STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525321	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Health Care Center	1000 N. Wisconsin Ave. 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review, the facility failed to protect residents' right to be free from neglect. This had the potential to affect all affected 43 residents who reside in the building. CNA M (Certified Nursing Assistant) stated she was the only CNA for PM shift on 6/20/25. Residents did not receive care on 6/20/25 between the hours of 2:00 PM and 9:00 PM. R16, R18, R14, R15, and R17 voiced concerns regarding care. This is evidenced by:The facility's policy titled Abuse, Neglect, and Exploitation, dated 10/1/22, states in part; it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures to prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. III. Prevention of Abuse, Neglect and Exploitation B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms. IV. Identification of Abuse, Neglect and Exploitation. B. Possible indicators of abuse include but are not limited to 8. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & positioning. The facility's policy titled Activities of Daily Living (ADLs), Supporting, dated 1/25, includes: Residents will provide [sic] with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting); d. Dining (meals and snacks); Example 1 The facility document titled Punched in and out, dated 6/20/25, indicates CNA M was the only CNA working on 6/20/25 for the evening shift.The facility Staff Posting, dated 6/20/25, indicates the resident census was 43. On 6/23/25 at 12:05 PM, R15 requested Surveyor to come to the table. R15 indicated a CNA, CNA M, quit over the weekend because they had her working alone. On 6/24/25 at 4:41 PM, Surveyor interviewed CNA M regarding staffing. CNA M indicated on Friday, 6/20/25, she was the only CNA in the building for all the residents. CNA M said when she came to work at 2:00 PM, the schedule was not posted and there was no one to work with her. CNA M stated she finished her shift and quit. CNA M indicated she stayed on the 100 hallway and cared for those residents. CNA M said she did not give any showers, did not perform oral care on the residents, was unable to perform 2 hours checks and change the incontinent residents, and was unable to give repositioning to the residents who are at risk for pressure injuries. CNA M said she could not say how long call lights were on for. CNA M indicated she believed all the residents received their meal trays but could not be certain. CNA M stated, I can't even tell you everything I didn't get done. CNA M stated she did not go down the 200 hallway the entire shift. CNA M indicated there were residents who were not touched from the start of her shift at 2:00 PM until CNA O came in around 9:00 PM. On 6/25/25 at 1:05 PM, Surveyor interviewed MT F (Medication Tech) regarding the evening shift she worked on Friday, 6/20/25. MT F stated she has weight restrictions for how much she can lift along with a bad back and hip. MT F indicated she tried to help CNA M with transfers, but she was working as the med tech for the 100 hallway. MT F indicated she did not go down the 200 hallway or assist with any residents on the 200 hallway. On 6/24/25 at 1:56 PM, Surveyor interviewed LPN H (Licensed Practical Nurse) regarding the evening shift she worked on Friday, 6/20/25. LPN H indicated she was working with MT F and CNA M that shift. LPN H indicated when she is the only nurse in the building, she is responsible for all the assessments, any change in condition, all wound care and treatments and anything else that may come up. LPN H indicated she is unable to assist the CNAs when LPN H is only working with a med tech. LPN H did indicate she assisted 2 residents with toileting needs on Friday 6/20/25. LPN H indicated due to her workload as a nurse, she was unable to ensure cares, toileting, and repositioning were done for the residents on the 200 hallway. LPN H indicated she was not aware CNA M had not assisted or provided any cares to any of the residents on the 200 hallway. On 6/24/25 at 8:44 AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated having

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law through established procedures for 1 of 9 abuse investigations reviewed regarding misappropriation of medications. The facility submitted a Facility Reported Incident to the State Agency involving misappropriation of medications, but did not notify the police. Evidenced by: The facility's policy titled Abuse, Neglect, and Exploitation, dated 10/1/22, states in part POLICY: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which include staff to resident abuse and certain resident to resident altercation . It includes verbal abuse, sexual abuse, physical abuse, and mental abuse . Policy Explanation and Compliance Guidelines: . VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . On 5/14/24, the facility was made aware of an allegation of a nurse signing out a resident's narcotic medication and putting the pill in her pocket. The facility immediately started an investigation and submitted a report to the State Agency. On 6/24/25, Surveyor reviewed the facility's investigation regarding the misappropriation of medication for R9. Surveyor noted that staff was educated, and an investigation was performed. Surveyor noted that the facility did not notify the police about the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/25 at 3:37 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A what the process is for when a staff member reports misappropriation of a resident's medication, NHA A stated that the staff member should notify herself, the DON (Director of Nursing), suspend the accused, interview residents and staff, and after the investigation is complete, convene with the DON to determine the outcome. Surveyor asked NHA A if misappropriation of medications should be reported to the police, NHA A stated yes. Surveyor reviewed the self- report regarding R9 with NHA A. Surveyor asked NHA A if law enforcement should have been contacted regarding this incident, NHA A stated yes.