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	08/25/2025

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 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 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 16 residents (R10) reviewed for abuse.Multiple staff made an allegation that a staff member was mentally abusing R10, and the facility did not report the allegation to the State Survey Agency.evidenced by:According to the State Operations Manual, as described in S483.70(o)(2)(ii)(J), The nursing home must follow all of the requirements within S483.12(a)(b) and (c), Free From Abuse.for the prevention, identification, protection, reporting and investigation of allegations of abuse, neglect, verbal, mental, sexual abuse, mistreatment and injuries of unknown source. This also includes prohibiting taking and/or posting photos or recordings that are demeaning and or humiliating to a nursing home resident or the use of an authorized photo or recording in a demeaning/humiliating manner.The facility's abuse policy states, Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. The facility will have written procedures that include: reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies within specified timeframes.R10 was admitted to the facility on [DATE] and has diagnoses that include Parkison's disease. R10 has a guardian in place.An anonymous complaint was received by the state agency stating that CNA O (Certified Nursing Assistant) had been taking videos and pictures of R10. Documentation received from the facility on 8/25/25 includes statements from staff CNA C, CNA T, LPN G (License Practical Nurse), and LPN U. Statements from these staff all indicated that they had seen CNA O taking videos and pictures with R10 at the nurse's station in the evening on 8/12/25. CNA C's statement states, in part, She (CNA O) was telling R10 to work it and dance baby dance. CNA C's statement goes on to say that he, LPN G and LPN U had seen this and felt they needed to contact NHA A (Nursing Home Administrator), who then requested that they write statements.Surveyors were unable to get into contact with CNA C or CNA T.On 8/25/25 at 11:46 AM, Surveyor interviewed LPN G who stated that R10 does like to dance, and he has some very spastic-like movements due to his Parkinson's. LPN G stated that when she saw CNA O recording R10, she thought it was inappropriate and demeaning to R10.On 8/25/25 at 2:31 PM, Surveyor interviewed LPN U who stated that she witnessed CNA O recording R10 for 5 minutes. LPN U then showed Surveyor a picture she took of CNA O taking a selfie of herself and R10. LPN U stated she did not want to get in trouble, so she did not share the picture with administration. LPN U stated she believed CNA O was taking Snapchats of R10 dancing.On 8/25/25 at 2:15 PM, CNA O denied recording R10.R10 refused to speak with Surveyors.On 8/25/25 at 3:30 PM, Surveyor interviewed NHA A (Nursing Home Administrator) who stated that she was unable to prove that any abuse had happened. When asked if an allegation that a staff member was recording a resident would be considered potential abuse, NHA A stated, Yes. When asked why she did not submit an initial abuse report to the State Survey Agency, NHA A stated that she investigated the allegation and could not substantiate the allegation, so she did not report it.The facility did not submit a report to the State Survey Agency.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, that alleged violations are thoroughly investigated for 2 of 4 residents reviewed for abuse (R4 & R6). CNA C (Certified Nursing Assistant) reported an allegation of verbal and sexual abuse to NHA A (Nursing Home Administrator). The facility failed to conduct a thorough investigation of the allegations made regarding R6. R4 experienced a change in condition that resulted in his unexpected death. The facility failed to conduct a thorough investigation to rule out neglect of R4. Evidenced by: Facility policy, titled Abuse Neglect Exploitation, undated, includes: It is the policy of the facility to provide protection 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… Establish policies and procedures to investigate any such allegations… Investigations of alleged abuse, neglect, and exploitation: An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Written procedures for investigations include: Identifying staff responsible for the investigation… Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations… Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause… Providing complete and thorough documentation of the investigation. Example 1: R6 admitted to the facility on [DATE] with the following diagnoses: Chronic Respiratory Failure, Type 2 Diabetes Mellitus, Anxiety disorder, and depression. His most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/28/25, indicates R6 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Text message, dated 8/5/25 at 10:04 PM, from CNA C (Certified Nursing Assistant) to NHA A (Nursing Home Administrator), includes in part: Ok, we need to do something about CNA F. This is absolutely ridiculous and I am getting sick of the way she has been treating the other CNA H [sic] myself, … and even some of the residents. She is abusive towards the resident. She doesn’t care. There is sexual conductivity going on in the resident’s room. Her and R6 flirt so she brought it [sic] so R6 buys her (local restaurant named). There’s so many sexual disgusting activities that is going on in this facility that no one is talking about and I’m sick of just hiding all of this away. …. please, please, please do something about this. (It is important to note the allegation of sexual abuse and the allegation of verbal abuse within this text message.) