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	06/16/2026

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 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. **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, including injuries of unknown source, are reported immediately for 1 of 16 sampled residents (R) reviewed for abuse (R14).R14 made an allegation she was emotionally and sexually abused at the facility. The facility was aware on 6/9/26 of R14's allegations and did not report to the state agency timely. This is evidenced by: The facility's policy Abuse/Neglect/Exploitation, undated, includes: VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies. 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.R14 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (mental health condition marked by hallucinations and delusions), and bipolar disorder (severe shifts in mood).R14's BIMS (Brief Interview for Mental Status), dated 3/6/26, has a score of 14, indicating R14 is cognitively intact. On 6/2/26, R14 was admitted to the hospital. On 6/9/26, R14's hospital progress notes include; Patient reports that she refuses to go to SNF (Skilled Nursing Facility), accusing SNF of emotional, psychical, and sexual abuse. On 6/15/26 at 3:33 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding R14's allegations of abuse. NHA A indicated that the social worker at the hospital had called the facility on 6/9/26 and informed the facility of R14's allegations of abuse. NHA A indicated all allegations of abuse should be reported to the state agency within 2 hours. NHA A indicated they had not reported R14's allegation of abuse to the state agency.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 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 interview and record review the facility did not have evidence all allegations of abuse were thoroughly investigated for 1 of 16 sampled residents (R14).R14's allegation of emotional, psychical, and sexual abuse was not thoroughly investigated. This is evidenced by:The facility's policy Abuse/Neglect/Exploitation, undated, includes: V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. R14 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (mental health condition marked by hallucinations and delusions), bipolar disorder (severe unusual shifts in mood).R14's BIMS (Brief Interview for Mental Status), dated 3/6/26, has a score of 14, indicating R14 is cognitively intact. On 6/2/26, R14 was admitted to the hospital. On 6/9/26, R14's hospital progress notes include; Patient reports that she refuses to go to SNF (Skilled Nursing Facility), accusing SNF of emotional, psychical, and sexual abuse. On 6/16/26, NHA A (Nursing Home Administrator) provided a typed document, dated 6/9/26, that states: R14 told the social worker at [Hospital Name] that she was harmed at [Facility Name]. Social worker, [Name] called to discuss patients status and to let me know that she had made some accusations and that they had reported it to [Name] County APS (Adult Protective Services). Social worker stated that APS would be investigating.On 6/15/26 at 3:33 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding R14's allegation of abuse. NHA A indicated that the social worker at the hospital had called the facility on 6/9/26 and informed the facility of R14's allegations of abuse. NHA A stated she did not reach out to or speak to R14 about the allegations of abuse. NHA A indicated the facility was unaware of the type of abuse allegation R14 made and therefore, they were unable to investigate the allegations of abuse. NHA A indicated adult protective services was going to investigate R14's allegation of abuse. Surveyor requested the investigation documentation for R14's allegations of abuse from NHA A. NHA A was unable to provide a completed and thorough investigation into R14's allegations of abuse.

