at bedtime for diabetes. Start date 7/10/24.<br><br>R16's Treatment Administration Record (TAR) indicates diabetic foot check nightly at bedtime for diabetes. Diabetic foot checks were not completed on the following days based on R16's TARs.<br><br>R16's January 2025 TAR indicated on January 16, 17, and 18, R16's diabetic foot checks were not completed.<br><br>R16's February 2025 TAR indicated on February 7, 8, 9, 10, 24, and 27, R16's diabetic foot checks were not completed.<br><br>R16's March 2025 TAR indicated on March 5, 8, 12, and 13, R16's diabetic foot checks were not completed.<br><br>On 4/16/25 at 3:15 PM, Surveyor interviewed LPN W (Licensed Practical Nurse) regarding diabetic foot checks. LPN W indicated if the order was on the TAR she would have completed a diabetic foot check. Surveyor asked LPN W if she had completed a diabetic foot check for R16, and LPN W indicated she had completed diabetic foot checks for R16. LPN W indicated she could not recall anything in particular with R16's foot checks. When asked if LPN W could recall wounds or open areas to R16's feet, LPN W could not recall. LPN W indicated R16 would become agitated if staff approached him when he was in bed, so many times the diabetic foot check would be rushed and not as thorough as it should be.<br><br>Of note, Podiatry had placed a gauze dressing to R16's foot on 3/14/25 and the same dressing was on R16's foot on 3/18/25 during the follow up appointment with podiatry. LPN W signed out the TAR as completing a diabetic foot check for R16 on 3/15/25 and 3/16/25 and was unable to recall any concerns about R16's foot.<br><br>(continued on next page) |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/17/25 at 10:19 AM, Surveyor interviewed IDON X (Interim Director of Nursing) regarding diabetic foot checks. IDON X indicated she would expect diabetic foot checks to be completed as ordered and to be signed out in the TAR. IDON X indicated if there was an abnormality found or something unusual, there would be a progress note indicating what was found/observed. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992<br><br>Based on observation, interview, and record review, the facility did not ensure each resident received adequate supervision to ensure each residents' environment remains free of accidents and hazards for 2 of 5 sampled residents (R17 and R1.) R17 is being cited at a scope and severity level 3 (actual harm.)<br><br>R17 requires staff assistance to, in part, stand, transfer, and toilet. On 2/5/25, PT Y (Physical Therapist) recommended R17 be provided with: 1:1 supervision required due to falls and history of seizures. The facility did not implement 1:1 supervision. On 3/2/25, R17 fell and fractured his hip while self transferring from his wheelchair to bed.<br><br>Surveyor observed R1's motorized wheelchair charging in his room and not behind a fire safe door.<br><br>As evidenced by:<br><br>The facility's policy, Falls Management Process, undated, indicates in part as follows: .The nurse will complete an event documentation report, fall risk assessment, pain assessment, and obtain witness statements. The nursing supervisor will determine the most appropriate intervention, implement and update care plan.American Medical Directors Association (AMDA.) Falls and Fall Risk Clinical Practice Guideline [NAME], MD: AMDA 2011<br><br>Example 1:<br><br>R17 was admitted to the facility with diagnoses including, but not limited to, Parkinson's disease (a disorder of the central nervous system that affects movement), traumatic brain injury with loss of consciousness (a complex injury to the brain), epilepsy (seizure disorder), difficulty walking, generalized anxiety disorder (severe ongoing anxiety that can interfere with daily life), and major depressive disorder (persistently depressed mood).<br><br>R17's Significant Change Minimum Data Set (MDS) dated [DATE] indicates R17 scored 9 out of 15 on his Brief Interview for Mental Status (BIMS) indicating he is moderately cognitively impaired. R17 has a guardian.<br><br>R17's comprehensive care plan documents, in part: (Date Initiated: 11/16/22) (R17) has a physical functioning deficit related to: Mobility impairment, self care impairment, need for assistance with personal care. Goal: I will improve my current level of physical functioning; receiving PT (Physical Therapy) OT (Occupational Therapy) ST (Speech Therapy). (Date Initiated: 6/16/23, Revised on 3/8/25) Toileting assistance of 2 with hoyer.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R17's comprehensive care plan documents, in part: Focus: At risk for falls related to: history of falls, fall 3/2/25 with right femur fx (fracture). DX (diagnoses) including parkinson's (a disorder of the central nervous system that affects movement), a-fib (an irregular rapid heart rate that causes poor blood flow), epilepsy (seizure disorder), difficulty walking, weakness, TBI (Traumatic Brain Injury) (a complex injury to the brain) . Date Initiated: 11/16/22 Goal: No Falls No serious fall related injuries Interventions: (8/19/24) Anti roll backs applied to wheelchair; (Date initiated: 11/16/22) Assess for pain; (Date Initiated: 11/16/22) Call light and personal items available an in easy reach or provide reacher; (Date Initiated: 4/20/24) Clear and monitor environmental obstacles (tubing, cords, etc.); (Date Initiated : 11/6/24) Dycem placed in wheelchair .(Date Initiated: 11/16/22) Encourage to wear footwear to prevent slipping including grippy socks to bed. (Date Initiated: 4/20/24) Keep bed locked; (Date Initiated: 4/20/24) Keep personal items in reach; (Date Initiated: 1/10/25) Placed new non-skid strips on floor at bedside; (Date Initiated: 11/8/24) Placed signage in room to remind resident to call for assist for help don't fall; (Date Initiated: 9/27/24) Scoop mattress; (Date Initiated: 10/23/24) Therapy to work with resident with reinforcing safe self transfer techniques.<br><br>On 9/11/24, PT Y (Physical Therapist) documented the following for R17: Functional Skills Assessment: Sit to stand = Supervision or touching assistance; Chair/bed-to-chair transfer=Supervision or touching assistance; Toilet Transfer = Supervision or touching assistance; Justification for Continued Skilled Services: Remaining impairment. Subject (R17) sudden outbursts of frustration and struggles to transfer in a consistent manner.