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	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivers Edge Nursing and Rehab	1000 N. Wisconsin Ave. Muscoda, WI 53573

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that each resident receives food that is palatable and at a safe and appetizing temperature. This has the potential to affect all 37 residents who reside in the facility. Food being held in the steam table, did not meet the required hot holding temperature. Four residents (R26, R 31, R36, R46) voiced concerns about food being cold. Evidenced by: Facility policy, entitled Food Preparation and Service, last revised January 2025, includes in part: . Food Preparation, Cooking and Holding Temperatures and Times. 1. The danger zone for food temperatures is between 41 degrees F and 135 degrees F. The temperature range promotes the rapid growth of pathogenic microorganisms that cause food borne illness. The following internal temperatures/times for specific foods must be reached to kill or sufficiently inactivate pathogenic microorganisms: c. Fish and other meats - 145 degrees F for 15 seconds. c. Fresh, frozen or canned fruits/vegetables - 135 degrees F. 6. Previously cooked food must be reheated to an internal temperature of 165 degrees F for at least 15 seconds. Food Service/Distribution, 3. The temperature of foods held in steam tables will be monitored by food and nutrition services staff. Facility policy, entitled Metal Stem Food Thermometers: Calibration includes in part: . Policy: It is the policy of the Dietary department to ensure that handheld thermometers for ascertaining that food thermometers for food temperatures – at time of preparing, cooking, storing, or holding foods – are in satisfactory functioning condition to register accurate temperatures. Procedure: 1. Each numbered thermometer will be tested for accuracy at least one time per week, by the Food Service Department/designee. 5. The new, number engraved thermometer is to be entered on the tracking sheet for subsequent weekly quality assurance monitoring of handheld, metal stemmed thermometers. 6. The Director of Food Service is responsible for ensuring that the handheld, metal stemmed thermometers are engraved with an assigned numbers are tested weekly and that the findings/actions taken are recorded on the tracking sheet, accordingly. 7. Recorded tracking of the accuracy of handheld, metal stemmed food thermometers will be retained in a logbook. At least six month's records are to be retained at any given time. Example 1 On 9/26/25 at 11:15 AM Surveyor observed DC D (Dietary Cook) near the steam table. DC D indicated the food was taken out of the oven at 10:45 AM. Surveyor asked DC D to take a temperature reading of the food in the steam table. DC D used a food grade thermometer to temp the food and got the (continued on next page)

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

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	525321	A. Building B. Wing	12/01/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	following results: Hamburgers- 100 degrees F (Fahrenheit), French Fries- 70 degrees F. DC D indicated these temperatures are too low and she does not think she has enough water in the steam table or in the pan with the hamburgers. Surveyor asked DC D when she routinely takes a temperature reading of the food in hot holding. DC C indicated she only temps the food coming out of the ovens and does not take the temperature again before serving the food.Of note, all residents who receive meals are served from the steam table being used. On 9/25/25 at 1:05 PM DC D indicated that food can be in hot holding at 10:30 AM and start plating at noon. DC D stated she does not re temp the food in hot holding prior to plating. DC D indicated that today she would have used the original temperatures out of the oven and not re temped prior to serving. Surveyor asked DC D how often calibration is done on the thermometers. DC D answered monthly. On 9/29/25 at 3:15PM Surveyor interviewed DM C. How often should thermometers be calibrated. DM C responded weekly. DM C indicated that she did not have logs for the calibration. Surveyor asked DM C how often you should be temping the food. DM C indicated she would be temping when it comes out of the oven, then before she serves from the steam table. On 9/29/25 at 3:30 PM NHA A indicated that thermometers should be calibrated weekly, and that food should be temped both coming out of the oven and before serving. Example 2 R36 was admitted to the facility on [DATE]. R36's most recent MDS (Minimum Data Set), with a target date of 8/11/25, indicates a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating R36 is cognitively intact. 0n 9/25/2025 9:45 AM R36 indicated that food was hot only 50% of the time. Eggs and toast are always ice cold. Example 3 R26 admitted to the facility on [DATE]. His most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 8/27/25 indicates R26's cognition is moderately impaired with a BIMS (Brief Interview for Mental Status) score of 10 out of 15. On 9/24/25 at 11:20 AM R26 indicated he receives his hot food cold at times. R26 indicated this happens a few times a week. Example 4 R46 admitted to the facility on [DATE]. His most recent MDS with ARD of 9/21/25 indicates R46'a cognition is intact with a BIMS score of 14 out of 15. On 9/24/25 at 11:35 AM R46 indicated his hot food comes cold and at a undesirable temperature. Example 5: R31 admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS) with an (continued on next page)

