

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Rivers Edge Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N. Wisconsin Ave. Muscodia, 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**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 to the State Survey Agency for 1 (R12) of 5 investigations reviewed. R12 indicated the nurse threw him on R12's bed. Facility did not report incident to state agency and did not contact law enforcement. The facility policy, Abuse/Neglect/Exploitation, with no date, states, in part;. 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. B. The Administrator will follow up with the government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. R12 was admitted to the facility on [DATE], with a diagnoses including Bipolar disorder (chronic mental health condition), antisocial personality disorder (mental health condition persistent pattern of disregard for and violation of the rights of others), kidney disease, and diabetes. R12's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 8/4/25, indicates R12 has a BIMS (Brief Interview for Mental Status) score of 12 indicating R12 is moderately cognitively impaired. R12 has an activated power of attorney. Nursing Home Administrator A (NHA) timeline states, in part;. 9/19/25 Registered Nurse Care Coordinator from hospital called to voice a concern over a recent concern that was voiced. R12 was taken to the ER and told a nurse there that our nurse had threw him on the bed. NHA A told RN Care Coordinator that she would follow up and report back to her what was found. On 9/29/25 at 10:44AM, Nursing Home Administrator A (NHA) indicated the hospital care coordinator called NHA A on 9/19/25 to report a concern that R12 had voiced when R12 was at ER on [DATE]. NHA A indicated R12 told hospital staff that the night nurse threw R12 on the bed. NHA A indicated she talked to the nurse and Certified Nursing Assistant (CNA) that was working with R12 that night. The statements matched so NHA A did not investigate further. NHA A indicated she talked with R12 as well and R12 did not have any concerns, feels safe at the facility, and could not remember any incident that had occurred. On 9/30/25 at 11:03AM, Hospital Manager G indicated she did call and report R12's allegation of abuse to Nursing Home Administrator A (NHA) on 9/19/25. Hospital Manager G indicated it was reported that R12 told staff that the nurse at the facility threw him on the bed. Hospital Nurse G indicated NHA A followed back up and reported that she talked to the nurse and Certified Nursing Assistant that worked with R12 that night. On 9/30/25 at 12:21PM, Nursing Home Administrator A indicated she did not report R12's allegation to law enforcement and state agency. NHA A indicated R12 stating he was thrown on the bed could be an allegation of abuse and should be investigated and reported. The facility did not report an allegation of abuse to the state agency and law enforcement for 1 of 5 investigations reviewed.</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations are thoroughly investigated and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken this affected 1 (R12) of 5 investigations reviewed. R12 reported an allegation of abuse. The facility did not complete a thorough investigation. Evidenced by: The facility policy, Abuse/Neglect/Exploitation, no date, states, in part; A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. R12 was admitted to the facility on [DATE], with a diagnoses including Bipolar disorder (chronic mental health condition), antisocial personality disorder (mental health condition persistent pattern of disregard for and violation of the rights of others), kidney disease, and diabetes. R12's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 8/4/25, indicates R12 has a BIMS (Brief Interview for Mental Status) score of 12 indicating R12 is moderately cognitively impaired. R12 has an activated power of attorney. Nursing Home Administrator A (NHA) timeline states, in part; 9/19/25 Registered Nurse Care Coordinator from hospital called to voice a concern over a recent concern that was voiced. R12 was taken to the ER and told a nurse there that our nurse had thrown him on the bed. NHA A told RN Care Coordinator that she would follow up and report back to her what was found. On 9/29/25 at 10:44AM, Nursing Home Administrator A (NHA) indicated the hospital care coordinator called NHA A on 9/19/25 to report a concern that R12 had voiced when R12 was at ER on [DATE]. NHA A indicated R12 told hospital staff that the night nurse threw R12 on the bed. NHA A indicated she talked to the nurse and Certified Nursing Assistant (CNA) that was working with R12 that night. The statements matched so NHA A did not investigate further. NHA A indicated she talked with R12 as well and R12 did not have any concerns, feels safe at the facility, and could not remember any incident that had occurred. On 9/30/25 at 11:03AM, Hospital Manager G indicated she did call and report R12's allegation of abuse to Nursing Home Administrator A (NHA) on 9/19/25. Hospital Manager G indicated it was reported that R12 told staff that the nurse at the facility threw him on the bed. Hospital Manager G indicated NHA A followed back up and reported that she talked to the nurse and Certified Nursing Assistant that worked with R12 that night. On 9/30/25 at 12:21PM, Nursing Home Administrator A indicated she did not interview other residents and staff. NHA A indicated R12 stating he was thrown on the bed could be an allegation of abuse and should be thoroughly investigated. The facility did not complete a thorough investigation for 1 of 5 investigations reviewed.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a person-centered comprehensive care plan to meet personal preferences and goals, or address the resident's medical, physical, mental and psychosocial needs for 1 or 16 sampled residents (R1).R1 displayed behaviors of making sexual remarks to a staff member and the facility failed to develop a behavior care plan with goals and interventions related to R1's behavior. Evidenced by:Facility policy, titled Comprehensive Care Plan, dated 3/1/23, includes: . it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessments. R1 admitted to the facility on [DATE]. His most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 7/18/25, indicates R1 is severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 8 out of 15.On 09/25/25 at 9:59 AM LPN O (Licensed Practical Nurse) indicated there was an incident on 9/1/25 at 8:00 PM in which R1 and another resident were making sexual remarks to her and threatening to sexually assault her. The police came and arrested the other resident and he has not been back to the facility.R1's Comprehensive Care Plan, reviewed 9/25/25, initiated 3/28/24, does not include goals or interventions related to inappropriate sexual behaviors.On 9/25/25 at 3:09 PM NHA A (Nursing Home Administrator) indicated R1 was involved in an incident that occurred on 9/1/25 around 8:00 PM in the shared gathering room. NHA A indicated staff reported to NHA A that R1 was making sexual remarks to LPN O and verbalizing a desire of sexual misconduct with LPN O. NHA A indicated other residents and staff were in the room while this was happening. NHA A indicated the facility did not add interventions or goals in R1's care plan related to this behavior. NHA A indicated the facility is not monitoring R1 for inappropriate sexual comments to staff or other residents, but they should be.</p>		