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Self-Reported Initial Report, dated 8/6/25, includes: Brief description of the incident: Writer was texted regarding an allegation of abuse from the evening of 8/5/25. Director of Nursing (DON B) was in the building, so she asked the accused employee to leave, pending the investigation. Called and message left for CNA C, who sent the text and was the accuser. Also sent him a text to call me. Accused employee, CNA C, was immediately asked to leave the facility. DON B was in the facility at the time, so she asked the accused to leave the facility… Describe the effect that the incident had on the affected person: R6 stated he liked to purchase extra food and offer it to the staff as a thank you. He stated that no staff has ever asked him to buy them food. He likes to get extra some times so he can share it. He did not want any staff member to get in trouble, he truly appreciates all the care and help they provide to him and it makes him feel good to offer them food. No harm to resident or other residents. …Explain what steps the entity took upon learning of the incident to protect the affected person: Accused was removed from the facility immediately upon writer being informed. Interviews started of all involved. Police report filed… Date and time of occurrence: 8/5/25 at 10:00 PM… Date and time discovered: 8/6/25… Brief summary of incident: PM CNA sent a text message to (NHA A) at 10:04 PM on 8/5/25, received at 4:48 AM, stating that an employee is verbally abusive to residents and staff. CNA reported that there is sexual conduct going on in the resident room. Accused flirts with resident and he buys her food. Also stated that there is other sexual activities going on. NHA A immediately sent a text and asked for a phone call back. Also, called the accuser and left a message. No return call at this time. Facility’s Investigation, dated 8/6/25, includes: CNA C written interview, includes: Was there garbage and dirty depends left in the garbages? I was charting and had not done my final rounds so yes. What sexual activity is going on? CNA F is flirting with R6 to get him to buy her food. Have you witnessed any other residents this has occurred with? No, but it happens all of the time. What happens all of the time? She just telling me what to do. She thinks she is the boss. This is ridiculous and I will not tolerate it. Tolerate what? Being pushed around by a mean CNA. Do something or I will quit and call the state. CNA I written interview, includes: No sexual activity witnessed. No concerns . LPN G written interview, includes: Has not heard any inappropriate comments. Would address if sees anything. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Summary, 8/6/25, includes: Writer was texted regarding an allegation of abuse from the evening of 8/5/25. DON B was in the building, so she asked the accused employee to leave, pending the investigation. Called and message left for CNA C, who sent the text and was the accuser. Also sent him a text to call me. Accused employee, CNA F was immediately asked to leave the facility. Interviewed LPN E regarding accusations. LPN E stated that CNA F is an exceptional CNA. She has high expectations and expects others to do their jobs. Can sometime come off harsh but it is only if someone is not doing their job correctly. On a previous night LPN E was brought in to help diffuse a situation between CNA F and CNA C… He stated that there was trash left in the rooms, and this upset CNA F. He pulled them together and did education on the importance of rounding together and taking out the trash timely. CNA C is a new CNA and LPN E stated that he just needs some more training, which he has provided. Nurse was asked if residents ever eat resident food, he said no. Do staff ever flirt or tell the resident they will do something for them if they get them food. No. Spoke with CNA F. She states that she has high expectations and when they are not being met, she can come across harsh. CNA F stated R6 did order food, but that she has never eaten his food. She has never asked him to order her food or pay for her food. CNA F stated her and another CNA did become verbal and the other CNA did become verbally aggressive towards each other but not in front of any residents. She stated that she felt they were out to get her because she wants the work done well and when it is not, she gets frustrated. All CNAs have spoken with their nurse and it has already been settled. DO staff ever eat resident food, she said no. Do staff flirt or tell the resident they will do something for them if they get them food? No. R6 was interviewed. Do you ever purchase food and have it delivered? Yes. Do you purchase food for employees? R6 stated he likes to order extra so he can share with the staff. He said he likes to offer them some of his fries. R6 was asked if staff ever asked him to order them food and pay for it. He said no. He said, “ I just like to be nice and offer them, they are so good to me and I want to thank them. ” (It is important to note the facility’s investigation is not thorough as it does not contain interviews of other residents who would maybe have information regarding the allegations, and it does not include an interview with the second CNA who was working on the PM shift at the time the allegation was made.) On 8/12/25 at 11:48 AM, NHA A indicated the text message contains an allegation of verbal abuse and sexual abuse. NHA A indicated she conducted an investigation and the staff interviewed were LPN E, CNA F, CNA C, CNA I, LPN G, and R6. NHA A indicated she did not interview CNA H because she could not get ahold of her. NHA A indicated she should have kept trying to get a statement from CNA H, because she was working when the allegation was made. NHA A indicated [NAME] H has worked since this date and is on the floor today. NHA A indicated she did not interview any other residents regarding the allegation. NHA A indicated this would have helped her understand the scope of the allegation and collect any additional information other residents had. The facility did not thoroughly investigate an allegation of abuse involving R6. Example 2: R4 was admitted to the facility on [DATE] with a diagnosis including, Alzheimer’s disease, kidney disease, dysphagia (difficulty swallowing), unsteadiness on feet, dementia, weakness, obstructive and reflux uropathy (blockage in the urinary tract), neurocognitive disorder. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4’s most recent Minimum Data Set (MDS) dated [DATE] indicates R4 had a Brief Interview for Mental Status (BIMS) of 00 indicating R4 was severely cognitively impaired. R4 had an activated power of attorney. Facility Misconduct Incident Report, states, in part: … Date occurred: 8/1/25…Date Discovered: 8/2/25…On 7/29/25 vitals were taken on resident on 7/29/25, showing a slight temperature of 99.6F, blood pressure 141/81. Resident was lethargic and appeared unwell. POA (Power of Attorney) was contacted, and it was determined that resident should go to the emergency room. Resident was transported via ambulance and was seen in emergency room and admitted to the hospital. Resident passed on 8/1/25 due to sepsis…Describe the effect, Staff reported that resident had a swollen elbow with pain on 7/26/25. Nurse assessed and requested x-rays to rule out fracture. X-rays were taken with the findings that the elbow joint is intact. No fracture or dislocation is seen…Resident was diagnosed with cellulitis of toe… It is important to note there are no staff interviews or other resident care interviews. On 8/13/25 at 11:53 AM, NHA A (Nursing Home Administrator) indicated she had