<br><br>Prior to falling and fracturing his hip, R17 would transfer independently without having the staff assistance that he needed. R17's most recent falls are documented as follows:<br><br>R17's three (3) most recent falls are as follows:<br><br>R17 fell on [DATE] at 8:50 PM. The fall investigation includes the following:<br><br>Incident Location: Resident's Bathroom<br><br>Person Preparing the Report: A nurse (title unknown) that no longer works at the facility<br><br>Incident Description: Resident found on bathroom floor after attempting to ambulate self from wheelchair to toilet. Resident is not compliant with calling for assistance when he needs help. Resident did hit head on bathroom floor, so he was immediately sent out to ED (emergency department) further evaluation being that is his second fall this week with him hitting his head. Resident had minor contusion on r (right) side of forehead when assessed skin. Resident state that there was pain all over his body when asked about where his pain was coming from.<br><br>Resident Description: Resident unable to give description<br><br>Was the incident witnessed: No<br><br>Immediate Action Taken: Blank<br><br>Resident Taken to Hospital: Yes<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Injuries Observed at Time of Incident: Bruise/Contusion Face<br><br>Level of Pain: 10<br><br>Mental Status: Blank<br><br>Injuries Report Post Incident: No injuries observed post incident<br><br>Predisposing Environmental Factors: Blank<br><br>Predisposing Physiological Factors: Gait Imbalance<br><br>Predisposing Situation Factors: Blank<br><br>Statements: No statements found<br><br>Notes: Resident found down in bathroom. Nurse completed assessment and vitals. Resident was sent to ER (emergency room ) due to he hit his head during fall. Resident attempted to self transfer and fell in bathroom (root cause). Signage placed in room to remind resident to call for assist don't fall. Care plan reviewed and updated.<br><br>R17 fell on [DATE] at 1:53 PM. The fall investigation includes the following:<br><br>Incident Location: Resident's room<br><br>Person Preparing the Report: (A nurse (title unknown) that no longer works at the facility)<br><br>Incident Description: Paged to room, resident on floor sitting upright bedside bed, no apparent injuries noted, bed lowered and locked, floor free of spills and clutter, room well lit. When asked pt what happened he stated, he was trying to get up out of bed to transfer and lost his balance, pt denies pain or any discomfort, assisted off floor by CNA and DON and placed back in bed, pt was given verbal education of importance of call light usage and risks of attempting to transfer without assistance, pt verbalized understanding, will continue to observe for remainder of shift.<br><br>Was the incident witnessed: No<br><br>Immediate Action Taken: Resident assisted off of floor by staff and placed back in bed<br><br>Resident Taken to Hospital: No<br><br>Injuries Observed at Time of Incident: No injuries observed at time of incident<br><br>Level of Pain: Blank<br><br>Level of Consciousness: Alert<br><br>Mobility: Wheelchair<br><br>(continued on next page) |

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| | 525321 | A. Building<br>B. Wing | 04/21/2025 |

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| Riverdale Health Care Center | 1000 N Wisconsin Ave<br>Muscoda, WI 53573 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Mental Status: Oriented to person<br><br>Injuries Report Post Incident: No injuries observed post incident<br><br>Predisposing Physiological Factors: Confused, mental illness<br><br>Predisposing Situation Factors: Ambulating without assist<br><br>Statements: No statements found<br><br>Notes: Found resident on the floor. Pain indicators noticed such as grimacing, moaning and guarding of Rt (right) hip. His Rt leg was stabilized while vital signs was taken. He was alert and oriented x2 which is his baseline. Skin was intact. Resident said he was transferring from wheelchair to bed. Provider was notified and an order was given to send resident to hospital. During questioning of CNA (Certified Nursing Assistant) on that hall resident was noted to be sitting in his wheelchair with feet elevated on his bed around 2:10 PM. Nurse helping with assessment and CNA noted wheelchair was locked and resident was not incontinent of bowel of bladder [sic]. Resident was assisted off floor with hoyer lift and more than 2 nursing staff. MD (Medical Doctor) notified and new orders received to send to ER (emergency room ) for further evaluation. 911 was called. Care plan reviewed and current interventions remain appropriate.<br><br>On 2/5/25, PT Y (Physical Therapist) documented in part the following in R17's Physical Therapy note: Summary of Daily Skilled Services - Precautions: 1:1 Supervision required (falls) and history of seizures<br><br>The facility did not implement 1:1 supervision for R17 or add new interventions to ensure R17's safety.<br><br>R17 fell on [DATE] at 2:45 PM. The fall investigation includes the following:<br><br>Incident Location: Resident's room<br><br>Person Preparing the Report: (An RN (Registered Nurse) that no longer works at the facility)<br><br>Incident Description: Found resident on the floor. Pain indicators noticed such as grimacing, moaning and guarding of Rt (right) hip. His Rt leg was stabilized while vital signs was taken. He was alert and oriented x2 which is his baseline. Skin was intact. Resident said he was transferring from wheelchair to bed.<br><br>Was the incident witnessed: No<br><br>Immediate Action Taken: Provider was notified and an order was given to send resident to hospital.<br><br>Level of Pain:<br><br>Negative Vocalization: Repeated Troubled Calling Out. Loud Moaning or Groaning, Crying<br><br>Facial Expression: Facial Grimacing<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Body Language: Tensed, Distressed Pacing<br><br>Consolability: Unable to Console, Distract or Reassure<br><br>Mental Status: Oriented to person and place<br><br>Injury: Abrasion and other<br><br>Predisposing Situation Factors: Ambulating without assist<br><br>Statements: No statements found<br><br>Notes: Found resident on the floor. Pain indicators noticed such as grimacing, moaning and guarding of Rt (right) hip. His Rt leg was stabilized while vital signs was [sic] taken. He was alert and oriented x2 which is his baseline. Skin was intact. Resident said he was transferring from wheelchair to bed. Provider was notified and an order was given to send resident to hospital. During questioning of CNA (Certified Nursing Assistant) on that hall resident was noted to be sitting in his wheelchair with feet elevated on his bed around 2:10 PM. Nurse helping with assessment and CNA noted wheelchair was locked and resident was not incontinent of bowel of bladder [sic]. Resident was assisted off floor with hoyer lift and more than 2 nursing staff. MD (Medical Doctor) notified and new orders received to send to ER (emergency room ) for further evaluation. 