

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  01/21/2026
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>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 2 of 8 residents (R3 &amp; R4) reviewed for abuse involved in 1 of 4 self-reports. The facility did not contact law enforcement on a resident-to-resident altercation regarding R3 and R4 on 12/23/25. Evidenced by: The facility policy entitled Abuse/Neglect/Exploitation, dated 11/2017, 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. VII. Reporting/Response 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 (e.g., law enforcement when applicable) within specified timeframes: . R4 admitted to the facility 11/21/25 and has diagnoses that include dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbances. R4's MDS (Minimum Data Set) admission Assessment, dated 11/25/25 shows R4 has a Brief Interview of Mental Status score of 00, indicating R4 has severe cognitive impairment. R3 admitted to the facility 2/20/25 and has diagnoses that include dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R3's MDS (Minimum Data Set) Quarterly Assessment, dated 11/26/25 shows R3 has a Brief Interview of Mental Status score of 10 indicating R3 has moderate cognitive impairment. The facility's Misconduct Incident Report, submitted 12/30/25 3:11 PM, states, in part: . Briefly Describe the Incident. R4 was walking to the dining room. R3 was sitting in the lobby and R4 came up and slapped her in the face. Staff witnessed from around the corner and came immediately and removed R4 from the lobby. Nursing came immediately and assessed R3. No injuries. R4 was taken to her room and regular checks were implemented. Both residents have dementia. We are not sure if R3 said anything to R4 prior to the incident. Other residents interviewed regarding their [sic] feeling safe. No residents witnessed the incident. Affected Person Information: R3. Accused Person: R4. Law Enforcement Involvement: Was law enforcement contacted or involved? No Person Preparing This Report: NHA A (Nursing Home Administrator) . Report Submitted Date: 12/30/25 3:11:33PM On 1/21/26, at 09:30AM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked when law enforcement should be notified. NHA A indicated with every facility self-report. Surveyor asked NHA A if law enforcement was notified regarding R4 and R3's incident in December. NHA A indicated no, and it should have been. NHA A indicated it must have been forgotten.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525321
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not ensure each resident received adequate supervision to prevent accidents for 1 (R2) of 8 sampled residents. R2 was at risk for falls and had three falls while residing at the facility. R2 had a care planned intervention to remain in line of sight while up in her broda chair (wheelchair that tilt and reclines). R2 experienced a fall from her broda chair while not in line of sight of staff. Neurological checks following the fall were not completed. This is evidenced by: The facility policy entitled, Fall Management Process, dated 2011, states, in part: 1. In the event a resident has fallen and/or is found on the ground, a complete head-to-toe assessment must be performed prior to moving the resident unless life-threatening safety concerns are present. 8. Obtain neurological check (neuro-checks) per policy for any unwitnessed fall or any fall with evidence of injury to head. 12. Contact physician and family and document in the medical record, including time and person spoken with. R2 was admitted to the facility on [DATE] with diagnoses including inflammatory spondylopathy, lumbar region (inflammation of the spine and associated structures in the lower back commonly causing pain and stiffness), chronic obstructive pulmonary disease (progressive lung disease resulting in damage to the lung tissue that leads to difficulty breathing), acute on chronic systolic (congestive) heart failure (chronic condition where the heart is unable to pump enough blood to meet the body's needs for blood and oxygen), type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage caused by diabetes), unspecified symptoms and signs involving cognitive functions following cerebral infarction (stroke), muscle wasting and atrophy (reduction in size of muscle), unsteadiness on feet, and combined forms of age-related cataract (lens of eye becomes cloudy due to advanced age commonly causing blurred vision and difficulty seeing) right eye and left eye. R2's Minimum Data Set (MDS) with an Assessment Reference Date of 10/6/25, indicates R2 has a Brief Interview of Mental Status (BIMS) score of 99 indicating severe cognitive impairment. On 9/19/25, R2's Fall Risk Evaluation was conducted with a score of 10, indicating R2 is at risk for falls. On 9/19/25, R2's Comprehensive Care Plan was updated to include the focus: I am at risk for falls related to: use of medication, episodes of dizziness, cognitive impairment and unaware of safety with interventions including: assess me for pain, assess that I have a broda chair that is of appropriate size, clear and monitor environmental obstacles (tubing, cords, etc.), do not leave