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide the proper discharge documentation for 3 of 4 residents reviewed for discharge (R8, R12, and R13). R8 and R12 transferred out of the facility (resident-initiated discharge) and both residents had incomplete discharge documentation. R8's discharge was delayed. R13 was transferred to the hospital and had incomplete discharge documentation. Findings include: The facility policy, titled Transfer and Discharge, dated 10/1/22, states in part: .10. For a transfer to another provider, for any reason, the following information must be provided to the receiving provider: a. Contact information of the practitioner who was responsible for the care of the resident; b. Resident representative information, including contact information; c. Advance directive information; d. All other information necessary to meet the resident's needs, which included, but may not be limited to: i. Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; ii. Diagnoses and allergies; iii. Medications (including when last received); and iv. Most recent relevant labs, other diagnostic tests, and recent immunizations. e. All special instructions and/or precautions for ongoing care, as appropriate .f. The resident's comprehensive care plan goals; g. All other information necessary to meet the resident's needs . 12. Emergency Transfer/Discharges - initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident .a. Obtain physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis .f. Document assessment findings and other relevant information regarding the transfer in the medical record. g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated . 14. Anticipated Transfers or Discharges - resident-initiated discharges. a. Obtain physician's orders for transfer or discharge and instructions or precautions for ongoing care. b. A member of the interdisciplinary team completes relevant sections of the Discharge Summery. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but limited to, the following: i. A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results. ii. A final summary of the resident's status. iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). iv. A post discharge plan that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment d. Assist with transportation arrangements to the new facility and any other arrangements as needed. Example 1 (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8 was admitted to the facility on [DATE] and discharged to an ALF (Assisted Living Facility) on 5/21/25. R8's quarterly Minimum Data Set (MDS) assessment, dated 3/13/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R8 was not cognitively impaired. Surveyor reviewed R8's progress notes and physician orders. A general note dated 5/1/25 at 1526 (3:26 PM) states: New written orders received [Physician Name] to facility transfer to ALF .[R8] aware. [SSD N] (Social Services Director) aware. A discharge order request was faxed to R8's primary physician on 4/30/25. R8's primary physician ordered a bariatric bed for the ALF transfer on 5/1/25. R8's primary physician met with her at the facility on 5/9/25 for a discharge planning meeting. SSD N only wrote one progress note relating to R8's discharge on [DATE]: Sent order for bariatric bed to case manager so she [R8] can be moved to assisted living. A durable medical equipment prescription was electronically signed by R8's primary physician on 5/13/25. The remaining orders from R8's primary physician were documented on 5/20/25 and 5/21/25. On 6/24/25 at 3:40 PM, Surveyor interviewed DON B (Director of Nursing) and asked who handles discharges in the facility. DON B indicated the social worker mainly handles discharges, but everyone handles a few pieces of it. The facility does not currently have a social worker on staff. On 6/24/25 at 4:15 PM, Surveyor interviewed DON B about R8's discharge. DON B indicated she was out of the facility when R8 discharged . SSD N was handling the discharge. Of note, SSD N no longer works at the facility. Surveyor asked if there was a delay with R8's discharge. DON B noted R8's discharge was delayed by one to two weeks. SSD N kept coming to her (DON B) and asking what kind of language was needed for certain forms. Orders had to be written a certain way. The equipment and medication orders kept needing to be changed. DON B stated R8's discharge summary looks terrible. SSD N didn't make any notes pertaining to the discharge. DON B indicated SSD N did not even know which facility R8 was transferring to. Surveyor reviewed R8's Interdisciplinary Discharge Summary, which was incomplete. The following sections were not completed: care during stay, recapitulation of stay (including course of illness, treatment, and therapy during nursing center stay), functional status (activities of daily living, self-performance and support), continence, skin review, dental status, and pre-discharge preparation of resident. Example 2 R12 was admitted to the facility on [DATE] and discharged home on 5/16/25. R12's Minimum Data Set (MDS) assessment, dated 4/17/25, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R12 was moderately cognitively impaired. Surveyor reviewed R12's Progress Notes, which include: (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/16/25 at 1359 (1:59 PM): Resident was discharged to home at 1400 [2:00 PM]. Family/son [son's name] accompanied her with all her belongings and suitcase. Resident received all medications from cart. Resident dressing on left leg changed and intact. No c/o (complaints of) pain at time of discharge. Social worker helped with discharge. On 6/24/25 at 3:40 PM, Surveyor interviewed DON B (Director of Nursing) and asked who handles discharges in the facility. DON B indicated the social worker mainly handles discharges, but everyone handles a few pieces of it. The facility does not currently have a social worker on staff. On 6/24/25 at 4:10 PM, Surveyor interviewed DON B about R12's discharge. DON B indicated she was out of the facility when R12 discharged , and SSD N (Social Services Director) should have been handling the discharge planning. DON B indicated she attended a discharge planning meeting with R12 when SSD N was out. DON B stated R12's Interdisciplinary Discharge Summary looks pretty empty. DON B showed Surveyor that SSD N had started working on the document but never completed it. Notes for the Discharge Summary state: In Progress as of 5/14/25. R12's Care Plan does not discuss discharge planning. DON B indicated SSD N should have addressed that. The Interdisciplinary Discharge Summary was never given to R12 when she left the facility; instead, she received a printout of her order summary, which included an active medication list without the date and times of the last medication administration at the facility. The Order Summary Report was signed by R12, R12's son, SSD N, and R12's physician. R12 did not receive a complete recapitulation of her stay, which should have included: diagnoses, course of illness/treatment