911 was called. Care plan reviewed and current interventions remain appropriate.<br><br>On 3/2/25, R17's hospital report documents, in part: Principal diagnosis: Hip fracture; Major Procedures: 3/3/25 R (Right) IM (Intramedullary nailing is a surgical procedure used to treat femoral fractures) nail fixation femur. R17 was hospitalized from 3/2 - 3/6/25.<br><br>Of note, staff present at the time of these falls are no longer employed at the facility.<br><br>Of note, PT Y recommended R17 be on 1:1 supervision. The facility did not implement 1:1 supervision or any increased supervision despite R17 self-ambulating repeatedly.<br><br>On 4/17/25 at 3:10 PM, Surveyor spoke with NHA A (Nursing Home Administrator). NHA A started working as the NHA on 3/3/25 (the day after R17's fall with fracture). Surveyor asked NHA A if the facility provided education to staff following R17's fall with fracture on 3/2/25. NHA A stated he does not know what was done. NHA A stated he does not see that education was done from the documentation. Surveyor asked NHA A, would you expect education to be done with all staff. NHA A stated, With any injury, yes. Surveyor asked NHA A if therapy is recommending 1:1 supervision for R17 do you expect the facility to provide 1:1. NHA A stated yes. Surveyor asked NHA A, why would 1:1 be important. NHA A stated, if R17 gets up independently staff could redirect him to sit back down or fall softer to the ground. NHA A added, staff would redirect him to sit down before he would hurt himself.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 4/17/25 at 3:30 PM, Surveyor spoke with CNA AA (Certified Nursing Assistant). Surveyor asked CNA AA how long she has worked at the facility. CNA AA stated 3.5 years. Surveyor asked CNA AA, has R17 ever been on 1:1 supervision. CNA AA stated no. Surveyor asked CNA AA does R17 self transfer. CNA AA stated, not so much now since breaking his hip but before his fall with fracture yes he would self transfer and self ambulate. CNA AA stated, since the hip fracture R17 now transfers with a hoyer (full body lift). CNA AA stated, R17 transferred with a stand lift prior to the fall with fracture. Surveyor asked CNA AA, do you recall if the facility provided education regarding falls to you as well as other staff after R17's fall with fracture. CNA AA stated no.<br><br>On 4/17/25 at approximately 4:00 PM, Surveyor spoke with CNO Z (Chief Nursing Officer). CNO Z stated, We're not accustomed to providing 1:1. CNO Z stated, we'll do it if we have to for the safety of the resident. CNO Z stated there needs to be a discussion with IDT (Interdisciplinary Team) before 1:1 is implemented. There is no further documentation as to why 1:1 was not implemented as recommended by PT Y (Physical Therapist).<br><br>On 4/22/25 at 2:00 PM, Surveyor called PT Y (Physical Therapist). PT Y was not available to speak with Surveyor on 4/17/25. Surveyor has not received a return phone call.<br><br>PT Y recommended R17 be provided with 1:1 supervision due to falls and history of seizures. The facility did not implement 1:1 supervision or any additional interventions to increase supervision for R17, resulting in R17 having a fall with fracture while self transferring from his wheelchair to bed.<br><br>38882<br><br>Example 2:<br><br>The facility did not provide a policy and procedure for power wheelchair charging.<br><br>R1 was admitted to the facility on [DATE] with diagnoses that include Type 2 diabetes mellitus with foot ulcer, muscle weakness, morbid obesity, dysphagia, pressure ulcer stage 3, nicotine dependence, mild cognitive impairment, and polyneuropathy.<br><br>R1's most recent MDS (Minimum Data Set) dated 2/16/25 states R1 has a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating R1 is cognitively intact.<br><br>On 4/3/25 at 10:43, AM Surveyor observed R1's power wheelchair to be charging in R1's room. R1 disconnected his powerchair and indicated he charges his chair over there as he pointed to the outlet with the charging cord hanging from it.<br><br>On 4/3/25 at 11:41 AM, NHA A and Surveyor observed R1's room where his wheelchair had been charging and where now only the charging cord was attached to the outlet. NHA A stated, The chair should not be charging in here. It should be in the charging room. NHA A disconnected the cord from the outlet and removed it from R1's room. NHA A indicated the facility does not have a policy related to power wheelchair charging. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849<br><br>Based on observation, interview, and record review, the facility failed to ensure other alternatives were tried prior to installing/utilizing side rails. The facility failed to have a system in place to assess for risk of entrapment between the mattress and side rail and failed to identify and recognize that the use of side rails with an air mattress increases the risk for entrapment for 6 of 6 (R3, R7, R10, R6, R5, and R4) residents reviewed for bed rails.<br><br>R4, R5, and R6 have an air mattress with enabler bars/bedrails. The facility did not complete all requirements as listed in F700 of the State Operations Manual prior to installing bed rails/enabler bars.<br><br>The facility failed to re-assess R3's risk of entrapment, complete a safety/gap test with the air mattress, provide written documentation of ongoing monitoring of bed rails, and provide documentation of alternatives tried prior to installing bed rails.<br><br>The facility failed to re-assess R7's risk of entrapment, complete safety/gap tests with the air mattress, provide written documentation of ongoing monitoring of bed rails, provide documentation of alternatives tried prior to installing bed rails, and provide evidence of the individual risk and benefits that were reviewed.<br><br>The facility failed to assess R10's risk of entrapment, complete safety/gap tests with the air mattress, provide written documentation of ongoing monitoring of bed rails, provide documentation of alternatives tried prior to installing bed rails, and provide evidence of the individual risk and benefits that were reviewed.<br><br>Evidenced by<br><br>The facility policy, Proper Use of Bed Rails, dated 10/1/22, states, in part:<br><br>Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Definitions: Bed Rails . Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars .<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Policy Explanation and Compliance Guidelines: Resident Assessment: 1. As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bedrails meets those needs: a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms b. Size and weight c. Sleep habits d. Medications e. Acute medical or surgical interventions f. Underlying medical conditions g. Existence of delirium h. Ability to toilet self safely i. Cognition j. Communication k. Mobility l. Risk of falling. 2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. 3. The resident assessment must also assess the resident's risk from using bed rails .4. The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself .Informed Consent: 6. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails .Installation and Maintenance of Bed Rails: 12. The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes: a. Checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible. Rails should be selected and placed to discourage climbing over rails. b. Ensuring that the bed's dimensions are appropriate for the resident by: i. Confirming that the bed rails are appropriate for the size and weight of the resident using the bed; .iii. Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment; iv. Ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/or depth. v. Checking bed rails regularly to make sure they are still installed correctly, and have not shifted or loosened over time .d. Conducting routine preventative maintenance of beds and bed rails to ensure they meet current safety standards and are not in need of repair .Ongoing Monitoring and Supervision: .16. Responsibilities of ongoing monitoring and supervision are specified as follows: .b. A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail .d. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails.<br><br>According to the Food and Drug Administration (FDA), The FDA recommends the following actions to prevent deaths and injuries from entrapment and falls from adult portable bed rails: .<br><br>When installing and using bed rails:<br><br>*Confirm that the age, size, and weight of the person using the bed rails are appropriate for the bed rails used.<br><br>*Install bed rails using the manufacturer's instructions to ensure a proper fit.<br><br>*Ensure that the safety strap or bed rail retention system is permanently attached to the rail and secured to the bed frame according to the manufacturer's instructions.<br><br>*Regularly inspect the mattress and bed rails for gaps and areas of possible entrapment. *Regardless of mattress width, length, and depth, the bed frame, bed rail and mattress should leave no gap wide enough to entrap a patient's head or body.<br><br>*Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed.<br><br>*Check bed rails regularly to make sure they are still installed correctly as rails may shift or loosen over time.<br><br>*When in doubt, call the manufacturer of the bed rails for assistance.<br><br>https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-consumers-and-caregivers-about-adult-portable-bed-rails<br><br>Example 1<br><br>R3 was admitted to the facility on [DATE] with diagnoses that include, in part: Parkinson's Disease with Dyskineasia: Fibromyalgia; Spinal Stenosis; Abnormal Posture; and Age-Related Osteoporosis.<br><br>R3's most recent Minimum Data Set (MDS) with a target date of 2/21/25, indicates R3 had a Brief Interview for Mental Status (BIMS) of 03, indicating R3 has a severe cognitive impairment.<br><br>R3's Physician orders include, in part: bilateral 1/4 enabler bars: used to assist with repositioning and transfers. Order Date: 5/17/24.<br><br>Air Mattress for wound care. Order Date: 4/11/23.<br><br>R3's most recent Bed Rail Assessment was completed on 5/17/24.<br><br>R3 was assessed on 2/3/25 to be At Risk for falls.<br><br>R3's Comprehensive Care Plan, indicates, in part: .Bed Mobility: Assist of 1, may use 2 assist as needed. Revision on 7/13/21 .Bilateral 1/4 enabler bars: used to assist with repositioning and transfers. Date Initiated: 6/20/24 .Transfer with assist of Hoyer (Full Body Lift) and 2 assist. Revision on: 6/15/23 .At Risk for Falls . Date Initiated: 1/5/17 .Provide Pressure reduction/relieving mattress. Revision on: 4/25/21 .<br><br>Of note, R3's Post Fall Evaluation on 8/3/24 indicates, in part: Fall Details: .Date/Time of Fall: 8/3/24 1:31AM .Activity at the time of fall: resident rolled out of bed .<br><br>There is no evidence that R3 had the following: measurements completed for a safety/gap test with the air mattress; an updated bed rail assessment for entrapment; written documentation of ongoing monitoring of bed rails or audits of bed rails; and documentation of alternatives tried prior to installing bed rails.<br><br>Example 2<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R7 was admitted to the facility on [DATE] with diagnoses that include, in part: Osteoarthritis (a degenerative joint disease where the protective cartilage that cushions the ends of bones wears down over time, leading to pain, stiffness, and reduced joint function); muscle wasting, and difficulty in walking.<br><br>R7's most recent MDS with a target date of 12/30/24 indicates R7 has a BIMS score of 15, indicating R7 is cognitively intact.<br><br>R7's physician orders include, in part: bilateral 1/4 enabler bars: used to assist with repositioning and transfers in/out of bed. Order Date: 5/17/24.<br><br>Pressure redistribution mattress (Air Mattress). Order Date: 4/18/22.<br><br>R7's most recent Bed Rail Assessment was completed on 5/17/24.<br><br>R7 was assessed on 2/5/24 to be At Risk for falls<br><br>R7's Comprehensive Care Plan, indicates, in part: .Bed Mobility: Assistance of (one). Revision on: 4/21/22 . Positioning bar to be placed on right side of bed to enable repositioning. Revision on: 5/20/23 .Transfer to Broda Chair with Hoyer .EZ Stand with assist of 2 for sitting balance support. Revision on: 2/16/24 .Provide pressure reduction/relieving mattress low air loss mattress. Revision on: 9/30/22 .At Risk for Falls .Date Initiated: 4/21/22 .<br><br>On 4/3/25 at 1:50PM Surveyors interviewed R7 and asked if she recalled receiving any education and/or risk and benefits regarding the use of bedrails. R7 indicated she did not.<br><br>There is no evidence R7 had the following: measurements completed for a safety/gap test with the air mattress; an updated bed rail assessment for entrapment; written documentation of ongoing monitoring of bed rails or audits of bed rails; documentation of alternatives tried prior to installing bed rails; and evidence of what individual risks and benefits were reviewed.