unattended in bathroom, elevate HOB (head of bed) before getting OOB (out of bed), encourage fluids, encourage me to participate in activities to improve strength or balance, encourage rest periods if feeling fatigued, I need to wear appropriate footwear to prevent slipping, involve me in activity programming - exercise, TV programs, make sure my bed is in a low position when I'm in it, make sure my call light and personal items are available in easy reach or provide reacher, monitor me for restlessness and implement interventions, monitor use of over bed table and discourage its use as a mobility aide, observe me for side effects of medications, and use a gait belt with transfers. On 9/23/25, R2's Comprehensive Care Plan was updated to include the intervention: Falling Star-check q (every) 60 minutes. On 9/25/25, R2 experienced an unwitnessed fall in which she was found sitting on the floor in the doorway to her room. R2 was unable to state what happened. No injury was reported. On 9/26/25, R2's Comprehensive Care Plan was updated to include the intervention: I need to be with in eyesight when I'm up in my broda chair. On 9/28/25, R2's Fall Risk Evaluation was conducted with a score of 19, indicating R2 is at risk for falls. On 9/28/25, R2's Comprehensive Care Plan was updated to include the focus: Risk for Falls with interventions including: assist resident with ambulant and transfers utilizing therapy recommendations, determine resident's ability to transfer, evaluate fall risk on</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>admission and PRN (as needed), If a fall occurs, alert provider, If a fall occurs, initiate frequent neuro (neurological) and bleeding evaluation per facility protocol, If resident is a fall risk, initiate fall risk precautions. On 11/1/25, R2's Fall Risk Evaluation was conducted with a score of 15, indicating R2 is at risk for falls. On 11/2/25, a Hospice Note is written by a registered nurse that indicates the time of the visit to be from 5:20 PM to 7:20 PM. This note indicates an assessment was conducted with findings including an irregular respiratory pattern with intermittent episodes of apnea followed by quick, labored, deep breathing and small period of shallow breathing at a regular rate. The assessment also notes the presence of abdominal pain. Neurologic findings include: R2 is alert, did not speak for the first half of the visit but would nod head to some questions and provide simple answers such as yes or no. The section titled, Encounter Notes includes recommendations of pain and anxiety management along with the monitoring of continued decline. On 11/1/25 at 9:15 PM, R2 experienced an unwitnessed fall. A Progress Note, written 11/1/25 at 22:17 (10:17 PM), indicates R2 was walking unsupervised in her room at the time of the fall. A document titled IDT Weekly Fall indicates R2 fell in her room while attempting to self-transfer from bed. On 11/2/25 at 11:01 PM, R2 experienced an unwitnessed fall from her wheelchair in the hallway. A statement written by a CNA indicates R2 was on the other side of the nurses' station while CNA and another staff member were gathering their paperwork for the night. It also states, in part: . I looked to see where she was less than 5 minutes from the last time I saw her. I saw that she wasn't by the med cart. I stood up from my chair at the nurses station and her w/c (wheelchair) was down 100 hall and she wasn't in her w/c (wheelchair). I saw her laying on her right side in front of room [number] on the floor . (Of note: R2's care plan included the intervention that R2 must remain in eyesight while in her Broda chair at the time of the fall) On 11/2/25 at 23:00 (11:00 PM), R2's Neurological Assessment indicates she is fully conscious, has movement in all four extremities, has equal and strong hand grasp in both hands, pupil size is 2 mm in both eyes, has brisk pupil reaction in both eyes, and has clear speech. On 11/2/25 at 23:15 (11:15 PM), R2's Neurological Assessment indicates she is fully conscious, has movement in all four extremities, has equal and strong hand grasp in both hands, pupil size is 2 mm in both eyes, has brisk pupil reaction in both eyes, and has clear speech. On 11/2/25 at 23:30 (11:30 PM), R2's Neurological Assessment indicates she is fully conscious, has movement in all four extremities, has equal and strong hand grasp in both hands, pupil size is 2 mm in both eyes, has brisk pupil reaction in both eyes, and has clear speech. On 11/2/25 at 23:45 (11:45 PM), R2's Neurological Assessment indicates she is fully conscious, has movement in all four extremities, has equal and strong hand grasp in both hands, pupil size is 2 mm in both eyes, has brisk pupil reaction in both eyes, and has clear speech. On 11/2/25 at 23:55 (11:55 PM) a Progress Note is written that indicates R2 sustained a fall with a subsequent physical assessment that notes the presence of pain. Under the section titled, Recommendations it states, Hospice was here and no new orders. Awaiting response from [Physician Name]. Under the section titled, New Intervention Orders, it indicates increase oral fluids and provide oxygen (if available). On 11/2/25 at 23:58 (11:58 PM) a Progress Note