or therapy, pertinent labs, radiology, and consultation results. Example 3 R13 was admitted to the facility on [DATE] and discharged to the hospital on 4/15/25. R13's Minimum Data Set (MDS) assessment, dated 3/12/25, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated R13 was severely cognitively impaired. Surveyor reviewed R13's Progress Notes and Orders, which include: -4/12/25 at 10:03 AM: Physician Note / Discharge planning - The discharge planning has urgency to it as patient is eligible for discharge to a facility that can take him at the short notice but requires ruling out TB (tuberculosis) . -Chest x-ray was ordered and completed on 4/14/25 -Physician order 4/15: Please arrange visiting nurse/home health for wound care on resident. Of note: The progress notes fail to address R13 being discharged from the facility. R13's face sheet indicates he was discharged to an acute hospital. On 6/24/25 at 3:40 PM, Surveyor interviewed DON B (Director of Nursing) and asked who handles discharges in the facility. DON B indicated the social worker mainly handles discharges, but everyone handles a few pieces of it. The facility does not currently have a social worker on staff. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/25 at 4:03 PM, Surveyor interviewed DON B about R13's discharge, as there was minimal discharge information in his chart. R13 discharged from the facility before DON B worked here. Looking through R13's chart, DON B indicated there was no documentation in there and said she was pretty sure he went to the hospital. She indicated, there are no progress notes saying what happened, and said, I'm sorry. DON B recalled being told R13 was planning on discharging to another facility but ended up being sent to the hospital because of a wound that was getting worse. DON B pulled up R13's Interdisciplinary Discharge Summary, which had never been completed. SSD N (Social Services Director) had started working on the document but never completed it. Notes for the Discharge Summary state, In Progress as of 4/14/25. The facility did not ensure this transfer was documented and appropriate information was communicated to the receiving provider, such as a copy of R13's discharge summary - including a recapitulation of his stay: diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. No reason for the hospital transfer was recorded in R13's chart, and there was no bed-hold notice or explanation if R13 was planning on returning to this facility or discharging to the new one after his hospital stay. The facility did not provide the proper discharge documentation to R8, R12 and R13 upon discharge.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 2: R6 was admitted to the facility on [DATE] and has diagnoses that include infection and inflammatory reaction due to indwelling urethral catheter, hydronephrosis (condition characterized by excess fluid in the kidney due to a backup of urine) and type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). R6's Minimum Data Set Quarterly Assessment, dated 3/25/25, shows R6 has a brief interview if mental status score of 14 indicating R6 is cognitively intact. R6's physician's orders, dated 6/25/25, states, in part: .Perform foley catheter care every shift. Order Date: 2/07/2024 03:39 . Enhanced Barrier Precautions (EBP) in place for indwelling urinary catheter every shift. Order Date: 5/22/2025 10:16 . On 6/25/25 at 10:25 AM, Surveyor observed CNA C (certified nursing assistant) perform catheter cares on R6. CNA C reached into the wash basin for a clean washcloth to rinse R6 after cleansing R6's suprapubic catheter without perfoming hand hygiene and did not change gloves when going from dirty to clean. CNA C had opened R6's nightstand drawer, reached in and opened up wipes, CNA C retrieved wipes from the package and used them to cleanse R6's catheter tubing. CNA C cleansed R6's peri area and then reached into the clean wash basin with the same pair of gloves on and retrieved a new washcloth to rinse without performing hand hygiene in between going from dirty to clean. CNA C placed the wash basin on R6's nightstand without a barrier underneath it. DON B (director of nursing) then placed the wash basin on R6's bed, next to R6 without a barrier underneath it. On 6/25/25, at 11:00AM, Surveyor interviewed CNA C and asked when should hand hygiene be performed during catheter/peri cares. CNA C indicated when gloves are changed. CNA C indicated gloves and hand hygiene should be completed when going from dirty to clean. Surveyor asked CNA C if hand hygiene was completed after cleansing catheter site to reaching into basin for a rinse wash cloth and CNA C indicated no, she had not performed hand hygiene, and she should have as she contaminated the basin of water. CNA C indicated she should have performed hand hygiene after opening R6's nightstand drawer. Surveyor asked CNA C if there should be a clean barrier placed under the basin. CNA C indicated yes she should have had one under the wash basin and did not. On 6/25/25, at 11:12 AM, Surveyor interviewed DON B and asked when hand hygiene should be completed while providing catheter cares/peri cares. DON B indicated before and after cares and in between going from dirty to clean. Surveyor asked if a barrier should be placed under wash basin and DON B indicated yes. Based on observation, interview, and record review the facility did not ensure that residents with an indwelling catheter received the appropriate care and services to prevent infections or complications for 2 of 2 Residents (R1 and R6) reviewed for catheters. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 has a history of UTI (Urinary Tract Infection) and bladder retention. LPN D (Licensed Practical Nurse) did not fully utilize standard precautions during catheter care to prevent further CAUTI (Catheter Associated Urinary Tract Infections) from occurring. Staff did not use proper hand hygiene per standards of practice during R6's suprapubic catheter care. Evidenced by: The facility's policy, Catheter Care undated; states, in part: It is the policy of this facility to provide catheter care to all residents that have an indwelling catheter in an effort to reduce bladder and kidney infections . Policy Explanation and Compliance Guidelines: . 8. Perform hand hygiene. 9. [NAME] gloves . 20. Bag and gather all supplies used, discarding disposable items in the trash can . 