<br><br>Example 3<br><br>R10 was admitted to the facility on [DATE] with diagnoses that include, in part: Secondary Malignant Neoplasm (Cancer that has the potential to spread to other parts of the body) of Breast; Secondary Malignant Neoplasm of Bone; Muscle Wasting and Atrophy; and Unsteadiness on Feet.<br><br>R10's most recent MDS with a target date of 3/13/25 indicates, R10 has a BIMS of 15, indicating R10 is cognitively intact.<br><br>R10's Physician orders include, in part: bilateral enabler bars to assist with bed mobility and transfers in and out of bed. Order Date: 12/9/24.<br><br>Of note, no order for an air mattress was noted in the physician orders provided by the facility.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R10's Comprehensive Care Plan, indicates, in part: .Bed Mobility: assistance of (1) assist as needed when feeling fatigued .Revision on: 7/18/24 .1/4 enabler bars to assist with repositioning and transfers in/out bed. Date Initiated: 8/9/24 .Transfer assistance of (1) as needed when feeling fatigued. Revision on: 7/18/24 .At Risk for Falls .Date Initiated: 7/5/24 .Air Mattress .Revision on: 3/31/25.<br><br>Of note, no evidence of a bed rail assessment was noted in R10's medical record and no further documentation was provided by the facility when requested.<br><br>R10 was assessed on 12/9/24 to be At Risk for falls.<br><br>On 4/3/25 at 1:50 PM, Surveyors interviewed R10 and asked if she recalled receiving education and/or risk and benefits for bed rail use. R10 indicated she couldn't recall due to memory issues with her current treatment regimen and requested we contact Family Member R who may have more information.<br><br>On 4/3/25 at 2:54 PM, Surveyors contacted Family Member R who indicated that she did not receive education and/or risk and benefits in regard to bed rails.<br><br>There is no evidence R10 had the following: measurements completed for a safety/gap test with the air mattress; a bed rail assessment for entrapment; written documentation of ongoing monitoring of bed rails or audits of bed rails; documentation of alternatives tried prior to installing bed rails; and evidence of what individual risks and benefits were reviewed.<br><br>50285<br><br>Example 4<br><br>R6 was admitted to the facility on [DATE] with diagnoses that include, in part, Multiple Sclerosis, Morbid Obesity, Type 2 Diabetes Mellitus, Muscle wasting and atrophy, Paraplegia, Unspecified lack of coordination, Muscle weakness generalized, Unspecified abnormalities of gait and mobility, anxiety disorder unspecified, Major depressive disorder unspecified and Pain unspecified.<br><br>R6's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/19/25 indicates R6 has a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating, R6 is cognitively intact.<br><br>R6's physician orders include, in part: Bilateral 1/4 enabler bars: used to assist in repositioning and transfers in/out of bed. Start Date: 5/17/24.<br><br>R6's Comprehensive Care Plan, states, in part; .Bed mobility moderate to max assistance of (2) staff. Start Date: 8/22/16 . Transfer assistance of three with Hoyer. Start Date: 8/22/16 . Bilateral 1/4 side rails on bed to promote independent bed mobility. Start Date: 8/22/16 At risk for falls. Start Date: 2/17/25 . Provide pressure reduction/relieving mattress. Start Date: 8/16/21.<br><br>R6's MDS Section GG indicates the following: Mobility: The resident is totally dependent on staff for rolling in bed, sitting to lying and lying to sitting on the side of the bed, and for transferring in/out of bed.<br><br>(continued on next page) |

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|---|---|
| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R6 was assessed on 2/17/25 to be at risk for falls.<br><br>R6 did not have measurements for gaps with the mattress and bed rails, did not have an updated bed rail assessment for entrapment, no written proof of risk vs. benefits for bed rails, no ongoing monitoring or audits of bed rails, no alternatives tried prior to installing bed rails, and no written proof of consent for bed rails.<br><br>On 4/3/25 at 1:41 PM, Surveyor interviewed R6, who stated he had never signed a consent or been provided education on the risks and benefits of the use of side rails.<br><br>Example 5<br><br>R5 was admitted to the facility on [DATE] with diagnoses that include, in part, Cerebral infarction d/t (due to) unspecified occlusion of middle cerebral artery, Type 2 diabetes mellitus, Acute respiratory failure, Morbid obesity, Central auditory processing disorder, Depression unspecified and Metabolic encephalopathy<br><br>R5's most recent MDS with ARD of 1/10/25 indicates R5 has a BIMS score of 15 out of 15, indicates that R5 is cognitively intact.<br><br>R5's physician orders include, in part: Bilateral 1/4 enabler bars: used for repositioning and transfers in/out of bed. Start Date: 5/17/24.<br><br>R5's Comprehensive Care Plan, states, in part; .Bed mobility: assistance of (total assist of 2 staff). Start Date: 7/18/23 . Transfer assistance: assistance of (total assist of 2 staff). Start Date: 7/18/23 . Bilateral 1/4 side rails on bed to promote independent bed mobility. Start Date: 1/30/24 At risk for falls. Start Date: 7/18/23 . Provide pressure reduction/relieving mattress. Start Date: 1/10/24.<br><br>R5's MDS Section GG indicates the following: Mobility: The resident needs substantial/maximum assistance of staff for rolling in bed, sitting to lying and lying to sitting on the side of the bed, and dependent on staff for transferring in/out of bed.<br><br>R5 was assessed to be a high risk for falls.<br><br>R5 did not have measurements for gaps with the mattress and bed rails, did not have an updated bed rail assessment for entrapment, no written proof of risk vs. benefits for bed rails, no ongoing monitoring or audits of bed rails, no alternatives tried prior to installing bed rails, and no written proof of consent for bed rails.<br><br>On 4/3/25 at 1:39 PM, Surveyor interviewed R5, who stated he had never signed a consent or been provided education on the risks and benefits of the use of side rails.<br><br>Example 6<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 525321 | A. Building<br>B. Wing | 04/21/2025 |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R4 was admitted to the facility on [DATE] with diagnoses that include, in part, Muscle wasting and atrophy, Morbid obesity, chronic kidney disease stage 3, Atrial fibrillation, Chronic pain syndrome, Acute kidney failure, other abnormalities of gait and mobility, Encephalopathy unspecified, Difficulty in walking, Weakness, Depression unspecified and Muscle weakness generalized.