known about the concern with R4’s elbow. NHA A indicated she was on vacation from 7/19/25-7/27/25. NHA A indicated RN R (Registered Nurse) sent R4 out on 7/29/25, NHA A indicated Power of Attorney stopped at the facility after R4 went out and indicated R4 was not doing well. NHA A indicated she called the hospital Friday, and hospital returned her call on Saturday. NHA A indicated the hospital told her R4 had passed away due to sepsis. NHA A indicated she started a self-report investigation because R4 was diagnosed with sepsis and passed away. NHA A indicated she did not interview any staff, did not complete any house audits, and did not provide any education regarding this incident. NHA A indicated she would expect nursing to report changes in condition to primary physician and complete assessments. It is important to note that Surveyors discovered through staff interviews and record review concerns with change of condition, assessments, and physician notification. The facility failed to complete a thorough investigation for the reported incident involving R4.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 of 7 sampled residents (R4 and R5) reviewed for change of condition. R4 experienced a change in condition as evidenced by a change in mental status, decrease in intake, and change in urine color and output. Certified Nursing Assistants (CNAs) reported these changes to nursing staff. R4’s nurse did not complete an assessment, monitor resident, or report change in condition to the provider. R4 continued to deteriorate over the weekend and was found to be unarousable and then sent to ER. R4 was admitted to the hospital on [DATE] with bacteremia UTI (bacteremia presence of bacteria in the blood stream; if left untreated it can progress to sepsis), Urinary tract infection (UTI), severe sepsis (life threatening condition that occurs when the body responds to an infection leading to organ dysfunction/failure and can progress to shock if not treated), catheter-associated urinary tract infection, acute respiratory distress, and chronic indwelling foley catheter. R4 passed away at the hospital on 8/1/25 due to severe sepsis, bacteremia, acute respiratory distress, and UTI. The facility failed to provide care consistent with professional standards of practice for R4 when the facility failed to recognize a change of condition, failed to complete an RN assessment, failed to monitor R4's condition, failed to consult with the physician timely, and failed to monitor/document R4's intake and output. These failures created a finding of immediate jeopardy that began on 7/26/25. The Nursing Home Administrator (NHA) was notified of the immediate jeopardy on 8/14/25 at 2:45 PM. The immediate jeopardy was removed on 8/18/25; however, the deficient practice continues at a scope and severity of D (Potential for more than minimal harm/Isolated) as evidenced by the following example: R5 had a change of condition on 7/23/25. LPN K (Licensed Practical Nurse) utilized a straight catheterization (an invasive medical device used to drain urine from the bladder) without a Physician’s Order to obtain a urine sample. R5 has wounds to her left hip, left shoulder, right great toe, and right second toe that have not been consistently measured or assessed by staff since admission. The facility did not complete an admission skin assessment, did not complete treatments per physician orders, and no documentation was located indicating the classification or cause of R5’s wounds (e.g. pressure, diabetic, etc.). Evidenced by: The facility policy, “Notification of Changes Policy,” dated 3/19, states in part:…It is the policy of this facility that changes in a resident’s condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate….Requirements for notification of resident, the resident representative and their physician:…A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications… (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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: (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. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (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. (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. 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 . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data . 1.R4 was admitted to the facility on [DATE] with diagnoses including Alzheimer’s disease, kidney disease, dysphagia (difficulty swallowing), unsteadiness on feet, dementia, weakness, obstructive and reflux uropathy (blockage in the urinary tract), and neurocognitive disorder. R4’s most recent Minimum Data Set (MDS) dated [DATE] indicates R4 had a Brief Interview for Mental Status (BIMS) of 00 indicating R4 was severely cognitively impaired. R4 had an activated power of attorney. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4’s Comprehensive Care Plan, stated, in part: “…5/6/22…Focus: Alteration in elimination of bowel and bladder Indwelling Urinary Catheter DX (diagnosis) obstructive uropathy, pyelitis cystica (multiple small cysts in the renal pelvis area). Bowel incontinence…Goal: I will be free of UTI. I will have no complications from use of my indwelling catheter such as pain, infection, obstruction…Interventions: Anchor catheter, avoid excessive tugging on the catheter during transfer and delivery care…Change catheter bag…change foley catheter monthly and PRN (as needed) per MD (Medical Doctor) order. 20Fr (French) coude (type of catheter)10ml (milliliter) balloon…Check catheter tubing for proper drainage and positioning…Encourage fluids…Indwelling catheter care every shift and as needed…Irrigate catheter as ordered…Keep drainage bag of catheter below the level of the bladder at all times and off floor…Labs as ordered…Monitor and report S&S (signs and symptoms) of UTI: changes in color, odor, or consistency of urine, dysuria, frequency, fever, pain… … Urinary Tract Infection (UTI), potential due to: recurrent urinary tract infections, indwelling foley catheter 7/7/22…Goal: will remain free of urinary tract infections…Interventions: Encourage fluids unless contradicted…Encourage fluids until urine is light yellow in color…Enhance barrier precautions…monitor and record foley output every shift…Notify practitioner if symptoms worsen or do not resolve…Observe and report signs and symptoms of UTI: changes in color, odor or consistency of urine, dysuria, frequency, fever, pain…Provide indwelling catheter care every shift and as needed. Secure catheter and tubing appropriately…” R4’s Kardex states, in part:…Monitor foley output, if reduced, change PRN (as needed) to decrease feelings of urgency…Monitor and report S & S (signs and symptoms) of UTI: changes in color, odor, or consistency of urine, dysuria, frequency, fever, pain… R4’s July 2025 output on Treatment Administration Record (TAR) states in part:…21st DAY: plus sign, EVENING: plus sign, NIGHT: plus sign. 22nd DAY: plus sign, EVENING: Blank, NIGHT: 50. 