24. Perform hand hygiene . The CDC (Centers for Disease Control) Guidelines for Prevention of Catheter Associated Urinary Tract Infections (2009) state, in part: . III. Proper Techniques for Urinary Catheter Maintenance . C. Use Standard Precautions, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system . Example 1 R1 was admitted to the facility on [DATE] with diagnosis that include, in part: Chronic Kidney Disease, Stage 3, unspecified, Pyelitis Cystica (a rare situation of the renal pelvis and ureters, characterized by cystical formations of the epithelium (layers of cells)), and Obstructive and Reflux Uropathy unspecified (a disorder of the urinary tract that occurs when urine cannot drain through the urinary tract). R1's Comprehensive Care Plan dated 5/6/22 states, in part: . Focus: Alteration and elimination of bowel and bladder, indwelling urinary catheter diagnosis obstructive uropathy, pyelitis cystica, bowel incontinence. Date initiated: 5/6/22. Goal: I will be free of UTI (Urinary Tract Infection). Date initiated: 5/6/22. Revision on: 10/26/24. Target date: 7/30/25. I will have no complications from use of my indwelling catheter such as pain, infection, obstruction. Date initiated: 5/6/22. Revision on: 10/26/24. Target date: 7/30/25. Interventions: Anchor catheter, avoid excessive tugging on the catheter during transfer and delivery of care. Date initiated: 5/6/22. Revision on: 5/6/22 . Check catheter tubing for proper drainage and positioning. Date initiated: 5/6/22. Revision on: 5/6/22 . Indwelling catheter care every shift and as needed. Date initiated: 5/6/22. Revision on: 5/6/22 . Focus: Urinary tract infection, potential due to: Recurrent urinary tract infections, indwelling Foley catheter. Date initiated: 7/7/22. Goal: Will remain free of urinary tract infection. Date initiated: 7/7/22. Revision on: 10/26/24. Target date: 7/30/25. Interventions: . Enhanced barrier precautions. Date initiated: 8/23/23 . Provide indwelling catheter care every shift and as needed. Secure catheter and tubing appropriately. Date initiated: 7/7/22. Revision on: 8/22/23. (continued on next page)

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Riverdale Health Care Center	1000 N. Wisconsin Ave. Muscoda, WI 53573

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Physician's Orders include, in part: Change stat lock (device which secures a Foley catheter in place, stabilizes the catheter and reduces the likelihood of a sudden pull) for Foley catheter once every seven days. Date the stat lock one time a day every seven days for [sic] to avoid tension against penis. Order date: 6/4/25. Check that resident's catheter is draining Q (every) shift. Every shift. Order date: 7/30/23 . Enhanced Barrier Precautions (EBP) in place for indwelling urinary catheter and wound care. Every shift. Order date: 10/6/22. Enhanced Barrier Precautions. Order date: 7/22/24 . Keep Foley tubing attached to leg at all times to avoid tension against penis. Every day and evening shift for Foley catheter. Order date: 6/4/25 . May use urinary leg bag on AM/PM shifts two times a day for urine bag. Order date: 4/12/25 . Perform catheter care every shift every shift for catheter care. Order date: 2/15/24. On 6/24/25 at 10:58 AM, Surveyor observed LPN D (Licensed Practical Nurse) provide catheter care on R1. LPN D stated that she does not normally do catheter care, as the CNAs (Certified Nursing Assistants) usually do it. LPN D washed her hands and put on gloves, but did not don a gown. R1 was resting in bed and LPN D noted that R1's clothing was soaked. LPN D assisted R1 to the bathroom and noted that R1's catheter was not hooked up to the leg bag, resulting in urine-soaked pants and shirt. LPN D began to assist R1 in getting cleaned up. LPN D dropped a cleansing wipe in the toilet, picked it up and threw it away in the garbage can, but did not change gloves or perform hand hygiene. LPN D continued in cleaning stool off R1's bottom and stated that the stool was dried on. LPN D washed her hands and donned new gloves. LPN D assisted R1 with removing his wet clothes, washed R1 with a washcloth and dried R1. LPN D then began to clean the hub of R1's catheter with an alcohol wipe, but did not change gloves or perform hand hygiene. After cleaning the hub of the catheter, LPN D changed gloves and washed her hands. LPN D stated that the stat lock was missing and that R1 was supposed to have one, and that the extension tubing was also missing and that was why R1 was soaked. LPN D stated she did not know how long R1's catheter had been unhooked. (of note: LPN D did not perform hand hygiene or change her gloves at the appropriate times while doing cares.) On 6/24/25 at 12:47 PM, Surveyor interviewed LPN D and asked her about the catheter care performed with R1. Surveyor asked LPN D about the facility's catheter care policy. LPN D stated that she had never been told where to find the policy and procedure. Surveyor asked LPN D when it is appropriate to change gloves and perform hand hygiene. LPN D stated anytime you get the gloves dirty. Surveyor asked LPN D if a cleansing wipe had fallen in the toilet. LPN D stated yes, she had grabbed the wipe and thrown it away. Surveyor asked LPN D if that would have been an opportunity to change gloves and perform hand hygiene. LPN D stated yes that she should change her gloves after that. On 6/24/25 at 1:14 PM, Surveyor interviewed DON B (Director of Nursing) about the observation of R1's catheter care with LPN D. DON B stated that she was aware that R1 had an order for a stat lock and that she realized that he did not have one on earlier. DON B stated she did not know why R1 did not have a stat lock on or why there was no extension tubing attached to the catheter. Surveyor shared with DON B her observation of the cleansing wipe falling in the toilet and LPN D not changing gloves or performing hand hygiene after she picked the cleansing wipe out of the toilet and threw it in the garbage can. DON B stated, that was just sloppy and that she teaches the staff to triple glove and just pull one set of gloves off when they become soiled. Surveyor asked DON B if that was a CDC recommendation. DON B stated that she wasn't sure, but that was how she had always done it. Cross Reference: F880.