<br><br>R4's most recent MDS with ARD of 1/10/25 indicates R4 has a BIMS score of 15 out of 15, indicates that R4 is cognitively intact.<br><br>R4s's physician orders include, in part: 1/4 enabler bars: use for repositioning and assist with transfers. Start Date: 5/17/24.<br><br>R4's Comprehensive Care Plan, states, in part; .Bed mobility: independent. Start Date: 1/10/23 . Transfer assistance: independent with walker or wheelchair. Start Date: 1/13/24 . 1/4 enabler bars: use for repositioning and assist with transfers. Start Date: 6/21/24 At risk for falls. Start Date: 1/10/23 . Provide pressure reduction/relieving mattress. Start Date: 1/10/23 . Air Mattress. Start Date: 4/19/24.<br><br>R4's MDS Section GG indicates the following: Mobility: Independent for rolling in bed, sitting to lying and lying to sitting on the side of the bed, and independent on staff for transferring in/out of bed.<br><br>R4 was assessed on 1/10/23 to be a high risk for falls.<br><br>R4 did not have measurements for gaps with the mattress and bed rails, did not have an updated bed rail assessment for entrapment, no written proof of risk vs. benefits for bed rails, no ongoing monitoring or audits of bed rails, no alternatives tried prior to installing bed rails, and no written proof of consent for bed rails.<br><br>On 4/3/25 at 1:34 PM, Surveyor interviewed R4, who stated he had never signed a consent or been provided education on the risks and benefits of the use of side rails.<br><br>On 4/3/25 at 2:55 PM, Surveyor interviewed MD M (Maintenance Director) and asked how he assessed the resident for risk of entrapment prior to installing or using bed rails. MD M stated that it would be the nursing department that does that assessment. Surveyor asked MD M if he had done any gap measurements to ensure there would be no entrapments with the air mattresses and bed rails. MD M stated he had never measured the gaps for the mattresses. Surveyor asked MD M how he ensured that the dimensions of the bed were appropriate for the resident's size and weight. MD M indicated that would be therapy or nursing that would do that. Surveyor asked MD M how often was scheduled maintenance or audits completed on the bed rails already in use. MD M stated that he completes a walk around inspection of the facility weekly and tries to check the bed rails at that time to make sure they are working properly. Surveyor asked MD M if he had documentation of bed rail maintenance. MD M indicated that information was all kept in their online maintenance system, and he did not have any logs or documentation of that.<br><br>(continued on next page) |

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|---|---|---|---|
| | 525321 | A. Building<br>B. Wing | 04/21/2025 |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/3/25 at 3:49 PM, Surveyor interviewed DON B (Director of Nursing) and asked how she assessed the resident for risk of entrapment prior to installing or using bed rails. DON B stated that it was maintenance that would go around and do measurements. Surveyor asked DON B how often maintenance should be doing measurements and completing audits on the bed rails. DON B indicated that their policy stated they should be done quarterly. Surveyor asked DON B how often bed rail assessments should be completed on the bed rails already in place. DON B stated those should be done quarterly also, but that they hadn't been completed since last May. Surveyor asked DON B if it was her expectation that they be completed quarterly. DON B stated yes, that would be her expectation. Surveyor asked DON B if the resident or family representative actually signs the bed rail assessment. DON B indicated that residents and/or family members don't physically sign, but when they have the discussion with them, they just type in their name. Surveyor asked DON B if there were any entrapment assessments. DON B indicated no; she did not see an assessment for that. Surveyor asked DON B what kind of education or risk, and benefits was completed with the residents and or family members for the use of side rails with air mattresses. DON B stated that they were told of the risks and benefits, but that she did not have any documentation of it. DON B pulled up a bed rail assessment on her computer and expanded field 3A, which indicated the following, The positive and negative aspects of side rail/assist bar have been discussed with the resident and/or family, and the resident and/or responsible parties are aware of the risk involved with the side rail use. Surveyor asked DON B if she had any documentation that listed what those risks were. DON B stated that she thought there was something but that she couldn't find it. Surveyor asked DON B if any alternatives are tried before installing the bed rails. DON B indicated that they use the assessments, such as the bed rail assessment, fall risk assessment, Braden scale, a lift transfer evaluation, fall risk assessment, elopement assessment and ADL (Activities of Daily Living) assessment. Surveyor asked DON B how she would ensure the correct use of an installed bed rail. DON B said that would be the maintenance department. Surveyor asked DON B who would be responsible for measuring the gap between the side rail and the air mattress to reduce the risk of entrapment. DON B said that would be maintenance. Surveyor asked DON B who assesses to determine that the bed dimensions are appropriate for the resident size and weight. DON B said that would be maintenance too. Surveyor asked DON B if the measurements for gaps with the mattress and bed rails, a bed rail assessment that the resident or family signed, and written proof of risk vs. benefits for bed rails should be part of the resident's electronic medical record. DON B stated yes, it should all be included in the medical record. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436<br><br>Based on interview and record review, the facility did not ensure residents are free of any significant medication errors for 1 of 1 residents (R16) reviewed for medications.<br><br>R16 was prescribed an antibiotic for right third toe cellulitis. The facility delayed entering the order into R16's Medication Administration Record (MAR) and delayed starting the antibiotic.