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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 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 each resident received adequate supervision to prevent accidents for 1 (R3) of 3 residents reviewed for falls out of a sample of 16.R3 had four falls within a month's time. R3 has frequent falls. The facility has not completed root cause analysis for three of the falls to implement appropriate fall interventions.Evidenced by:The facility policy entitled Accidents and Supervision- [NAME] Edge Nursing and Rehab, dated 1/2026, states, in part: . Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1) Identifying hazard(s) and risk(s). 2) Evaluating and analyzing hazard(s) and risk(s). 3) Implementing interventions to reduce hazard(s) and risk(s). 4) Monitoring for effectiveness and modifying interventions when necessary.Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents.1. Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident.b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident.3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: .f. Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidence-based practice. R3 was admitted to the facility on [DATE] and has diagnoses that include dementia, anxiety, unsteadiness on feet, and unspecified fall.R3's Quarterly Minimum Data Set (MDS) Assessment, dated 3/5/26, shows that R3 has a Brief Interview of Mental Status Score (BIMS) of 6 indicating R3 has severe cognitive impairment.R3's Care Plan, dated 9/13/25, states, in part: . Focus: I am at risk for falls related to dizziness. Fell in the past 31-180 days, use of medication. Repeated fall risk- 7 falls since 3/2026 r/t (related to): cognitive impairment/unaware of safety. Date Initiated: 9/17/25.Goal: I will not have a serious injury requiring hospitalization as a result of a fall. Date Initiated: 9/17/2025. Revision on: 6/16/2026. Target Date: 9/08/2026.Focus: I have a physical functioning deficit related to: Self-care impairment, decrease cognition, weakness. Date Initiated: 9/17.2025.I transfer independently- I sometimes use my walker when I remember. Date initiated: 9/17/2025 Revision on: 6/16/2026.Locomotion: Independent ambulation using walker. Sometimes I need reminders to use my walker. Date Initiated: 9/17/2025. R3's Fall Report 3/26/25: Date: 3/26/26 7:30AM.Incident Description: . Resident was found on floor with head and back resting on 2 pillows. Resident says they slowly lowered herself to the ground because she was tired.Immediate Action Taken: Resident had vital signs taken immediately and then a ROM (Range of Motion) assessment, skin assessment and pain assessment were done. Resident stated no pain, had ROM [SIC] and skin assessment was [SIC]. Vitals were [SIC] except the BP (Blood Pressure) being slightly elevated. Noted that her bed was not locked. Dr notified. Updated POAHC (Power of Attorney for Health Care) and DON (Director of Nursing). Staff educated to make sure beds are locked.IDT (interdisciplinary team) Weekly Fall, dated 3/26/26: Date: 3/26/26 Time: 7:30AM Location of fall: Her Room.Root/cause Analysis/cause of fall: Resident found on floor with head and back resting on two pillows. Noted bed was not locked. She stated she lowered herself to the floor.Note: The report does not indicate what R3 was trying to do when she lowered herself to floor. Therefore, the intervention that would be implemented would not be specific to fall. R3's Fall Report 4/7/26: Date: 4/7/26 2:00PM Incident Location: Resident's Room.Incident Description: R3 was found lying on the floor of her room. She said she was walking and fell. She was supported off the floor by staff. No obvious injuries. Staff continues to monitor.Immediate Action Taken: R3 was supported off the floor by staff. No obvious injuries. Staff continue to observe for delayed injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Supervisor informed. NP (Nurse Practitioner) informed and requested monitoring as per protocol and to update with any changes in mental or physical status. Vital signs and neuro observations WNL (within normal limits). Phone call to son and message left. Must wear grippy socks at all times. IDT Weekly Fall, dated 4/7/26. Time: 1:00PM. Location of fall: Her room. Root/Cause Analysis/Cause of Fall: Found lying on the floor. Ambulating by herself, dementia- unaware of safety.Note: The root/cause has not been identified. The facility did not identify what R3 was trying to do when she fell. R3's Fall Report 4/28/2026: Date: 4/28/2026 10:50AM. Incident Location: Resident's Room.Incident Description: Patient found sitting on the floor in her room. Unable to tell nurse what happened. Questioning if she had self-transferred from bed and lost balance. Noted to have her grippy socks on. Patient doesn't remember how she ended up on the floor. I didn't get hurt.Immediate Action Taken: RN (Registered