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have sufficient staffing to ensure resident safety and attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the required facility assessment. This has the potential to affect all 43 residents residing in the facility. R16 stated she did not receive any cares on a PM shift (evening shift). R18 stated she had concerns regarding the long wait times when using the call light. R14 did not get up for dinner due to low staffing. R15 complained of long wait times when using her call light and her plan of care was not followed due to low staffing. CNA M (Certified Nursing Assistant) stated she was the only CNA for PM shift on 6/20/25. R17 and R7 voiced concerns with the facility's lack of staff. Facility staff stated they are short staffed and unable to meet the resident's needs. Staff Postings and schedules indicate the facility is staffed significantly lower than what the facility assessment indicates is required to provide adequate care to the residents. This is evidenced by: The facility assessment, dated June 2025, includes the following:This facility assessment will be used to: Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care.Information about our staffing patterns:Registered Nurse Hours per Resident Day 0.49Licensed Nurse Hours per Resident Day 0. 73Nurse Aide Hours per Resident Day 2.25Total Nursing Hours per Resident Day 3.47Staffing as described above is adequate as evidenced by: cares completed, documentation completed, and lack of resident grievance/concerns regarding cares provided. The facility's policy titled Activities of Daily Living (ADLs), Suppoorting [sic], dated 1/25, includes: Residents will provided [sic] with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting); d. Dining (meals and snacks); Example 1 R16 admitted to the facility on [DATE] with diagnoses including morbid obesity, functional urinary incontinence, major depressive disorder, and muscle wasting. R16's comprehensive care plan printed 6/24/25 includes the following: Focus: I have a physical functioning deficit .Interventions/Tasks: Dressing assistance: dependent. I am dependent on staff for personal hygiene, grooming, sponge bathing and showering. I am dependent on staff for toileting. I need assistance of 1 for Bed mobility. I need assistance of 1 for oral cares. Focus: I am risk for skin alteration for pressure ulcer . Assistance required in bed mobility. Interventions/Tasks: Encourage offloading side to side as res (resident) tolerates every 2 hours for skin protection. Float heels. Provide thorough skin care after incontinent episodes and apply barrier cream. Turning and repositioning every 2-3 hours . On 6/24/25 at 1:03 PM, Surveyor observed R16 in her room. R16 was in bed with her lunch tray in front of her on her overbed table. She was slouched down in bed. Her feet were against the foot board of the bed and her heels were on the mattress. R16's head of the bed was elevated, and the bend of her mattress was aligned with the middle of her ribs. On 6/24/25 at 1:03 PM, Surveyor interviewed R16 about the facility staffing and her cares. R16 stated she was not comfortable with the position she was lying in, and it was making it difficult for her to eat lunch. R16 indicated she had been in that position when the staff delivered her lunch tray. R16 explained she is on an air mattress because she has a history of pressure injuries. R16 stated the facility is under staffed. R16 stated on Friday, 6/20/25, she did not receive any cares on the PM shift (evening shift). R16 stated she was not repositioned, not provided incontinent care, and was not provided oral care on the PM shift of 6/20/25. R16 indicated there was only one CNA in the building. R16 indicated she's afraid of getting another pressure injury because there is not enough staff to care for her properly. Example 2 R18 admitted to the facility on [DATE] with diagnoses including anxiety disorder, depression, and a history of falls. R18's comprehensive MDS (Minimum Data Set) assessment, dated 6/1/25, includes Frequently incontinent of urine and bowel. Toileting hygiene: Substantial/maximal assistance. Personal hygiene: partial/moderate assistance. On 6/25/25 at 1:18 PM, Surveyor interviewed R18 regarding the care she receives in the facility. R18 states

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility did not ensure staff postings were accurate which has the potential to affect 43 out of 43 residents residing at the facility. Review of staffing schedules and required staff postings revealed discrepancies between the documents. This resulted in inaccuracies with the total number and the actual hours worked for licensed and non-licensed staff directly responsible for resident care each shift. This is evidenced by: Surveyor reviewed the schedules and staff postings from 6/10/25 thru 6/23/25 and noted the following inaccuracies: On 6/10/25, the Staff Posting indicates for AM shift, 4 CNAs (Certified Nursing Assistant), 2 Med Techs (Medication Technician), and 1 RN (Registered Nurse). The schedule indicates 3 CNA's, and 2 LPNs (Licensed Practical Nurse) worked. Of note, the Staff Posting indicates the RN was DON B (Director of Nursing). The Staff Posting is to include direct patient care staff. On 6/11/25, the Staff Posting indicates on AM shift, 4 CNAs, 1 LPN, 1 Med Tech, and 1 RN. The schedule indicates 4 CNAs, 2 LPNs, and DON B worked. On 6/12/25, the Staff Posting indicates on AM shift 3 CNAs, 1 LPN, 1 Med Tech, and 1 RN. The schedule indicates 3 CNAs, 1 LPN, 1 Med Tech, and DON B worked. The Staff Posting on PM shift indicates 2 CNA's, and the schedule indicates 2 CNAs, 2 LPNs, and 1 LPN in training worked. On 6/13/25, the Staff Posting indicates on AM shift, 3 CNAs, 1 LPN, 1 Med Tech, and 1 RN (DON B). The schedule indicates 3 CNAs, 1 LPN, 1 Med Tech, 1 RN for 6:00 AM - 10:00 AM, and DON B worked. On 6/14/25, the Staff Posting indicates on AM shift, 3 CNAs and 2 Med Techs. The schedule indicates 3 CNA's, and 2 LPNs worked. On 6/15/25, the Staff Posting indicates on AM shift, 3 CNAs and 2 Med Techs. The schedule indicates 3 CNA's, and 2 LPNs worked. On 6/17/25, the Staff Posting indicates on AM shift, 5 CNAs, 1 LPN, 2 Med Techs, and 1 RN (DON B). The schedule indicates 4 CNAs, 1 LPN, 2 Med Techs, and DON B worked. On 6/18/25, the Staff Posting indicates on AM shift, 3 CNAs, 2 LPNs, and 1 RN (DON B). The schedule indicates 4 CNAs, 2 LPNs, and DON B worked. On 6/19/25, the Staff Posting indicates on AM shift, 3 CNAs, 2 LPNs, and 1 RN (DON B). The schedule indicates 4 CNAs, 2 LPNs, and 1 Med Tech worked. On 6/20/25, the Staff Posting indicates on AM shift, 3 CNAs, 2 Med Techs, and 1 RN. The schedule indicates 5 CNAs, 1 LPN and 1 Med Tech worked. The Staff Posting on PM shift indicates 2 CNAs and 2 LPNs. The schedule indicates 1 CNA, 2 LPNs, and 1 Med Tech. On 6/21/25, the Staff Posting indicates on PM shift, 2 CNAs and 2 LPNs. The schedule indicates 1 CNA, 2 Med Techs, and 1 RN. On 6/22/25, the Staff Posting indicates on PM shift, 2 CNAs and 2 LPNs. The schedule indicates 1 CNA, 3 LPNs, and 1 Med Tech. The staffing total hours for all the dates indicated above are also inaccurate due to the discrepancies in the schedules and staff postings. On 6/24/25 at 11:03 AM, Surveyor interviewed MDR J (Medical Records) regarding the Staff Postings. MDR J indicated she is responsible for the Staff Postings. MDR J indicated she completes the Staff Postings from the printed schedule. MDR J indicated she includes DON B's hours even if she is not working direct patient care. Surveyor reviewed the Staff Postings and schedules with MDR J and NHA A (Nursing Home Administrator). MDR J and NHA A indicated the Staff Postings and schedules are not accurate and do not match each other. NHA A indicated the Staff Postings and schedules should match and be accurate.