23rd DAY: 350, EVENING: 900, NIGHT: 420. 24th DAY: 550, EVENING: plus sign, NIGHT: plus sign. 25th DAY: 700, EVENING: Blank, NIGHT: Blank. 26th DAY: plus sign, EVENING: 450, NIGHT: 120. 27th DAY: Blank, EVENING: 300, NIGHT: 200. 28th DAY: 250, EVENING: plus sign, NIGHT: 400…R4’s documentation on task charting states in part:…23rd, 24th, 25th, 26th, and 28th are double documented showing an incorrect total. R4’s documentation for the 27th is Blank. Of note, staff were charting plus signs instead of an output amount, therefore it is unknown how much urine R4 had out each day. There is no documented nursing assessment of R4’s urine output. On 8/13/25 at 8:52 AM, NHA A (Nursing Home Administrator) indicated the plus signs on R4’s output documentation indicates positive output. NHA A indicated the documentation should have an actual amount for output. NHA A indicated they have started education with staff on correctly documenting on the output forms. R4’s July 2025 intake documentation states in part:…23rd Total 750cc, 24th Total 640cc, 25th 900cc, 26th 240cc, 27th 360cc, and 28th 600cc… R4’s July 2025 meal intake indicates in part:…26th Breakfast NPO (which indicates nothing by mouth.) Breakfast and Lunch documentation shows that R4 needed full staff assistance for meals. It is important to note this is a change from the rest of the month. Supper: blank. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	July 27th Breakfast 50%, Lunch and Supper Blank. July 28th Breakfast 75%, Lunch 25% with full assistance needed, Supper Blank…. R4’s Progress notes, state, in part:…7/26/25, Author LPN L (Licensed Practical Nurse) …Foley catheter patent with 600 cc (cubic centimeters) dark yellow urine, staff report concern “he’s been more sleepy lately.” He has remained in bed with the exception of ADLs (activities of daily living) and bed sheets being changed. Arouses easily. At meals in bed with HOB (head of bed) elevated. Fluids encouraged. Staff report concern of his left elbow, PROM (passive range of motion) with c/o (complaints of) discomfort and facial grimacing when left arm extended away from his body. Elbow appears swollen. Resident has advanced dementia and unable to indicate any cause of injury, harm, or recent fall/incident. Does not appear fearful of staff during assessment. Call placed to [Physician name] with an order for an x-ray to r/o (rule out) injury… On 8/12/25 at 11:20 AM, in interview with Surveyor, LPN L (Licensed Practical Nurse) indicated a Certified Nursing Assistant (CNA) had reported R4 was lethargic and staying in bed more. LPN L indicated that the noc (night) nurse on 7/25/25 would have been the nurse to report the concerns if they were reported to the doctor. LPN L indicated she requested an x-ray on R4’s elbow and that was what her message was to the doctor on the 26th. LPN L indicated the Registered Nurse (RN) on 7/29/25 sent R4 out by ambulance. LPN L indicated notifications and assessments should be completed if there is a change in condition with a resident. There was no documented RN assessment of R4’s condition on 7/26, 7/27, or 7/28/25. Facility documentation states in part:…On 7/29/25 vitals were taken on resident on 7/29/25, showing a slight temperature of 99.6F (Fahrenheit), blood pressure 141/81. Resident was lethargic (lack of energy/decreased alertness) and appeared unwell. POA (Power of Attorney) was contacted, and it was determined that resident should go to the emergency room. Resident was transported via ambulance and was seen in emergency room and admitted to the hospital. Resident passed on 8/1/25 due to sepsis. Hospital notes state: R4 presented to the hospital on 7/29 with bacteremia UTI, severe sepsis, catheter associated urinary tract infection, acute respiratory distress, chronic indwelling foley catheter. Can not talk and history is very limited…. R4 hospital course included antibiotics for bacteremia and urinary tract infection. Patient initially presented with confusion and lethargy from [Name of facility]. Patient remained relatively unresponsive despite treatment of severe sepsis. Decision made to withdraw care on 7/31. Patient expired on 8/1. Comfort measures including morphine and Ativan. MD notes state: in my opinion, R4’s cause of death was severe sepsis, bacteremia, acute respiratory distress, UTI… On 8/14/25 at 8:20 AM, in interview with Surveyor, RN R indicated she was the nurse working on 7/29/25 and she sent out R4 by ambulance. RN R indicated staff told her that R4 “didn’t look right. ” RN R indicated she took R4’s vitals. R4 had a slight temperature, but everything else looked fine. RN R indicated it also concerned her because R4 had a catheter, and it was always dragging on the ground or wrapped around a wheel because R4 had advanced dementia. RN R indicated she also decided to send R4 out because of the wound on his toe. RN R indicated she was not familiar with R4 because she had only worked with him a couple times. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/12/25 at 11:45 AM, in interview with Surveyor, CNA M indicated she noticed changes in R4 prior to 7/29/25. CNA M indicated she noticed that R4 was sleeping more, lethargic, urine was not as clear, and that he was just staying in bed more. CNA M indicated she did report these changes. CNA M indicated on 7/29/25, R4 was not responding, was having difficulty breathing, and he just didn’t seem to be himself. CNA M indicated she reported on the 29th as well. CNA M indicated she also reported the concern with the band aid on R4’s toe and that the toe was red. CNA M indicated prior to the changes with R4 he was up and down a lot, self-transferring and he would be out in the common area. On 8/12/25 at 2:00 PM, in interview with Surveyor, CNA N indicated she was told by her coworker that R4 was more lethargic and just not himself around 5 days before being sent out on the 29th. CNA N indicated a coworker that had worked the weekend prior told her R4 was lethargic all weekend. CNA N indicated she saw R4 on 7/29/25 because she was helping down his hallway. CNA N indicated R4 had labored breathing and was not responding to staff on the 29th. On 8/12/25 at 3:20 PM, in interview with Surveyor, CNA O indicated she was probably the first person to notice a change in R4. CNA O indicated she believed it was around the middle or end of July. CNA O indicated she has worked with R4 for a few years now. CNA O indicated R4’s norm was he would wander all over the