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	525321	A. Building B. Wing	12/01/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assessment Reference Date (ARD) of 9/27/25 indicates R31's cognition is intact with a Brief Interview of Mental Status (BIMS) score of 15 out of 15. On 9/24/25 at 11:24 AM, Surveyor interviewed R31 and asked her how the food was at the facility. R31 replied that the food was lousy, really bad and that is one thing that still needs a lot of improvement. R31 stated there is no way I could eat a reasonable diet living here and most of the food is not what I would call edible. Surveyor asked R31 if she ate in the dining room or in her room. R31 stated that she ate in her room and that sometimes the food was hot but most of the time it was not hot. R31 stated I never order French fries. I like French fries but they never come hot and they are always undercooked so I can't eat them here. The facility did not ensure that each resident receives food that is palatable and at a safe and appetizing temperature

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	525321	A. Building B. Wing	12/01/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect all 39 residents who reside in the facility. Surveyor observed hairlike dust built up in the frame of the drop ceiling, along the electrical covers, and on top of the outlets in the main kitchen, in the freezer unit, and in the refrigerator unit. Surveyor observed Mighty Shakes to be in the refrigerator thawed with no thaw dates. Surveyor observed a cup left in the sugar bin that had been used as a scoop. Surveyor observed cereal in large plastic containers with a use by date that had passed. Surveyor observed frozen drips in and on boxes of food that is no longer sealed by the manufacturer and ice built up inside of the facility's walk-in freezer over opened boxes of food.Surveyor observed cookie dough to be opened and resealed without an open date inside of the facility's freezer.Surveyor observed a stored stand mixer to have been stored unclean. Surveyor observed staff remove a pan from the clean dishware storage rack that was stored unclean. Surveyor observed the microwave to have different colored food particles on the inside top and a large orange spill. Staff continued to use the microwave to heat resident food without covering and without cleaning the spills/splashes. Surveyor observed broken tiles on the floor around the sink, near the refrigerator, and under the coffee pot. Staff indicated there was no way to sanitize the cracked tiles. Surveyor observed missed hand hygiene opportunities while dishwashing. DA F used a dirty rag from her pocket to dry clean trays before putting clean dishes on it. Evidenced by:Example: Food datingOn 9/24/2025 at 9:45 AM, during initial tour of the kitchen, Surveyor observed cereal in large round bins (Bran Flakes exp 9/10/25) (Rice Krispies exp 9/14/25). Surveyor observed a bag of frozen cookie dough opened and then resealed but not labeled or dated. Surveyor observed two plastic containers of soup covered with plastic wrap with no label or expiration date. DC D (Dietary Cook) indicated all items in dry storage/refrigerator/freezer should have labels and be dated.Surveyor observed a tray of Mighty Shakes in the facility refrigerator. The shakes were completely thawed and did not have any thaw dates noted. The shakes state on the container that they should be discarded within 14 days. DC D indicated that the mighty shakes had been thawed yesterday for today, but no one had dated them. Surveyor observed a sugar bag in a garbage can. A plastic cup was in the bottom of the garbage can. DC D indicated that she used this cup as a scoop. She was unaware that the scoop needed to have a handle on this. DC D discarded the scoop in the trash. Example: Uncleanliness On 9/24/25 at 10:00 AM during initial tour of the kitchen, Surveyor observed fans/pipe/light in refrigerator had dirt and grime on them. Surveyor observed the freezer fan had dirt and grime on them. The Condenser was iced up (approximate size of 2-liter bottle), and ice was building up on the back, right side of the ceiling. There were open boxes below both iced areas. DC D stated that the maintenance man comes and de-ices the freezer every couple of days. Surveyor observed a pipe alongside the oven going up to the ceiling was full of dirt and grime with webs hooked to the ceiling, Surveyor observed numerous ceiling tiles with dirt in corners of the tiles throughout the kitchen ceiling and the tiles touching the wall. Surveyor observed the mixer was put away dirty, removed cover, under carriage and stand itself had debris, and pieces of food on it. DC D indicated that the mixer should be cleaned before being stored. Surveyor observed DC D pulling out a baking pan to use and stated it was dirty. DC D indicated it needed to be rewashed.Surveyor observed the inside of the microwave had red/pink dried liquid on turntable and walls. DC D indicated staff heated up soup last night and didn't clean the inside. Surveyor observed broken tiles on the floor around the sink, near the refrigerator, and under the coffee pot. Staff indicated there was no way to sanitize the cracked tiles. On 9/30/28 at 3:15 PM NHA A (Nursing Home Administrator) indicated that maintenance is currently getting quotes for tiles to order and replace the current tiles. NHA A indicated that there would be no way to sanitize the tiles. Example: DishwashingOn 9/29/25 at 11:30 AM Surveyor observed DA F (Dietary Aide) rinsing dirty (continued on next page)