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure the accurate administration of medication for 1 of 3 sampled residents (R8). R8 did not receive her morning medications on a day she left the facility for a pre-scheduled appointment, was missing documentation for medications on her Medication Administration Record (MAR) in May 2025, received a dose of her morning and afternoon medications at the same time, and received medications outside of the recommended time window. Findings include: The facility's medication administration policy, provided by DON B (Director of Nursing), is not titled or dated. The policy states: 3. Best practices in timely medication administration and steps to address potentially late administration. Timely medication administration is essential for ensuring therapeutic effectiveness, preventing complications, and maintaining patient safety. -Administer medications within the recommended time window (usually within 1 hour before or after the scheduled time.) . -Immediately document medication administration in the eMAR. (electronic medication administration record) -For any delays or omissions, record the reason. .4. Steps to take for an untimely medication administration .-Take immediate action - notify the prescribing provider .-Document the actual time given, reason for the delay, and any patient impact in the patient's medical record -Follow the facility's chain of reporting (i.e. nurse manager, DON/ADON (Assistant Director of Nursing)). .5. Appropriate documentation of medication administered. Once confirmation of the medication administered to the patient you must immediately document the administration in your MAR. Example 1 R8 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes without complications, neoplasm-related pain (pain caused by a tumor), acute kidney failure, secondary malignant neoplasm of breast (secondary breast cancer), malignant neoplasm of bone (a cancerous growth in a bone), depression, and anxiety disorder. R8's quarterly Minimum Data Set (MDS) assessment, dated 3/13/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R8 was not cognitively impaired. R8 discharged from the facility on 5/21/25. Surveyor reviewed the facility's Resident Appointment Log. Documentation indicated R8 had an appointment at 9:45 AM on 4/10/25. Documentation indicated R8 would be picked up at 7:45 AM. Surveyor reviewed R8's April 2025 and May 2025 MAR (Medication administration Record). Documentation of administration was missing for the following morning medication orders on 4/10/25, 5/1/25, and 5/2/25: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Anastrozole oral tablet 1 mg (miligram) / Give 1 tablet by mouth in the morning for cancer / Scheduled time: 8:00 AM -Cetirizine HCl (hydrochloride) oral tablet 10 mg / Give 1 tablet by mouth one time a day for seasonal allergies / Scheduled time: 8:00 AM -Fluticasone Propionate Nasal Suspension / 2 spray [sic] in both nostrils one time a day for allergies / Scheduled time: 8:00 AM -Furosemide oral tablet 40 mg / Give 1 tablet by mouth in the morning for edema / Scheduled time: 8:00 AM -Omeprazole oral capsule delayed release 20 mg / Give 1 capsule by mouth in the morning for indigestion / Scheduled time: 8:00 AM -Potassium chloride oral solution 20 mEq (milliequivalent) / 15 mL (mililiter) / Give 15 mL by mouth in the morning for Diuretic (medication that helps the body eliminate excess salt and water through urine) / Scheduled time: 8:00 AM -Vitamin B12 oral tablet extended release 1000 mcg (micrograms)/ Give 1 tablet by mouth in the morning for Vit B12 deficiency / Scheduled time: 8:00 AM -Buspirone HCl oral tablet 7.5 mg / Give 1 tablet by mouth two times a day related to anxiety disorder, unspecified / Scheduled time: 8:00 AM -Senna-Docusate Sodium oral tablet 8.6-50 mg / Give 2 tablet [sic] by mouth two times a day for constipation / Scheduled time: 8:00 AM -Acetaminophen oral tablet 500 mg / Give 2 tablet [sic] by mouth three times a day related to neoplasm related pain (acute) (chronic) / Scheduled times: 7:40 AM, 12:00 PM *Missed scheduled dose at 7:40 AM and 12:00 PM on 4/10 and 5/2 and missed the 7:40 AM dose on 5/1 -Gabapentin oral capsule / Give 400 mg by mouth three times a day for neuropathy pain / Scheduled times: 7:00 AM, 12:00 PM *7:00 AM dose is documented as given and 12:00 PM dose is missing on 4/10 *7:00 AM dose is missing on 5/1 and 5/2 and 12:00 PM dose is missing on 5/2 -Methadone HCl oral tablet 10 mg / Give 1 tablet by mouth three times a day for pain related to neoplasm related pain (acute) (chronic) (Order changed on 5/1 to: Give 1 tablet by mouth every 8 hours) / Scheduled time: 8:00 AM -Diclofenac Sodium external gel 1% / Apply to left hip topically four times a day for pain related to neoplasm related pain (acute) (chronic) / Scheduled times: 7:30 AM, 12:00 PM *7:30 AM dose is documented as given and 12:00 PM dose is missing on 4/10 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*7:30 AM dose is missing on 5/1 and 5/2 and 12:00 PM dose is missing on 5/2 *Additional medications not signed out on 5/1/25 and 5/2/25: -Lidoderm external patch 5% / Apply to right hip topically one time a day for pain related to neoplasm related pain (acute) (chronic) / Scheduled time: 7:30 AM -Metolazone oral tablet 2.5 mg / Give 1 tablet by mouth one time a day for edema / Scheduled time: 8:00 AM -Spironolactone oral tablet 50 mg / Give 50 mg by mouth one time a day for edema / Scheduled time: 7:30 AM *It should be noted that there was no documentation indicating that R8 was out of the facility on 5/1 or 5/2 and no progress notes indicating why she did not receive her medications on these days. On 6/23/25 at 4:25 PM, DON B (Director of Nursing) indicated medication audits are performed frequently to check for missing medications. At 1:50 PM, DON B