is written that indicates R2 was found on the floor and was assessed by a registered nurse. R2 initially denied pain. A hematoma (bruise) was identified on R2's forehead measuring 6.5 x 5 with no indication of unit of measurement. R2's family and hospice provider were notified. The note indicates DON (Director of Nursing) B and the physician were notified . On 11/3/25 at 00:15 (12:15 AM), R2's Neurological Assessment indicates she is asleep for all categories of assessment. On 11/3/25 at 00:25 (12:25 AM), a Progress Note is written that indicates a registered nurse from R2's hospice agency will arrive at the facility in 1.5 to 2 hours to assess R2. On 11/3/25 at 00:34 (12:34 AM), a Progress Note is written</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>that indicates a cold pack (ice pack) was applied to R2's forehead to relieve the swelling. On 11/3/25 at 00:45 (12:45 AM), a Progress Note is written that indicates the hospice agency registered nurse arrived to assess R2.(Of note: Surveyor requested the note from this assessment, however the facility was unable to provide one). On 11/3/25 at 00:45 (12:45 AM), R2's Neurological Assessment indicates she is asleep for all categories of assessment. On 11/3/25 at 01:36 (1:36 AM), a Progress Note is written indicating R2 was given 15 MG (milligrams) of Morphine Sulfate (opioid pain medication) for pain which was effective. A second Progress Note written at the same time and date indicates R2 also received 0.5 MG of lorazepam (anti-anxiety medication).(of note: R2 was noted to receive medication at 1:36 AM, no neurological assessment was completOn 11/3/25 at 01:45, R2's Neurological Assessment indicates she is asleep for all categories of assessment.On 11/3/25 at 02:34 (2:35 AM), a Progress Note is written indicating R2 self-transferred and walked to the bathroom and R2's roommate reported to facility staff that R2 was in the bathroom. Hospice registered nurse to room to further assess R2. On 11/3/25 at 02:45 (2:45 AM), R2's Neurological Assessment indicates she is asleep for all categories of assessment.(of note: R2 was indicated as being awake at 2:35 AM and no neurological assessment was completed)On 11/3/25 at 03:00 (3:00 AM), a Fall Risk Evaluation is completed indicating a score of 11, indicating R2 is at risk for falls. On 11/3/25 at 03:45 (3:45 AM), R2's Neurological Assessment indicates she is asleep for all categories of assessment. On 11/3/25 at 04:45 (4:45 AM), R2's Neurological Assessment indicates she is asleep for all categories of assessment. On 11/3/25 at 04:56 (4:56 AM), a Progress Note is written that states, in part: . Fall was not witnessed. Fall occurred in the hallway. A statement dated both 11/2/25 and 11/5/25, was written by CNA (Certified Nursing Assistant) I, and states, in part: I was at the nurses station with my co-worker for the night shift gathering our proper paperwork I would need for the night. The resident [Resident Initials] was directly on the other side of the nurses station near the med (medication) cart within my line of view. I looked to see where she was less than 5 minutes from the last time I saw her. I saw that she wasn't by the med cart. I stood up from my chair at the nurses station and her wheelchair was down the hall and she wasn't in her wheelchair. I saw her laying on her right side in front of room (number) on the floor. On 1/21/26 at 10:07 AM, Surveyor interviewed MT (Medication Tech) D. Surveyor asked MT D how long she has worked at the facility. MT D indicates 3 months. Surveyor asked MT D how she knows which residents have fall precautions. MT D indicates they have the falling star picture on their door, the interventions are in the chart on the care plan and on the closet door. Surveyor asked MT D what in line of sight means in terms of fall interventions. MT D indicates staff need to be able to physically see the resident. On 1/21/26 at 10:18 AM, Surveyor interviewed RN (Registered Nurse) E. Surveyor asked RN E how long she has been working at the facility. RN E indicates a few months and that she used to be agency staff but now works full-time for the facility. Surveyor asked RN E how staff know which residents have fall interventions or precautions. RN E indicates these residents have star pictures on their doors, the interventions are listed inside the closet doors, and on the care plan. Surveyor asked RN E what in line of sight means in terms of fall interventions. RN E indicates the resident must be able to be physically seen by staff. Surveyor asked RN E if it is acceptable to mark asleep or sleeping for neurological assessments. RN E indicates, you can't do a neurological exam if the resident is asleep because you must assess pupils, pain, etc. On 1/21/26 at 12:03 PM, Surveyor interviewed NHA (Nursing Home Administrator) A and DON (Director of Nursing) B. Surveyor asked NHA A and DON B how staff know which residents have fall precautions. NHA A and DON B indicate there are star pictures on the residents door and the interventions are on the care plan and the Kardex on the residents' closet doors. Surveyor asked NHA A and DON B what in line of sight means</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>on the care plans. NHA A and DON B indicate it means staff must be able to physically see the resident. Surveyor asked NHA A and DON B if it is acceptable to mark asleep or sleeping on a neurological assessment. DON B indicates she would wake the resident up because she wouldn't know if the resident has had a change in mental status. Surveyor asked NHA A and DON B what are some causes for concern or changes you would find pertinent on a neurological assessment. DON B indicates pupil size, vital signs . Surveyor notes R2's fall from her broda chair on 11/2/25 and asked NHA A and DON B if R2 should have been within line of sight of staff if she was in her broda chair. NHA A and DON B indicate they believe she was, but if she was not then R2 should have been kept within line of sight.