<br><br>This is evidenced by:<br><br>The facility's policy titled Non-Controlled Medication Order Documentation dated 10/25/14 states in part; Documentation of Medication Order: Each medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the order. The order is recorded on the physician order or the telephone order or entered int o the electronic medical records system, if it is a verbal order, and on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) or electronic medical records system. New Handwritten Orders: The nurse on duty at the time the order is received enters it on the physician order sheet/telephone order sheet or enters the order into the electronic medical records system if not written there by the prescriber. New Verbal Orders: The nurse documents the verbal order and the reason for its use on the telephone order sheet/physician's order sheet or enters the order into the electronic medical system. Transcribe newly prescribed medications on the MAR or TAR.<br><br>R16 admitted to the facility on [DATE] with diagnoses including diabetes type 2, closed fracture of the right tibia, fibula, and medial malleolus, (a serious ankle fracture) and dementia.<br><br>On 3/6/25, R16 went to the ER (emergency room ). R16's ER report states in part: R16 came in via ambulance from local nursing home with a complaint of right sided .abdominal pain .Right third toe redness and swelling for the last 1 week patient denies any trauma. Currently not on any treatment for the toe. Right third toe redness and swelling with bruising seems early cellulitis to the dorsum (back) of the right foot . Impression: right foot third toe cellulitis. Disposition: Follow-up with podiatrist in 1 week, return if problem worsening or change symptoms, follow-up with primary care doctor in 3 to 5 days for recheck of abdominal pain and right foot. New prescription Keflex (antibiotic) 500 mg capsule 4 times a day for 7 days, quantity 28.<br><br>R16's Physician orders include Cephalexin (antibiotic) 500 mg four times a day for infection for 7 days. Order was entered on 3/7/25 with a start date of 3/8/25.<br><br>R16's March Medication Administration Record (MAR) indicates Cephalexin (antibiotic) 500 mg by mouth for times a day for infection for 7 days. Order date on 3/7/25 at 9:50 AM. First dose of R16's antibiotic was given on 3/8/25.<br><br>Of note, R16 was seen in theER on [DATE] and was prescribed an antibiotic for cellulitis of his right third toe.<br><br>(continued on next page) |

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|---|---|---|---|
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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/17/25 at 10:19 AM, Surveyor interviewed IDON X (Interim Director of Nursing) regarding medication orders and implementing physician orders. IDON X stated any physician order should be processed within 24 hours even though that is not considered very expedient. IDON X indicated new orders are not always seen right away by facility staff.<br><br>On 4/17/25 at 12:04 PM, Surveyor interviewed MD V (Physician) regarding antibiotic orders and processing times for new orders. MD V indicated any order placed in the system by 5:00 PM, the pharmacy will have the new order delivered that night, any time after 5:00 PM, the pharmacy would deliver the medication the next day.<br><br>Of note, the order received on 3/6/25 was not placed into the system until 3/7/25 and R16s first dose of antibiotics was not given until 3/8/25. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>50285<br><br>Based on observation, interview, and policy review, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature. This has the potential to affect more than a minimal number of Residents (R).<br><br>2 of 2 test trays were served outside of temperature range.<br><br>Evidenced by:<br><br>The facility policy, titled Food Safety Requirements, dated 10/1/22, includes in part: .Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety . Police Explanation and Compliance Guidelines . 4. When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards . d. Holding - staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA (Food and Drug Administration) Food Code and facility policy for food temperatures as needed . 5. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include, but are not limited to: . f. Timely distribution of all meals/snacks .<br><br>Facility policy, titled Date Marking for Food Safety, undated, includes in part: . refrigerated, ready to eat, TCS (time/temperature control for safety) food shall be held at a temperature of 41 F (Fahrenheit) or less .<br><br>Example 1<br><br>On 4/3/25 at 8:45 AM, Surveyor received a breakfast test tray after all the dining room and hall trays had been served. (Of note, plates were being covered by plastic tops and bottoms, but no plate warmers were being used. The milk was poured into glasses and covered but were being kept on a tray without ice). Surveyor took the temperatures of the food that was served, including scrambled eggs, oatmeal, milk and coffee. Surveyor noted that the milk was in the temperature danger zone (temperature of 53.2 degrees F) and tasted warm.<br><br>Example 2<br><br>On 4/3/25 at 12:35 PM, Surveyor received a lunch test tray. Surveyor took the temperatures of the food that was served, including Salisbury steak, mashed potatoes and gravy, beets and milk. Surveyor noted again that the milk was in the temperature danger zone (temperature 48 degrees F) and tasted warm.<br><br>(It is important to note the milk should be held at 41 degrees F or less.)<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/3/25 at 8:54 AM, Surveyor interviewed DM D (Dietary Manager) and asked what the safe temperature was for serving hot and cold foods. DM D stated that hot foods should be served between 135 - 160 degrees F. DM D stated that cold foods should be served between 40 - 55 degrees F. Surveyor explained that cold foods should be kept below 41 degrees F and asked if she would expect food to be served at a safe and palatable temperature. DM D stated yes, that would be her expectation. |