stated, I have not documented any medication errors since I've been here. DON B previously indicated she has worked at the facility for approximately two months. On 6/25/25 at 9:01 AM, Surveyor interviewed MT F (Medication Technician) and asked what should happen when there is no documentation listed for a medication. MT F indicated the staff member who didn't document should be found and followed up with. Surveyor also asked how staff members know when a resident is leaving the facility for an appointment and needs medications before leaving. MT F indicated there is a book with appointments that should be checked along with the MAR. The book states what time transport is picking the resident up and how long the appointment is. On 6/25/25 at 9:35 AM, Surveyor interviewed DON B and asked how staff members know when a resident is leaving the facility for an appointment and needs medications before leaving. DON B indicated there is a 24-hour report board, a communication board, and an appointment itinerary that talks about medications and food posted every day and staff members should look at these every morning before beginning a shift. Surveyor pointed out the missed medications for R8 on 4/10, 5/1, and 5/2. DON B agreed that R8 did not get her medications on those days and said a progress note should have documented the reason. Surveyor did not see any progress notes regarding the appointment on 4/10 or missing medications. DON B indicated she would look into it. No additional documentation was provided. Example 2 Surveyor reviewed R8's May 2025 MAR, checked medication administration times on 5/5/25, and noted the following: Order: Gabapentin oral capsule / Give 400 mg by mouth three times a day for neuropathy -Scheduled for 7:00 AM ----- Administration time: 11:20 AM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Scheduled for 12:00 PM ----- Administration time: 11:20 AM -Scheduled for 1700 (5:00 PM) ---- Administration time: 2351 (11:51 PM) Order: Acetaminophen oral tablet 500 mg / Give 2 tablet [sic] by mouth three times a day related to neoplasm related pain (acute) (chronic) -Scheduled for 7:40 AM ---- Administration time: 11:11 AM -Scheduled for 12:00 PM ---- Administration time: 11:10 AM -Scheduled for 1700 (5:00 PM) ---- Administration time: 2351 (11:51 PM) *Note: several other medications were documented as being administered four to seven hours after their scheduled time on this date. On 6/25/25 at 9:20 AM, Surveyor interviewed DON B regarding medication administration issues. DON B stated, Oh, I'm sure we have med errors. She indicated the med pass can take four hours for one person and if any issue comes up, medications are administered even later. She acknowledged medications should be given within an hour before or after the scheduled administration time. Surveyor asked about R8's morning and afternoon medications being given at the same time on 5/5. DON B agreed that the administration times show double dosing, but indicated, I'm sure she only got one dose when she was supposed to and both doses were documented at the same time. DON B agreed that medication administration times should reflect when medications were actually administered. No additional documentation was provided regarding R8's medication errors.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents are free of any significant medication errors for 1 of 3 residents (R3) reviewed for medications. R3 did not receive his time sensitive medication timely 83 times, received 2 doses at once on 10 occasions, and was given doses too close together 8 times between the dates of 6/1/25 and 6/15/25. This is evidenced by: The facility's provided an untitled and undated document covering their medication policy. The document includes: 3. Best practices in timely medication administration and steps to address potentially late administration. Timely medication administration is essential for ensuring therapeutic effectiveness, preventing complications, and maintaining patient safety. Administer medications within the recommended time window . Prioritize time-critical medications . Ensure all orders are given at appropriate times . Immediately document medication administration in the eMAR (Electronic Medication Administration Record). For any delays or omissions, record the reason. 5. Appropriate documentation of medication administration. Once confirmation of the medication administration to the patient you must immediately document the administration in your MAR. According to the National Institutes of Health National Library of Medicine (www.nih.gov), patients with Parkinson's disease require strict adherence to an individualized, timed medication regimen . Dosing intervals are specific to each individual patient because of the complexity of the disease. When medications are not administered on time and according to the patient's unique schedule, patients may experience an immediate increase in symptoms. Delaying medications . can cause patients with Parkinson's disease to experience worsening tremors, increased rigidity, loss of balance, confusion, agitation, and difficulty communicating. R3 admitted to the facility on [DATE] with a diagnosis of Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors). R3's physician orders, printed 6/24/25, include: Carbidopa-Levodopa Oral Tablet 25-100 MG Give 2.5 tablets by mouth every 2 hours related to Parkinson's Disease. R3's comprehensive care plan, printed 6/24/25, includes Focus: Impaired neurological status related to: Parkinson's disease .Interventions/Tasks: Medication as ordered by physician R3's MAR (Medication administration record) includes Carbidopa-Levodopa Oral Tablet 25-100 MG (milligrams) Give 2. 