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	525321	A. Building B. Wing	12/01/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dishes and go to clean dishes and put them away without washing her hands between dirty and clean. Surveyor observed DA F wearing an apron with a pocket in the front to wash dirty dishes. DA F then pulled out a dirty rag from her pocket of the apron and wiped a tray off and put clean cups on the tray. DA F stated that she thought she washed her hands both times, but she may have forgot. DA F stated that no one ever told her about changing aprons when going from dirty side to clean side. DA F stated she understood why and would do that from now on.

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	525321	A. Building B. Wing	12/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, this has the potential to affect the census (39). The facility has no documentation of Infection Control Surveillance prior to August of 2025. The facility does not have documentation that Infection Control Policies and Procedures were reviewed annually. The facility does not have Infection Control rates documented. The facility has not been completing Legionella testing per their Water Management Plan. The facility has not completed their monthly NHSN (National Healthcare Safety Network) reporting since July. This is evidenced by: Example 1The only infection control documentation the facility could locate was from August of 2025 forward.On 9/29/25 at 10:37 AM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist). Surveyor asked DON/IP B regarding the infection control documentation prior to August 2025, DON/IP B stated, I started August 1st, I don't know about prior, it's not in our computer system under the infection control tab, we are unable to find an infection control binder from the previous DON. Example 2The facility does not have documentation that infection control policies and procedures were reviewed annually.The following policies and procedures were undated; Infection Control Program, Infection Surveillance, Antibiotic Stewardship, Influenza vaccine, Pneumococcal vaccine, and COVID vaccine. Norovirus policy and procedure dated 3/1/19. Hand hygiene policy and procedure dated 1/8/20. Legionnaire's disease policy and procedure dated 6/1/24.On 9/29/25 at 10:37 AM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist). Surveyor asked DON/IP B how often the infection control policies and procedures should be reviewed, DON/IP B stated policies should be reviewed annually, if they are not updated they should have been. Example 3The facility has no documentation that they are calculating monthly infection control rates by type.On 9/29/25 at 10:37 AM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist). Surveyor asked DON/IP B about the infection control rates, DON/IP B stated I have not been tracking monthly rates based on infections because I don't have access to the infection control part of our computer system. Example 4The facility does not have documentation of any Legionella testing.Per the facility's Water Management Plan, review date of 8/21/25: .performing at a minimum 2 (biannual) tests per year .On 9/25/25 at 10:15 AM, Surveyor interviewed MD S (Maintenance Director). Surveyor asked MD S if he could locate Legionella testing documentation, MD S stated no Legionella testing has been done since I started. Surveyor asked MD S when he started, MD S replied February 2025. MD S went on to state that tests have been ordered and will start once they arrive.On 9/29/25 at 1:32 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if Legionella testing should have been done, NHA A stated yes we should be testing, we ordered the tests, we are waiting on them to arrive and we will test then. I am aware we were not, and we need to be. Example 5The facility currently does not have access to NHSN (National Healthcare Safety Network) to complete their monthly reporting and confer rights.On 9/25/25 at 2:42 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A how long the facility has been without access to NHSN for reporting and conferred rights, NHA A stated, since July-ish when the receivership took place.On 9/29/25 at 10:37 AM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist). DON/IP B explained they are unable to complete NHSN reporting because no one has access, we are working on getting that, but we do not have anyone yet.