(Of note: Surveyor allowed NHA A and DON B additional time to review documentation for alternative evidence regarding R2 being in line of sight of staff on 11/2/25 when she fell, however none was provided)</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>Based on interview and record review the facility did not provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 of 1 resident (R3).Facility did not follow up on psycho-social needs with R3 after a resident-to-resident altercation involving R3 being slapped by another resident (R4).Evidenced by:The facility's policy Abuse/Neglect/Exploitation, dated 11/2017, 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. Protection of Resident:The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: .F. Providing emotional support and counseling to the resident during and after the investigation. The facility's policy Social Services Director, dated 2023, states, in part: . Required Qualifications: All facilities must provide medically related social services to residents.Major Duties and Responsibilities: The Social Services Director is responsible for overseeing the development, implementation, supervision and ongoing evaluation of the Social Services Department designed to meet and assist residents in attaining or maintaining their highest practicable well-being. This includes identifying the need for medically related social services and ensuring that these services are provided in accordance with State and Federal regulations.The Social Services Director will coordinate implementation and oversight of procedures to ensure social services actions and interactions are adequately documented in each resident's medical record, and that legal, ethical, and professional standards of social work practice and being upheld in written recordings The Social Services Director will participate in facility policy development in order to positively impact the quality care delivered to residents. The facility's Misconduct Incident Report, submitted 12/30/25 3:11 PM, states, in part: . Briefly Describe the Incident. R4 was walking to the dining room. R3 was sitting in the lobby and R4 came up and slapped her in the face. Staff witnessed from around the corner and came immediately and removed R4 from the lobby. Nursing came immediately and assessed R3. No injuries. R4 was taken to her room and regular checks were implemented. Both residents have dementia. We are not sure if R3 said anything to R4 prior to the incident. Other residents interviewed regarding their feeling safe. No residents witnessed the incident.Describe the Effect that the incident had on the affected person.R3 was concerned that she had done something wrong. Staff reassured her that she had not, and she was safe. She brought the incident up for a few hours after the incident but has forgotten about it. No other residents witnessed the incident. Affected Person Information: R3.Accused Person: R4. Law Enforcement Involvement:Was law enforcement contacted or involved? NoPerson Preparing This Report: NHA A (Nursing Home Administrator) .Report Submitted Date: 12/30/25 3:11:33PM R3 admitted to the facility 2/20/25 and has diagnoses that include dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R3's MDS (Minimum Data Set) Quarterly Assessment, dated11/26/25 shows R3 has a Brief Interview of Mental Status score of 10 indicating R3 has moderate cognitive impairment. R3's Progress Note dated 12/23/25 at 12:11PM, states, in part: . R3 involved in an altercation with another resident.she got slapped by another resident. I did an assessment and R3 ok physically but is shaken up. Of note: there is no follow up documentation with R3's psycho-social needs related to the resident-to-resident altercation. On 1/21/26 at 9:10 AM, Surveyor interviewed SW C (Social Worker) and asked if she was aware of the resident-to-resident altercation involving R3 and R4 on 12/23/25. SW C indicated she had heard about it but was not directly involved with the incident. Surveyor asked SW C</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility did not ensure residents are free of significant medication errors for 1 of 8 sampled residents (R5). R5 has an order for Metoprolol Succinate (medication that slows the heart rate and force of contraction of the heart which decreases blood pressure) 150 MG (milligrams) to be administered one time a day by mouth and to hold this medication for a systolic blood pressure (blood pressure when the heart contracts) below 110 and a heart rate less than 55 beats per minute. This medication was administered 14 times in December 2025 and 6 times from 1/1/26 through the survey date with a systolic blood pressure less than 110. As evidenced by The facility policy entitled, Medication Errors, undated, states, in part: . Definitions: Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety. Policy Explanation and Compliance Guidelines: 1. The facility shall ensure medications will be administered as follows: a. according to physician's orders. 3. Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines. c. Frequency of Error: If an error is occurring repeatedly such as an omission of a resident's medication several times. 8. If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. b. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. c. Document actions taken in the medical record. d. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report. R5 was admitted to the facility on [DATE] with diagnoses including: secondary parkinsonism (movement disorder that mimics Parkinson's disease such as tremors, stiffness, and slowed movements, but has different underlying causes such as medications or brain injuries), chronic obstructive pulmonary disease (progressive lung disease resulting in damage to the lung tissue that leads to difficulty breathing), type 2 diabetes mellitus without complications, acute on chronic systolic (congestive) heart failure (chronic condition where the heart is unable to pump enough blood to meet the body's needs for blood and oxygen), essential (primary) hypertension (high blood pressure), atrial fibrillation (irregular heart rhythm), and presence of coronary angioplasty implant and graph (stent placed in arteries that provide the heart muscle with oxygenated blood). R5's most recent Brief Interview for Mental Status (BIMS), conducted by an outside Psychiatric Nurse Practitioner, indicates R5 has a BIMS score of 15 out of 15, indicating he is cognitively intact. R5's Physician Orders indicate, in part:Metoprolol Succinate ER (Extended Release) Oral Tablet Extended Release 24 Hour. Give 150 MG by mouth one time a day related to Essential (Primary) Hypertension. Hold for SBP (Systolic Blood Pressure) below 110 and HR (Heart Rate) below 55. This medication is scheduled to be administered at 8:00 AM daily and has a start date of 9/9/25. R5's Medication Administration Record (MAR) indicates that staff administered Metoprolol Succinate with a systolic blood pressure under 110 on the following dates: 12/8/25: Administered with a blood pressure of 91/4512/9/25: Administered with a blood pressure of 103/5812/10/25: Administered with a blood pressure of 105/6112/16/25: Administered with a blood pressure of 109/7212/17/25: Administered with a blood pressure of 107/6812/18/25: Administered with a blood pressure of 101/7612/19/25: Administered with a blood pressure of 102/6812/20/25: Administered with a</p> <p>(continued on next page)</p>		

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  01/21/2026
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.			
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>blood pressure of 98/62/21/25: Administered with a blood pressure of 102/54/12/22/25: Administered with a blood pressure of 99/59/12/23/25: Administered with a blood pressure of 104/62/12/26/25: Administered with a blood pressure of 98/56/12/28/25: Administered with a blood pressure of 100/47/12/30/25: Administered with a blood pressure of 98/62 1/3/26: Administered with a blood pressure of 108/55/1/4/26: Administered with a blood pressure of 108/52/1/5/26: Administered with a blood pressure of 108/66/1/9/26: Administered with a blood pressure of 88/58/1/16/26: Administered with a blood pressure of 102/64/1/20/26: Administered with a blood pressure of 106/67 This resulted in 20 significant medication errors from 12/1/25 through 1/20/26. On 1/21/26 at 10:07 AM, Surveyor interviewed MT (Medication Tech) D. Surveyor asked MT D how long she has been working at the facility. MT D indicates, 3 months. Surveyor asked MT D which halls she normally works. MT D indicates she usually does not work on R5's hall. Surveyor asked MT D how she knows which orders have vital sign parameters. MT D indicates the MAR (Medication Administration Record) has the vital sign parameters in the order. Surveyor asked MT D if the MAR will give a warning if the entered vital signs are outside the orders parameters. MT D states, yes. Surveyor asked MT D if a medication should be held if the entered vital signs are outside of the orders parameters. MT D states, yes. Surveyor asked MT D what happens when a medication is held. MT D indicates she notifies the charge nurse and puts in a progress note. Surveyor asked MT D what happens if the medication is administered despite the blood pressure being outside of the ordered parameters. MT D indicates staff need to report it right away to the charge nurse and a physician needs to be notified. Surveyor asked MT D what monitoring should be conducted in this scenario. MT D indicates the blood pressure needs to be monitored every half hour or per facility protocol. On 1/21/26 at 