Nurse) assessed. VSS (Vital Signs Stable). Neuro checks WNL. Full ROM to upper and lower extremities. No injuries noted. No non-verbal s/sx (signs and symptoms) of pain. Dr. notified. Updated son. Risks and Benefits completed. Medication review per pharmacy consult.IDT Weekly Fall dated 4/28/26: .Time :10:50AM. Location of Fall: Her room.Root Cause Analysis/Cause of Fall: Resident found sitting on floor in her room. Self-transferring and lost balance. On 6/16/26 at 11:00 AM, Surveyor interviewed DON B (Director of Nursing) regarding R3's falls. Surveyor asked DON B what the root/cause was for R3's fall on 3/26/26. DON B indicated she was unsure. DON B indicated maybe R3 was getting up to go to the bathroom or breakfast. DON B indicated R3 was unable to give an answer due to dementia. Surveyor asked DON B if the root/cause should be identified with each fall regardless of if the resident is cognitively impaired or not to be able to implement an appropriate intervention. DON B indicated yes, the facility tries to but R3 is a frequent faller. Surveyor asked DON B what the root/cause was for R3's fall on 4/7/26. DON B indicated unknown. DON B indicated R3 was unable to answer what she was doing at the time of the fall. Surveyor asked DON B what the root/cause was for R3's fall on4/28/26. DON B indicated R3 was unable to tell staff what she was doing. She was self-transferring. Surveyor asked DON B how R3 ambulates and transfers. DON B indicated independently. Surveyor asked DON B how the facility would know what intervention to implement without knowing the root/cause of falls. DON B indicated she sees what Surveyor is saying and understands.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for experiences and preferences in order to eliminate or mitigate triggers that may care re-traumatization for 1 of 1 residents reviewed (R9) for PTSD (Post-Traumatic Stress Disorder).R9's Psychosocial Assessment and Trauma Informed Care Assessment indicated R9 has a history of childhood physical abuse by father while growing up. The facility did not implement a Trauma Informed Care Plan for R9. Evidenced by:The facility policy entitled Trauma Informed Care-[NAME] Edge Nursing and Rehab, dated 1/2026, states, in part: . Policy: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.Policy Explanation and Compliance Guidelines: .4. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions.6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the resident's care plan.7. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma. R9 was admitted to the facility on [DATE] and has diagnoses that include schizophrenia (a complex, chronic brain disorder that impairs a person's ability to interpret reality).R9's Quarterly Minimum Data Set (MDS) Assessment, dated 6/4/26 shows that R9 has a Brief Interview of Mental Status (BIMS) score of 12 indicating R9 has moderate cognitive impairment. R9's Psychosocial Assessment, dated 3/23/26, states, in part: . Abuse Assessment:In the past year has the patient been hit, kicked, or physically hurt by another person? Was hit 4 times, shoulder and head by his roommate. Argued over who to listen to on tv for music.Has the patient ever been abused? Yes. [name] his father, physically abused him while growing up.Developmental History: .Describe any traumatic experiences in the childhood: Father cursed him. R9's Trauma Informed Care Assessment, dated 6/15/26, states, in part: . Score: 1.Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic.1. Have you ever experienced this kind of event? Yes. R9's Care Plan does not include a trauma informed care plan. On 6/16/26 at 12:40PM, Surveyor interviewed SW E (Social Worker) and asked the process for care planning for a resident with a traumatic event in their past. SW E indicated on admission a Trauma Informed Care Assessment is completed. If answer yes to the question a care plan for trauma informed care is implemented. Surveyor showed SW E R9's Psychosocial assessment dated [DATE] regarding abuse assessment and R9's Trauma Informed Care Assessment, dated 6/15/26. Surveyor asked SW E if she would expect a Trauma Informed Care Plan to be in place for R9. SW E indicated yes. Surveyor asked SW E if there is a Trauma Informed Care Plan in place for R9. SW E reviewed R9's Care Plan and indicated no, she does not see one. SW E indicated there should be and she must have missed it for R9. On 6/16/26 at 3:00PM, Surveyor asked NHA A (Nursing Home Administrator) if she would expect a trauma informed care plan to be in place for R9 if a psychosocial assessment showed R9 had a childhood history of physical abuse. NHA A indicated yes. Surveyor informed NHA A of R9's Psychosocial Assessment and Trauma Informed Care Assessment indicating R9 had a history of childhood physical abuse by father growing up and R9 does not have a Trauma Informed Care Plan in place. NHA A indicated she would expect R9 to be care planned for trauma.