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	525321	A. Building B. Wing	12/01/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure they maintained medical records on each resident in accordance with professional standards of practice. This has the potential to affect 1 of 16 sampled residents (R3) and 3 of 3 supplemental Residents ((R27, R28, & R44) reviewed for medical records.R27's medical information was observed accessible in an unsecured area on 9/24/25.R28's medical information was observed accessible in an unsecured area on 9/24/25.R44's medical information was observed accessible in an unsecured area on 9/24/25.R3's medical information was observed accessible in an unsecured area on 9/24/25.Findings include:Facility policy, entitled HIPAA Security Measures, dated 3/1/19, includes, in part: Policy: It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality. of the resident's identifiable information. R27 was admitted to the facility on [DATE].R28 was admitted to the facility on [DATE].R44 was admitted to the facility on [DATE].R3 was admitted to the facility on [DATE].On 9/24/25 at 11:14 AM, Surveyor observed the medication cart on the 100 hallway with a form lying face up on the cart, halfway covered by another piece of paper. Surveyor observed the following names were left uncovered: R27, R28, R44, and R3. Surveyor observed this form included these residents' names, room numbers, medications, and other protected health information. Surveyor interviewed MT M (Med Tech) who was passing medications on the 100 hall. Surveyor asked MT M if the information that was uncovered was protected health information. MT M stated yes, and that usually the form was flipped over or covered while left out on top of the med cart.On 9/24/25 at 11:17 AM, Surveyor interviewed RN K (Registered Nurse) about resident's protected health information. RN K indicated that identifiable information related to residents should not be left unattended and visible on the medication carts. On 9/24/25 at 12:17 PM, Surveyor interviewed DON B (Director of Nursing) and shared with her the observation of resident information being visible on top of the medication cart. DON B indicated that the information that was visible was resident protected health information, and that staff should protect residents' private information, and should not leave paperwork with private information out and accessible to other residents or visitors.

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	525321	A. Building B. Wing	12/01/2025

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility did not provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals, to meet the needs for 1 of 16 sampled Residents (R31).R31 was observed with a cup of pills sitting on her bedside table. R31 did not have an order to self-administer medications, nor did she have an assessment completed to determine her competency for self-administering medications.This is evidenced by:The facility policy titled, Self-Administration of Medications, dated 10/25/14, states, in part: Policy: . residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. Procedures: A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive. physical, and visual ability to carry out this responsibility. B. If the resident indicates no desire to self-administer medications, this is documented in the appropriate place in the resident's medical record, and resident is deemed to have deferred this right to the facility.The facility policy titled, Medication Administration, undated, states, in part: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines:. 15. Observe resident consumption of medication.R31 was admitted to the facility on [DATE] and has diagnoses that include Type 2 Diabetes Mellitus, Muscle Wasting and Atrophy, Muscle Weakness, Other Reduced Mobility, Unsteadiness on Feet, Unspecified Dementia, Major Depressive Disorder, and Mild Cognitive Impairment of Unknown Etiology.R31's most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 9/27/25, indicated that R31 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R31 is cognitively intact. R31's Care Plan, dated 4/19/22, states in part: Focus: .Resident has history of refusals such as showers, Accu-checks, wound care, repositioning, and medications. Interventions: Administer medications as ordered.R31's Clinical Health Status Assessment, dated 3/31/23, indicates that resident does not wish to self-administer medications.Of note: R31 does not have a physician's order to self-administer medications, nor was there a competency assessment anywhere in R31's medical record for self-administering of medications.On 9/24/25 at 11:29 AM, Surveyor observed R31 in bed with a cup of medications in front of her on the bedside table. Surveyor asked R31 if those were her morning medications. R31 indicated that yes, those were all of her AM medications but that she wasn't ready to take them yet.On 9/29/25 at 11:17 AM, Surveyor interviewed MT M (Med Tech) and asked her if R31 was safe to self-administer her own medications. MT M stated that she didn't believe so but that she would double check. Surveyor observed MT M look up the information in R31's EHR (Electronic Health Record). MT M indicated that no, R31 did not have a physician's order to self-administer her own medications. Surveyor asked MT M if she normally would leave R31's medication on her table or if she would watch to ensure that she took them. MT M stated that she would stay there and make sure that R31 swallowed all of her medications before leaving the room. On 9/29/25 at 11:35 AM, Surveyor interviewed DON B (Director of Nursing) and asked her how she would determine if someone was safe to administer their own medications. DON B indicated that they would need to do a self-administration assessment. DON B stated that these are done upon admission or later if a resident decides that they want to take their own medications. Surveyor asked DON B who was responsible for completing the self-administer assessments. DON B indicated that the nurses do those. Surveyor asked DON B if there were any self-administer assessments or physician orders for R31. DON B stated no because her medications are administered by the staff. Surveyor asked DON B if R31 was safe to self-administer her medications. DON B indicated that no, R31 was not safe to self-administer medications. Surveyor (continued on next page)