building, he would be in and out of bed, sit at the nurses’ station, and was very happy. CNA O indicated R4 was very tough on his catheter and tubing. CNA O indicated R4 would forget about it and end up tugging it hard. CNA O indicated she noticed R4 wouldn’t get out of bed, had loose stools, not responding when staff would say his name, not eating as well, and face was flushed. CNA O indicated she saw his elbow and foot as well. CNA O indicated both had been reported to nursing timely. CNA O indicated she reported R4’s changes to the previous DON (Director of Nursing), LPN L, and LPN E. On 8/13/25 at 10:00 AM, in interview with Surveyor, LPN E indicated he had multiple days off prior to R4 being sent out on the 29th. LPN E remembers CNA O reporting that R4 had been tugging at his catheter tubing. LPN E indicated R4 would self-transfer, was very pleasant, was on 15-minute checks, would eat well, hang out at the nurses’ station, and was easy to care for. On 8/13/25 at 10:15 AM, in interview with Surveyor, CNA P indicated when she first started working at the facility R4 was in and out of his room and self-transferring. CNA P indicated she noticed a change in him around 7/23/25 and over the weekend (which would be 7/25 and 7/26/25) prior to R4 being sent out on the 29th. CNA P indicated R4 had loose bowel movements for 3 days prior to being sent out, declined, appetite changed, needed more assistance, urine was a red/brown tint color, and a decline in output. CNA P indicated she did report the change in condition to LPN L. CNA P indicated she felt like staff were making R4 get up in his wheelchair and go to activities. CNA P indicated, “I felt like it was not appropriate to keep getting him up.” On 8/13/25 at 10:47 AM, in interview with Surveyor, PA Q (Physician Assistant) indicated she saw R4 on 7/28/25 for his toe. PA Q indicated staff did not report any other changes in condition to her. PA Q indicated she had only seen R4 once or twice before the visit on 7/28/25. PA Q indicated she would expect staff to report all changes in condition. On 8/14/25 at 12:16 PM, in interview with Surveyor, NP S (Nurse Practitioner) indicated she does not remember being notified of any changes of condition with R4. NP S indicated she would expect to be notified of a change of condition with a resident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/13/25 at 11:53 AM, in interview with Surveyor, NHA A (Nursing Home Administrator) indicated she had known about the concern with R4’s elbow. NHA A indicated she was on vacation from 7/19/25-7/27/25. NHA A indicated RN R sent R4 out on 7/29/25, NHA A indicated Power of Attorney stopped at the facility after R4 went out and indicated R4 was not doing well. NHA A indicated she called the hospital Friday, and hospital returned her call on Saturday. NHA A indicated the hospital told her R4 had passed away due to sepsis. NHA A indicated she started a self-report investigation because R4 was diagnosed with sepsis and passed away. NHA A indicated she did not interview any staff and did not complete any audits. NHA A indicated she would look for any more documentation regarding MD notifications during R4’s change in condition and prior to being sent out on 7/29/25. NHA A indicated she would expect nursing to report changes in condition to primary physician and complete assessments. On 8/13/25 at 3:00 PM, in interview with Surveyor, DON B (Director of Nursing) indicated they will be doing education on documenting input and output. DON B indicated moving forward DON B will be the one responsible to review totals and documentation. DON B and NHA A indicated they do not know who is responsible right now for reviewing daily output totals and input documentation. DON B indicated output documentation should be an actual amount and not a plus sign or blank. DON B indicated if there is a change in a resident’s appetite and how much they are eating/drinking it should be documented, and proper notifications should be made to primary physician. DON B indicated nursing assessments should be completed timely as well. DON B indicated she would look for any documentation for physician notification prior to 7/29/25. DON B indicated an appropriate daily fluid intake would be 2,000ml unless the resident is on a fluid restriction. DON B indicated this could be found in the resident dietary assessment. It is important to note, DON B provided Surveyor with R4’s dietary assessment. The document does not include R4’s recommended daily fluid intake. On 8/13/25 at 5:00 PM, in interview with Surveyor, NHA A (Nursing Home Administrator) indicated understanding of the above concerns. NHA A indicated they would start change of condition education with staff immediately. The facility’s failure to ensure each resident received the necessary care and services in accordance with professional standards of practice when R4 experienced a change in condition created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy that began on 7/26/25. The facility removed the immediate jeopardy on 8/18/25 when the facility implemented the following action plan: -All nursing staff to be educated prior to next working shift, including agency on the following: 1) On 8/14/25 and 8/15/25 DON completed education on recognition of change of condition. If a resident is found to have a COC (Change of Condition), the staff will immediately report the COC to the nurse. The nurse will immediately perform a head to toe assessment and immediately notify the PCP of the findings. 2) On 8/14/25 and 8/15/25 DON completed education to staff on how to recognize a change of condition including changes in mental status, decreased intake or output, changes in urine color or output, talks or communicates less, pain, which is new or worsening, swollen legs/feet, tired, weak, changes in skin color. Use the stop and watch warning tool. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3) On 8/14/25 and 8/15/25 DON provided education when staff have recognized a possible COC they will report it to the nurse immediately. The nurse will do a full assessment including vitals, pain, GI (Gastrointestinal), respiratory symptoms, cardiac symptoms, GU (Genital Urinary) symptoms, call the MD immediately, follow directions of MD, document the change of condition, notify the POA/MCO (Power of attorney/Manage Care Organization), continue to monitor until resident returns to baseline or is sent for further evaluation. Complete documentation needs to be in resident’s charting, as well as in the 24-hour board binder and reported off to next shift. 