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	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivers Edge Nursing and Rehab	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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 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 observation, interview and record review, the facility failed to ensure each resident (R) received adequate supervision to prevent accidents for 1 of 4 sampled residents (R3) reviewed for falls. Surveyor observed R3's fall intervention not in place. R3 had a fall on 9/30/25 and facility failed to complete a falls investigation and update the physician on the fall. Evidenced by: The facility policy entitled Falls Management Process, undated, states, in part: . 1. In the event a resident has fallen and /or is found on the ground.11. The nurse will complete an event documentation report, fall risk assessment, pain assessment, and obtain witness statements.12. The nurse will determine the most appropriate intervention, implement, and update care plan. [12] Contact physician and family and document in the medical record, including time and person spoken with.13. Resident fall will be noted on 24-hour report for three days for post fall monitoring, assessing for injury, full vital signs every 8 hours, and pain assessment. R3 admitted to the facility on [DATE] and has diagnoses that include age related osteoporosis without current pathological fracture (a condition that weakens bones, making them more prone to fractures), acquired absence of right leg below knee and unilateral primary osteoarthritis (a type of joint disease that affects only one side of the body, typically in a single joint). R3's Quarterly MDS (Minimum Data Set) Assessment, dated 9/13/25, shows R3 has a BIMS (Brief Interview of Mental Status) score of 15 indicating R3 is cognitively intact. R3's Care Plan, dated 3/05/2024, states, in part: . Focus: At risk for falls related to bilateral amputee, impaired mobility. Interventions: .*Floor mat x 1 Date Initiated: 9/30/25*I need dycem in the seat of my wheelchair. Date Initiated: 9/30/25 R3's Progress Note dated 9/30/25, at 7:59 AM, states: Late Entry: Note Text: Resident went outside after breakfast and later in the day, a nurse from across the street brought him into the facility and stated he had been out there all day, and she was going to notify the state. HSKG D (housekeeping) environmental director, stated it was his right to be outside if he wanted to be. HSKG D informed this writer that he smelled like alcohol. When this nurse assessed him, his words were slurred. Eyes glazed. VSS (vital signs stable). Skin warm and dry. Denied having any pain or discomfort. I asked him if he wanted help for his drinking and he stated no. Will have social worker follow up with him. Dr updated per LPN C (licensed practical nurse).Of note: There is no mention of a fall. R3's Progress Note, dated 9/30/25, at 1:20 PM, states, in part: . Situation: The Change in Condition/s reported on this CIC (change in condition) Evaluation are/were: Altered mental status.Nursing observations, evaluation, and recommendations are: Resident is own person. Resident left facility in w/c (wheelchair). Does go out to smoke and to the local gas station. Resident was on sidewalk in w/c and writer was speaking to him earlier, offered to bring him inside and declined, noted 2 small bottles of alcohol in shorts. Resident was brought inside about 1 hour later and has squinty eyes, laughs at questions and has alcohol breath. Alcohol in shorts is gone. Resident stated he was fishing. Speech is slurred.Of note: There is no mention of a fall. On 10/13/25, at 09:25 AM, Surveyor observed R3 in bed with no fall mat on floor next to bed. On 10/13/25, at 09:40AM, Surveyor interviewed CNA E (certified nursing assistant) and asked if R3 is supposed to have floor mat in place next to bed while R3 is in bed. CNA E indicated yes. CNA E indicated maybe housekeeping had moved it while cleaning. CNA E indicated he would go in R3's room and place the mat down. On 10/13/25, at 10:40AM, Surveyor interviewed LPN C and asked her to tell Surveyor about the incident with R3 on 9/30/25. LPN C indicated R3 was sitting outside that morning for quite awhile and she approached him because he was getting red and asked him if he wanted to come inside and R3 told her no. LPN C reported later that day someone had brought R3 back into the facility from outside. LPN C indicated she did not know who it was as she did not see the person. LPN C was called to R3's room and assessed R3. It had been reported to LPN C R3 had been drinking. LPN C indicated after she had assessed R3 she had left the room and got called back to R3's room right away. R3 was on the floor and reported to LPN C he put himself on the floor. LPN C indicated DON B (Director of Nursing) came to room to assess R3. No injuries were noted. R3 reported to LPN C and DON B he was going fishing. R3 smelled to alcohol. LPN C indicated R3 was gotten up off the floor with the Hoyer lift and transferred into R3's bed. LPN C indicated bed was lowered to floor and floor mat was placed. LPN C indicated she had messaged the doctor. Fax to physician, dated 9/30/25, at 2:25PM, states: Resident Name: R3 Date: 9/30/25Note: Resident is own person. Left facility in w/c and came back intoxicated. No complaints of pain, no injuries noted. Stated he went fishing. Does have slurred speech and laughs at questions. Vital signs WNL (Within Normal Limits) Of note: Physician was not updated on fall. On 10/13/25