5 tablets by mouth every 2 hours scheduled at 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 AM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM each day. R3's MAR indicates his Carbidopa-Levodopa Oral Tablet 25-100 MG Give 2.5 tablets by mouth every 2 hours doses were administered as follows: On 6/1/25 12:00 PM dose was given at 1:01 PM 2:00 PM dose was given at 1:58 PM8:00 PM dose was given at 9:37 PM10:00 PM dose was given at 9:37 PM Of note, the 2:00 PM dose was given 57 minutes apart from the 12:00 PM dose. The 8:00 PM and 10:00 PM doses were given at the same time. 3 doses were not given timely. On 6/2/2512:00 PM dose was given at 11:10 AM6:00 PM dose was given at 5:30 PM8:00 PM dose was given at 7:13 PM10:00 PM dose was given at 9:00 PM Of note, these 4 doses were not given timely. On 6/3/252:00 AM dose was given at 3:18 AM4:00 AM dose was given at 4:10 AM4:00 PM dose was given at 3:19 PM6:00 PM dose was given at 6:36 PM8:00 PM dose was given at 9:26 PM10:00 PM dose was given at 9:26 PM Of note, the 2:00 AM and 4:00 AM doses are only 52 minutes apart. The 8:00 PM and 10:00 PM doses were given at the same time. 5 doses were not given timely. On 6/4/252:00 AM dose was given at 2:29 AM10:00 AM dose was given at 10:41 AM4:00 PM dose was given at 4:39 PM10:00 PM dose was given at 9:44 PM Of note, these 4 doses were not given timely. On 6/5/2512:00 AM dose was given at 12:35 AM2:00 AM dose was given at 2:45 AM4:00 AM dose was given at 4:30 AM6:00 AM dose was given at 5:39 AM10:00 AM dose was given at 11:03 AM4:00 PM dose was given at 3:42 PM10:00 PM dose was given at 9:43 PM Of note, these 7 doses were not given timely. On 6/6/258:00 AM dose was given at 8:54 AM10:00 AM dose was given at 9:51 AM4:00 PM dose was given at 4:38 PM8:00 PM dose was given at 8:54 PM10:00 PM dose was given at 9:00 PM Of note, the 8:00 AM and 10:00 AM doses are only 57 minutes apart. The 8:00 PM and 10:00 PM doses are only 6 minutes apart. These 5 doses were not given timely. On 6/7/252:00 AM dose was given at 2:38 AM4:00 AM dose was given at 4:24 AM4:00 PM dose was given at 3:16 PM6:00 PM dose was given at 6:50 PM8:00 PM dose was given at 8:43 PM10:00 PM dose was given at 10:19 PM Of note, these 6 doses were not given timely. On 6/8/252:00 AM dose was given at 2:24 AM4:00 AM dose was given at 5:18 AM6:00 AM dose was given at 5:18 AM12:00 PM dose was given at 11:18 AM2:00 PM dose was given at 1:06 PM4:00 PM dose was given at 4:21 PM6:00 PM dose was given at 5:32 PM8:00 PM dose was given at 9:16 PM10:00 PM dose was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525321	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Health Care Center	1000 N. Wisconsin Ave. 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to 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 infections, for 1 of 1 resident (R1) reviewed for transmission-based precautions. R1 had a sign posted on his door that he was under Enhanced Barrier Precautions (EBP), however a staff member entered R1's room and performed personal cares without following the EBP protocol or wearing the appropriate PPE (Personal Protective Equipment). This is evidenced by: The facility policy, titled Enhanced Barrier Precautions dated 3/25/24, with no revision or review date, states, in part: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Policy Explanation and Compliance Guidelines . 2. Initiation of Enhanced Barrier Precautions .b. An order for enhanced barrier precautions (in accordance with physician-approved standing orders will be initiated for residents with any of the following: . i. indwelling medical devices . 3. Implementation of Enhanced Barrier Precautions: b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities (described below) and may not need to be donned prior to entering the resident's room . 4. High-contact resident care activities include: . f. Changing briefs or assisting with toileting; g. Device care of use: . urinary catheters . 9. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk . The CDC (Centers for Disease Control) Guidelines for Prevention of Catheter Associated Urinary Tract Infections (2009) state, in part: . III. Proper Techniques for Urinary Catheter Maintenance . C. Use Standard Precautions, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system . The CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), revised July 12, 2022, states, in part: 1. Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. 2. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. 3. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: . indwelling medical devices, regardless of MDRO colonization status. 4. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. 5. Standard Precautions, which are a group of infection prevention practices, continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525321	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Health Care Center	1000 N. Wisconsin Ave. 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 was admitted to the facility on [DATE] with diagnosis that include, in part: Chronic Kidney Disease, Stage 3, unspecified, Pyelitis Cystica (a rare situation of the renal pelvis and ureters, characterized by cystical formations of the epithelium (layers of cells)), and Obstructive and Reflux Uropathy unspecified (a disorder of the urinary tract that occurs when urine cannot drain through the urinary tract). R1's Comprehensive Care Plan dated 5/6/22 states, in part: . Focus: Urinary Tract Infection, potential due to: Recurrent Urinary tract infections, indwelling foley catheter. Date initiated: 7/7/22. Goal: Will remain free of Urinary Tract Infection. Date initiated: 7/7/22. Revision on: 10/26/24. Target date: 7/30/25. Interventions: . Enhanced barrier precautions. Date initiated: 8/23/23 . Focus: Infection actual or at risk for related to enhanced barrier precautions (indwelling Foley). Date initiated: 7/22/24. Goal: Patients will be free from signs and symptoms of infection. Date initiated: 7/22/24. Revision on: 10/26/24. Target date: 7/30/25. Interventions: Wear appropriate PPE. Date initiated: 7/22/24 . R1's Physician's Orders include, in part: . Enhanced Barrier Precautions (EBP) in place for indwelling urinary catheter and wound care. Every shift. Order date: 10/6/22. Enhanced Barrier Precautions. Order date: 7/22/24 . On 6/24/25 at 10:58 AM, Surveyor observed that R1 had an Enhanced Barrier Precaution sign on his door that indicated providers and staff must wear gloves and a gown for the following high-contact resident care activities: Providing hygiene, changing briefs or assisting with toileting, device care or use: urinary catheter. Surveyor observed LPN D (Licensed Practical Nurse) enter R1's room and observed LPN D complete cares, including changing brief, toileting, and catheter care, without donning a gown. On 6/24/25 at 12:47 PM, Surveyor interviewed LPN D about what staff should be doing if a resident is on EBP. LPN D stated that she knew she was supposed to wear a gown to perform catheter care but had not. On 6/24/25 at 1:14 PM, Surveyor interviewed DON B (Director of Nursing) and asked her if it was her expectation that staff utilize EBP when performing high-contact resident care activities such as catheter care. DON B stated yes, that was her expectation. DON B stated that they had educated staff that anyone with a catheter or wounds should have EBP. DON B stated she had gone over that with staff, and they had signed it. Cross Reference: F690.