10:18 AM, Surveyor interviewed RN (Registered Nurse) E. Surveyor asked RN E how long she has been working at the facility. RN E indicates a few months. RN E also indicates she is now full-time with the facility but used to be agency staff. Surveyor asked RN E which halls she normally works. RN E indicates she usually works on R5's hall. Surveyor asked RN E how she knows which orders have vital sign parameters. RN E indicates since she works with the same residents frequently, she does have quite a few memorized but also showed Surveyor a document she keeps with resident vital signs. RN E also indicates the vital sign parameters are also listed in the medication orders in the MAR. The document presented to Surveyor appears to have multiple vital signs for many residents. RN E indicates she was previously employed in acute care and prefers to monitor residents more frequently than ordered, especially if she has any concerns. Surveyor asked RN E if the MAR will give a warning if the entered vital signs are outside the orders parameters. RN E indicates, she believes so, however she puts the medication on hold and will make separate notes regarding the vital sign readings and why the medication was held so she is not positive. RN E demonstrated on her computer how the system requires vital signs to be entered for R5 prior to signing off the medication in the MAR. Surveyor asked RN E if a medication should be held if the blood pressure is outside of the listed parameters. RN E states yes. Surveyor asked RN E what happens when a medication is held. RN E indicates the medication is not given, and my process is to reapproach, especially if the resident has just woken up, and recheck the blood pressure to ensure it is within parameters. Surveyor asked RN E what happens if the medication is administered despite the blood pressure being outside of the ordered parameters. RN E indicates a doctor needs to be called and the resident needs to be monitored. Surveyor asked RN E what monitoring should be conducted in this scenario. RN E indicates the resident's blood pressure should be monitored at least every 15 minutes along with a full assessment. Blood pressure monitoring should continue every hour, to monitor for peak effective of the medication. Additionally, if the resident needs to be sent to the emergency room a follow up needs to be completed upon</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Rivers Edge Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 N. Wisconsin Ave. Muscodia, WI 53573	
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the resident's return. Surveyor asked RN E how a physician should be notified. RN E indicates she calls and sends a fax to ensure multiple forms of communication are being sent. RN E also indicates in an emergency situation she would also call emergency services to ensure the resident receives the appropriate level of care in a timely manner. On 1/21/26 at 12:03 PM, Surveyor interviewed NHA (Nursing Home Administrator) A and DON (Director of Nursing) B. Surveyor asked NHA A and DON B how staff know which orders have vital sign parameters. DON B indicates it is written on the MAR and the order will say if less than or over than notify the physician. Surveyor asked NHA A and DON B how vital signs are put into the electronic medical record. NHA A and DON B indicate the vital signs get charted directly into the MAR. When staff sign-off that the medication was given, a pop-up will appear the requires staff to put in the required vital signs before completing the sign-off. Surveyor asked NHA A and DON B if the MAR alerts staff if the vital signs are outside the order's parameters. NHA A and DON B indicate they don't believe the MAR provides a warning. Surveyor asked NHA A and DON B if a medication should be held if the resident's blood pressure is outside the ordered vital sign parameters. NHA A and DON B state yes, and that the doctor should be notified. Surveyor asked NHA A and DON B if staff are expected to write a progress note when a medication is held. DON B states yes. Surveyor asked NHA A and DON B what happens if the medication is administered despite the blood pressure being outside the ordered vital sign parameters. DON B indicates staff need to notify a physician for orders and monitoring the resident. Surveyor asked NHA A and DON B what monitoring should be conducted in this scenario. DON B indicates the blood pressure should be monitored. Surveyor notes R5 has been administered his ordered Metoprolol Succinate with a blood pressure below the ordered parameter 14 times in December and 6 times from 1/1/26 through the survey date. Surveyor asked if R5's Metoprolol Succinate should have been held. NHA A and DON B state, yes. Surveyor asked NHA A and DON B if they would consider these instances medication errors. NHA A and DON B state, yes. DON B also indicates staff should also be reporting these instances to her when they occur. Surveyor asked NHA A and DON B if a physician have been notified when these instances have occurred. NHA and DON B state, yes. Surveyor asked NHA A and DON B if R5's blood pressure should have been monitored following these instances. NHA A and DON B state, yes.</p>		