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| | 525321 | A. Building<br>B. Wing | 04/21/2025 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>38882<br><br>Based on observation. interview, and record review, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 41 residents who reside in the facility.<br><br>Surveyor observed food that had been removed from the original box to be undated and unlabeled.<br><br>Surveyor observed milk to be opened with no open date.<br><br>Surveyor observed magic cups to be thawed and without a thaw date.<br><br>Evidenced by:<br><br>Facility policy titled Date Marking for Food Safety, undated, includes: the food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. The head cook or designee shall be responsible for checking the refrigerator daily for food items that are expiring and shall discard accordingly.<br><br>On 4/3/25 at 8:30 AM, Surveyor observed 3-gallon size white milks to be opened without an open date, mandarin oranges to have been removed from the original container without an open date or an expiration date, barbecue sauce opened with no open date, and 5 thawed magic cups with no thaw dates on them.<br><br>On 4/3/25 at 9:00 AM, DM D (Dietary Manager) indicated magic cups need to be labeled with thaw dates and all food or drink that is opened needs to be labeled with open dates. DM D indicated she was unsure when the milk was opened, when the mandarin oranges were opened, when the barbecue was opened, and when the magic cups were pulled from the freezer.<br><br>On 4/3/25 at 9:10 AM, NHA A (Nursing Home Administrator) and DON B (Director of Nursing) indicated food removed from the manufacturer's packaging needs to be labeled with a use by date or an opened date, opened milk needs to be labeled with an open date, and magic cups need a thaw date on them. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436<br><br>Based on observation, interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 2 of 2 residents (R2 and R15) reviewed for enhanced barrier precautions.<br><br>Staff did not follow Enhanced Barrier Precautions (EBP) of wearing personal protective equipment (PPE) when providing high-contact resident care activities for R2.<br><br>Staff did not follow EBP of wearing a gown when removing a wound dressing for R15.<br><br>This is evidenced by:<br><br>The facility's policy titled Enhanced Barrier Precautions, dated 3/25/24, states, in part: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. An order for enhanced barrier precautions .will be initiated for residents with any of the following: .wounds .indwelling medical devices . High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care .<br><br>R2 admitted to the facility on [DATE] with diagnoses including muscle weakness and indwelling urethral catheter (a type of catheter used for continuous drainage of urine from the bladder).<br><br>R2's physician orders include Enhanced Barrier Precautions start date 7/22/24.<br><br>R2's comprehensive care plan printed on 4/17/25 includes Focus: Infection actual or at risk for related to enhanced barrier precautions (foley). Interventions/Tasks: Wear appropriate PPE date initiated 7/22/24.<br><br>On 4/16/25 at 9:51 AM, Surveyor observed R2 sitting in her wheelchair in her room. R2's room is a double occupancy, and she does have a roommate. R2 has a sign on her door indicating EBP (Enhanced Barrier Precautions) and a bin outside her door in the hallway containing PPE (Personal Protective Equipment). R2's catheter bag was hanging under her wheelchair. R2 had her call light on, and 2 CNAs (Certified Nursing Assistants) came to R2's room to transfer R2 from wheelchair to the bathroom. R2 requires a sit to stand machine for transfers. CNA U pushed the sit to stand in front of R2. CNA T assisted with the sling placement and moved R2's catheter bag from the wheelchair to the sit to stand. CNA U raised the sit to stand and CNA T maneuvered R2 to the toilet. R2's pants were pulled down and brief was removed. CNA U lowered R2 to the toilet. Both CNAs washed their hands.<br><br>Of note, CNA U and CNA T did not wear gloves or a gown during this process.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/16/25 at 9:59 AM, Surveyor interviewed CNA T regarding R2. Surveyor asked which resident was on EBP per the sign on the door. CNA T indicated R2 is on EBP because of her catheter. CNA T then stated, we messed up. CNA T indicated she should have worn gloves and a gown when providing close contact cares like moving the catheter and transferring R2.<br><br>On 4/16/25 at 10:00 AM, Surveyor interviewed CNA U regarding R2. CNA U indicated R2 is on EBP for her catheter. CNA U stated she should have worn PPE when providing cares for R2 including during transfers and did not.<br><br>On 4/17/25 at 2:10 PM, Surveyor spoke with VPC S (Vice President of Clinical) regarding infection control. VPC S indicated staff should wear PPE for residents that have EBP.<br><br>50228<br><br>Example 2<br><br>R15 was admitted to the facility on [DATE] and has diagnoses that include pressure ulcer of right heel (localized injury to the skin and underlying tissue caused by prolonged pressure); chronic venous hypertension with ulcer of right lower extremity (a condition where the veins in the legs have consistently high pressure, which can lead to swelling, skin changes and leg ulcers/wounds); varicose veins of unspecified lower extremity with ulcer other part of lower leg (swollen, twisted veins that prevent blood from flowing back to the heart effectively, which can cause swelling and skin discoloration or ulcers/wounds.<br><br>R15's Care Plan states, in part: Focus-Infection actual or at risk for related to: enhanced Barrier Precautions (wounds) .Interventions/Tasks .Wear appropriate PPE date initiated 7/22/24.<br><br>On 4/17/25 at 9:16 AM, Surveyor observed R15's wound with IDON X (Interim DON). IDON X picked up R15's right leg and removed the bandage wrap. IDON X set down R15's leg, went into the bathroom, applied a set of gloves, returned to R15 and removed the border dressing to observe the wound. Surveyor asked IDON X about the cart sitting outside of R15's room. IDON X stated it was there to hold a supply of PPE for residents with wounds or catheters. Surveyor asked when the PPE would be used for R15. IDON X stated it would be used for any wound care. Surveyor asked if PPE is required when removing a dressing. IDON X stated yes, gloves. Surveyor asked if a gown is required. IDON X stated no, unless the resident has a positive wound culture or excessive drainage.<br><br>On 4/17/25 at 9:49 AM, Surveyor interviewed VPC S (Vice President of Clinical) and asked if any precautions are required when working with wounds. VPC S stated EBP; gowns and gloves when touching the resident. Surveyor asked if gown and gloves are required for removal of R15's wound dressing. VPC S stated yes.<br><br>On 4/17/25 at 3:20 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if staff is expected to wear a gown and gloves for removal of a wound dressing while on EBP. NHA A stated yes. |