4) On 8/14/25 and 8/15/25 DON provided education to the nurses on how to complete an assessment, including a head to toe review that includes vitals, pain, GI, respiratory, cardiac, GU symptoms, and immediately notify the MD regarding assessment. Continue to monitor until resident returns to baseline or is sent for further evaluation. Complete documentation needs to be in resident’s charting, as well in the 24-hour board binder and given in report to next shift. 5) On 8/14/25 and 8/15/25 DON provided training on properly recording the fluid cc’s of each resident on each shift including the intake of food %. CNA that is assigned to the dining room will record all the intakes on the clipboard and will then record any residents who have chosen to eat in their rooms or ask designee to record. CNA is responsible for charting this information into the resident’s chart on each shift. 6) On 8/14/25 and 8/15/25 DON provided education on recording the intakes by using the spreadsheet for each meal. Properly documenting in the residents chart and noting through out the day if the amount is off baseline and immediately report that to the nurse. 7) On 8/14/25 and 8/15/25 DON provided education to report immediately to the nurse if the resident’s intake or output has decreased. 8) On 8/14/25 and 8/15/25 DON provided education on the 24-hour board binder and the proper recording of COC of resident to be reviewed during report off. -8/14/25 completed a sweep of the building for any changes in condition. -8/14/25 reviewed policy related to changes of condition, notification of changes policy. -8/14/25 24-hour board binder implemented for monitoring. This binder will be collected and brought into stand up and reviewed. -8/14/25 implement process for monitoring fluid intake and output and when to notify MD/NP. -8/14/25 head to toe and system specific system reviewed for I and O. -8/14/25 implemented system to report off resident COC to next shift. -Audits: 1) The DON or designee will conduct 4 audits weekly for 4 weeks, then review at QAPI (Quality Assurance Performance Improvement) for ongoing monitoring of charting for COC, documentation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2) The DON or designee will conduct 4 audits weekly for 4 weeks of the 24 hour report for properly completed and documented assessments and MD notification immediately. 3) The DON or designee will conduct 4 audits weekly for 4 weeks on the audit charting to ensure COC are recognized, assessments completed, and MD notification. 4) The DON or designee will conduct 4 audits weekly for 4 weeks on the intake sheets and proper documentation in charts. 5) The DON or designee will conduct 4 audits weekly for 4 weeks of output documentation and proper reporting of inadequate output. 6) The DON or designee will conduct 4 audits weekly for 4 weeks of the intake sheet and proper documentation and proper reporting of decreased intake. 7) The DON or designee will conduct 4 audits weekly for 4 weeks on proper reporting the COC to the next shift. -All facility actions, education and audits will be reviewed at QAPI. 2. R5 was admitted to the facility on [DATE] with diagnoses including, but not limited to, cystitis (inflammation of the bladder often caused by a urinary tract infection), muscle wasting and atrophy (decrease in size and wasting of muscle tissue). On 7/22/25, the physician ordered a urinalysis culture and sensitivity (UAC&S) for dysuria f/u (follow up) recent UTI (urinary tract infection). On 7/23/25 the physician examined R5. Reason for visit: Anemia, Multiple wounds, self-neglect, failure to thrive. No complaints apart from patient concerned that she has another UTI. On 7/23/25 LPN K (Licensed Practical Nurse) obtained R5’s urine sample via straight catheterization and sent the sample to the hospital laboratory for testing. The physician did not order a straight catheter urine sample. Of note, RN’s (Registered Nurses) and LPN’s (Licensed Practical Nurses) may not perform a straight catheterization without a physician’s order. On 7/24/25, the physician ordered the following medication: Macrobid oral capsule 100 mg (milligrams) – Give 1 capsule by mouth two times a day for UTI for 7 days. On 7/24/24 at 4:00 PM, R5 received the first dose of Macrobid. On 7/25/25, R5’s UAC&S results documented the following: Colony count > (greater than) 100,000 CFU/ml (colony forming units per milliliter) gram negative rods isolated. See ID (Infectious Disease) and sensitivity. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/12/25 at 10:05 AM, Surveyor spoke with R5. During the conversation R5 stated, LPN K (Licensed Practical Nurse) straight catheterized her to obtain a urine sample. R5 stated, “It was so painful and caused a fierce burning.” R5 stated, LPN K attempted to obtain a urine sample twice. R5 stated, the first time there was a very small amount of urine. R5 stated, the second sample contained bowel movement and was contaminated. R5 stated, after the second attempt, LPN K straight catheterized her to obtain the urine sample. On 8/13/25 at 12:00 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, is it your expectation that staff obtain a physician order before performing a straight catheterization on a resident. DON B stated, yes. Surveyor stated, LPN K obtained R5’s urine sample via straight catheter. Surveyor asked DON B, would you expect LPN K to have a physician’s order to straight catheterize a resident. DON B stated, yes. DON B stated, LPN K should not be utilizing straight catheterization to obtain a urine sample without a physician’s order. Facility policy entitled 'Wound Management,' undated, states in part: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with the physician orders…, Treatment decisions will be based on 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. Incidents (i.e. skin tear, medical adhesive related skin injury) iv. Atypical (i.e. dermatological or cancerous lesion, pyoderma (skin disease caused by bacteria) Characteristics of the wound: i. Pressure injury stage (or level of tissue destruction if not a pressure injury) 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. The facility will follow specific physician orders for providing wound care. Treatments will be documented on the Treatment Administration Record. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: Lack of progression towards healing. Changes in the characteristics of the wound. On 7/2/25, R5’s hospital discharge paperwork documents she has chronic wounds. There is no further detail. The facility did not complete an admission skin assessment. R5’s Certified Nursing Assistant (CNA) Kardex indicates, in part, as follows: Mobility: I am unable to walk; I need limited assistance of 1 and help lifting legs in and out of bed and rolling. I use a wheelchair for locomotion, and I am independent to get around the facility. ADL’S (Activities of Daily Living) I need limited assist of 1 for lower and upper dressing. I need set-up to perform my personal hygiene. The facility has no documentation of an initial care plan prior to 7/21/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R5’s comprehensive care plan indicates, in part, as follows: (Date Initiated: 7/21/25) Pressure ulcer at risk due to: Assistance required in bed mobility, bowel incontinence, Braden Score 18. Goal: Will remain free from further breakdown. Interventions: Complete Braden Scale; Provide pressure reducing wheelchair cushion; Provide pressure reduction/relieving mattress; Provide thorough skin care after incontinent episodes and apply barrier cream; Referral to Therapy; Skin assessment to be completed per Living Center policy; Treatments as ordered. Note, all interventions were added 7/21/25. R5’s Braden scores are as follows: On 7/27/25, R5’s Braden score: 18 (Mild risk for pressure injury development) It is important to note, an agency nurse, that is no longer employed at the facility, was previously completing weekly wound measurements and assessments. It is important to note, weekly measurements and assessments were not being completed. There is no assessment of R5’s wounds, only periodic hand-written measurements that do not clarify tunneling from depth. R5's weekly wound measurements and assessments are as follows: Left Thigh Hip 7/7/25: 5.5 x 1.7 x 2.6 tunneling 7/14/25: 2.4 x 0.5 x 0.3 7/21/25: 3.0 x 1.5 x tunnel (no measurement) Left Thigh 7/7/25: 3.2 x 0.7 x 0.5 tunnel 7/14/25: 3.2 x 1.0 x 2.0 7/21/25: 0.5 x 0.5 x 0.1 Left Shoulder 7/14/25: 2.5 X 1.5 Right Second Toe 7/14/25: 0.2 x 0.2 7/21/25: 0.5 x 0.3 Right Great Toe 7/14/25: 0.5 x 0.3 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R5’s physician orders for wounds are as follows: 7/5/25 Wound Care Left Posterior Shoulder – Cleanse wound, and peri wound area with wound cleanser, pat dry; Paint wound with betadine; Leave OTA (open to air) – every day shift 7/5/25 Wound Care Right Foot – First/Second Toe – Cleanse wound with wound cleaner. Pat dry; Paint with Betadine; Leave OTA (open to air) – every day shift 7/7/25 Wound Care Left Lateral Hip – Cleanse wound, and peri wound with wound cleanser. Pat dry: Pack wound with iodoform gauze packing strips or sterile gauze FLUFFED; Cover with gauzed border dressing – island dressing - every day shift 7/31/25 Referral to wound care clinic. *Left hip wound with tunneling 8/8/25 Change wound dressing to 3x (times) week. Cleanse wound and apply dressing such as Mepilex – every day shift Monday, Wednesday, Friday for wound care On 7/31/25 R5 was seen by a PA (Physician Assistant). The PA documented Reason for visit: Advanced Directives Plans: Anemia, Multiple wounds,

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 1 of 12 sampled residents (R9). R9 voiced concern of being transferred with a Hoyer lift and only one staff present. This is evidenced by: Facility policy titled, Transfer Status dated 1/2025, states in part: It is a policy to ensure safe, consistent, and resident-centered transfer practices for all long-term care residents, minimizing risk of injury to residents, staff, and visitors, while maintaining dignity and compliance . Hoyer Lift - A mechanical lift used when resident requires full or partial support.All mechanical lifts require the assistance of 2. Example 1: R9 was admitted to the facility on [DATE] with diagnoses that include: Spina bifida, Type 2 Diabetes Mellitus without complications, asthma, chronic systolic (congestive) heart failure, and cardiomyopathy (heart muscle disease). R9's most recent Minimum Data Set (MDS) dated [DATE] indicates a staff assessment was conducted for a Brief Interview of Mental Status (BIMS). Staff assessment indicated that R9's memory was OK. Section GG of the MDS, states that R9 requires total dependence on staff for toileting, showering, and transfers. R9's Comprehensive Care Plan states, in part: Focus: I have a physical functioning deficit related to: mobility impairment, self care impairment, DX (diagnosis) spina bifida, DM (diabetes mellitus), asthma, OA (osteoarthritis), migraine, muscle weakness, TBI (traumatic brain injury) obesity, hx (history) falls.date initiated 9/26/2021. Interventions: .Hoyer to Broda chair, ensure patient and staff safety. 2 assist.date initiated 12/9/24, revision on 5/1/2025. On 8/12/25 at 10:45 AM, Surveyor interviewed R9 and asked about her care at the facility. R9 stated sometimes only 1 CNA (Certified Nursing Assistant) uses the Hoyer lift with her and this happens on PM shift. R9 stated she knows there are supposed to be 2 people when using the lift. On 8/12/25 at 2:20 PM, Surveyor interviewed CNA C (Certified Nursing Assistant), who usually works PM shift, about transferring residents with a Hoyer lift. Surveyor asked CNA C if he uses one or two staff with the Hoyer lift in this facility. CNA C indicated there's not always enough staff and stated he tries to have 2 people with a Hoyer transfer, tries to get help but can't, and sometimes he uses it alone. CNA C stated, It depends on the resident. We can use it with one or two. Surveyor asked CNA C who he can transfer with the Hoyer alone and CNA C stated R9. CNA C indicated he has transferred R9 with the Hoyer alone. It is important to note R9's care plan states R9 is a Hoyer transfer with 2 assist and facility transfer policy states all transfers with a mechanical lift are to be with 2 people. On 8/13/25 at 1:38 PM, Surveyor interviewed DON B (Director of Nursing) and asked her if she expected staff to follow the transfer policy and follow resident care plans. DON B stated yes, she expected staff to follow the facility policy for safe transfers using the Hoyer with two staff members and would expect staff to follow resident care plans. On 8/13/25 at 2:50 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked her if she expected staff to follow facility policies regarding safe transfers. NHA A stated yes, she expected the policy to be followed for Hoyer transfers and that they should always have two staff members to assist when using the Hoyer.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (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	08/25/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility did not ensure that its medication error rate was 5% or less for 24 medication pass opportunities and 2 of 2 residents observed (R12 and R5).The facility's medication error rate was 100% with 24 errors observed for R12 and R5.This is evidenced by:The facility policy, Medication Administration, dated 3/1/19, states in part, as follows: Compare medication source (bubble pack, vial, etc.) with MAR (Medication Administration Record) to verify resident name, medication name, dose, route, and time. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.Example 1R12's Physician Orders, signed 8/7/25, include, in part, the following medications:1. Vitamin C (Ascorbic Acid) - Give 500 mg (milligrams) by mouth two times a day to promote wound healing.R12's Medication Administration Record (MAR) indicates Vitamin C is scheduled to be administered at 7:00 AM and 4:00 PM. 2. Multivitamin-Minerals - Give 1 tablet by mouth one time a day to promote healingR12's MAR indicates Multivitamin-Mineral is scheduled to be administered at 7:30 AM. 3. Vitamin B12 (Cyanocobalamin) - Give 1,000 mcg (micrograms) by mouth one time a day related to anemia. R12's MAR indicates Vitamin B12 is scheduled to be administered at 7:30 AM. 4. Aspirin 81 mg (milligrams) Delayed Release - Give 1 tablet by mouth two times a day for prophylaxis CV (cerebrovascular/stroke) risk reduction R12's MAR indicates Aspirin is scheduled to be administered at 8:00 AM and 5:00 PM. 5. Famotidine 20 mg (milligrams) - Give 1 tablet by mouth in the morning for GERD (Gastroesophageal Reflux Disease)R12's MAR indicates Famotidine is scheduled to be administered at 8:00 AM. 6. Magnesium Oxide 400 mg (milligrams) - Give 1 tablet by mouth in the morning for supplement. R12's MAR indicates Magnesium Oxide is scheduled to be administered at 8:00 AM. 7. Sodium Chloride 1 gm (gram) - Give 1 ablet by mouth in the morning related to schizophreniaR12's MAR indicates Sodium Chloride is scheduled to be administered at 8:00 AM. 8. Vitamin D3 25 mcg (micrograms) - Give 2 tablets by mouth in the morning for Vit (Vitamin) D levelR12's MAR indicates Vitamin D3 is scheduled to be administered at 8:00 AM. 9. Benztropine 0.5 mg (milligrams) - Give 1 tablet by mouth two times a day for EPS (Extrapyramidal symptoms)R12's MAR indicates Benztropine is scheduled to be administered at 8:00 AM and 7:00 PM. 10. Cinacalcet - Give 30 mg (milligrams) - Give 2 tablets by mouth in morning related to Type 2 diabetes mellitus without complicationsR12's MAR indicates Cinacalcet is scheduled to be administered at 8:00 AM and 5:00 PM. 11. Doxycycline Hyclate 100 mg (milligrams) - Give 1 tablet by mouth two times a day for prophylactic for chronic knee infection R12's MAR indicates Doxycycline is scheduled to be administered at 8:00 AM and 5:00 PM. 12. Farxiga (Dapagliflozin) 10 mg (milligrams) - Give 1 tablet by mouth in the morning for diabetes. R12's MAR indicates Farxiga is scheduled to be administered at 8:00 AM.13. Metformin 500 mg (milligrams) - Give 1 tablet by mouth in the morning related to type 2 diabetes mellitusR12's MAR indicates Metformin is scheduled to be administered at 8:00 AM.14. Methenamine Hippurate 1 gm (gram) - Give 1 tablet by mouth two times a day for prophylaxis for UTI (urinary tract infection)R12's MAR indicates Methenamine Hippurate is scheduled to be administered at 8:00 AM and 5:00 PM. 15. Metoprolol Succinate ER 25 mg (milligrams) - Give 1 tablet by mouth in the morning related to hypertensionR12's MAR indicates Metoprolol Succinate is scheduled to be administered at 8:00 AM. 16. Movantik (Naloxegol Oxalate) 25 mg (milligrams) - Give 1 tablet by mouth in the morning related to Type 2 diabetes mellitus without complicationsR12's MAR indicates Movantik is scheduled to be administered at 8:00 AM. 17. Risperidone 4 mg (milligrams) - Give 1 tablet by mouth in the morning related to schizophreniaR12's MAR indicates Risperidone is scheduled to be administered at 8:00 AM. 18. Venlafaxine HCL ER (extended-release) 150 mg (milligrams) - Give 1 capsule by mouth in the morning related to depression. R12's MAR indicates Venlafaxine HCL ER (extended release) is scheduled to be administered at 8:00 AM. On 8/13/25 at 10:20 AM, Surveyor observed RN J (Registered Nurse) administer the eighteen (18) medications above to R12. This resulted in 18 medication errors due to timing (late administration). Example 2R5's Physician Orders, signed 8/7/25, include, in part, the following medications:19. Aspirin 81 mg (milligrams) - Give 1 tablet by mouth in the morning related to peripheral vascular disease R5's Medication Administration Record) indicates Aspirin is scheduled to be administered at 8:00 AM.20. Divalproex ER (extended-release) 250 mg (milligrams) - Give 1 capsule by mouth in the morning related to depression. R5's MAR indicates Divalproex ER is scheduled to be administered at 8:00 AM.21. Levetiracetam Oral tablet 500 mg - Give 2 tablets by mouth two times a day for seizuresR5's MAR indicates Levetiracetam is scheduled to be administered at 8:00 AM and 8:00 PM.22. Potassium Chloride ER (extended release) - Give 2 capsules by mouth two times a day for K

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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. Based on observation, interview, and record review, the facility did not ensure Residents are free of significant medication errors, for 1 of 2 residents reviewed for significant medication errors (R5).Surveyor observed RN J (Registered Nurse) crush R5's Divalproex (Depakote) extended- release and administered it to R5. Evidenced by:The facility policy, entitled, Medication Administration, dated 3/1/19, states in part: Administer medication as ordered in accordance with manufacturer specifications.Crush medications as ordered. Do not crush medications with do not crush instructions.R5's Physician Orders, signed 8/7/25, include, in part, the following medication:Divalproex Sodium ER (Extended Release) Oral Tablet 24-hour 250 mg (milligrams) - Give 1 tablet by mouth in the morning for seizures. Divalproex Sodium ER (Extended Release) Oral Tablet 24-hour 250 mg (milligrams) - Give 2 tablets by mouth in the evening for seizures. On 8/13/25 at 11:00 AM, Surveyor observed RN J (Registered Nurse) crush R5's Divalproex Extended-Release 250 mg tablet and administer it to R5. It is important to note, extended-release medications are not to be crushed.On 8/13/25 at 12:00 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, if she expects staff to follow Physician orders. DON B stated, Yes. Surveyor asked DON B, is it acceptable for Divalproex extended release to be crushed. DON B stated, It should not be crushed or chewed. Surveyor asked DON B if there is a physician order to crush R5's Divalproex. DON B reviewed R5's physician orders. DON B stated, R5 does not have a physician order to crush Divalproex extended release. Surveyor asked DON B, is it acceptable for nurses to crush R5's Divalproex extended-release tablet. DON B stated, No. On 8/13/25 at 12:45 PM, DON B (Director of Nursing) stated, the MD (Medical Doctor) will order liquid Divalproex ER (extended release) for R5.