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	525321	A. Building B. Wing	12/01/2025

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shared with DON B her observation of R31 having a cup of pills left in her room in front of her on the bedside table. Surveyor asked DON B if MT M should have remained with R31 while she took her medications, given that she was not safe to self-administer them. DON B stated absolutely that meds should not be left at R31's bedside and that MT M should have remained to watch R31 take them. On 9/29/25 at 11:42 AM, Surveyor interviewed R31 about the medications that had been left on her bedside table. R31 stated that the staff always leave the medications in a cup on the table until she is ready to take them. R31 stated that she has a colostomy and that she has to wait until her stomach feels good before she can take any medications. The facility's failure to adequately assess and supervise medication administration enabled the resident to keep medications at the bedside and self-administer without demonstrating competency to do so.

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	525321	A. Building B. Wing	12/01/2025

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview the facility did not provide the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) and did not provide the accurate potential financial liability to residents whose Medicare coverage was ending for 3 of 3 residents reviewed (R2, R8, and R50).R2 was receiving Medicare A benefits. R2 was not provided the SNFABN form thus not provided with the accurate financial liability. R8 was receiving Medicare A benefits. R8 was not provided the SNFABN form thus not provided with the accurate financial liability. R50 was receiving Medicare A benefits. R50 was not provided the SNFABN form thus not provided with the accurate financial liability. Evidenced by:The facility's policy titled Advance Beneficiary Notice dated 10/01/22 states in part .5. The current CMS (Center for Medicare and Medicaid Services)- approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form. a. For part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), Form CMS-10055.Example 1R2's Medicare coverage ended on 7/3/25. R2 was not provided with a SNF ABN form. R2 was not informed of his entire potential liability and reason for ending of benefits. Example 2R8's Medicare coverage ended on 5/7/25. R8 was not provided with a SNF ABN form. R8 was not informed of her entire potential liability and reason for ending of benefits.Example 3R50's Medicare coverage ended on 8/20/25. R50 was not provided with a SNF ABN form. R50 was not informed of her entire potential liability and reason for ending of benefits.It is important to note that Surveyor requested SNF ABN/ NOMNC (Notice of Medicare Non-coverage) information for R2, R8, and R50, BOM R (Business Office Manager) wrote on the SNF Beneficiary Protection Notification Review form I didn't know I needed ABN- just did training on NOMNC/ ABNs. Additionally, BOM R printed out a copy of CMS-R-131 form for each resident, unsigned, which is not the correct form.On 9/29/25 at 10:05 AM Surveyor interviewed BOM R. Surveyor asked BOM R how long she had been completing the SNF ABNs, BOM R stated she started doing them in June 2025. BOM R stated that she had just completed the training for SNF ABNs last week. Surveyor asked BOM R if residents that are being discharged from Medicare A services should receive a SNF ABN, BOM R stated that if they are staying in the facility, they should.On 9/29/25 at 10:15 AM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if she would expect that residents receive a SNF ABN form, NHA A stated yes.

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	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivers Edge Nursing and Rehab	1000 N. Wisconsin Ave. Muscoda, WI 53573

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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	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, 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.

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	525321	A. Building B. Wing	12/01/2025

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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 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 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 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.

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	525321	A. Building B. Wing	12/01/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility did not complete the PASRR Level II (Preadmission Screening and Resident Review) for residents having a major mentalDisorder and are receiving psychotropic medications to treat behaviors or symptoms of a major mental disorder affecting 1 of 3 residents (R8) reviewed for PASRR. R8 admitted to the facility with a major mental disorder and is receiving psychotropic medications. The facility did not ensure that a PASRR level 2 screen was performed by the PASRR contractor. Evidenced by: The Preadmission Screen and Resident Review Level 1 Screen directions include, in part, the following: 42 CFR 4830128(a) requires that the resident or his/her legal representative receive a written notice (copy of this front page) if the resident is suspected of having a serious mental illness or a developmental delay, and therefore, will require a Level II Screen. You may tell the resident or his/her legal representative that the Level II Screen will determine if the resident does have a serious mental illness or developmental disability, as defined in the federal regulations, and if so, if the resident is appropriate for nursing facility placement and if the resident needs specialized services or specialized psychiatric rehabilitative services to address his/her disability needs. Section D- Referring a person for a level 2 screen. If you have answered yes to any questions in section A and no to all of the exemptions listed in section B, follow these instructions: Contact the PASRR Contractor to notify them that the person is being considered for admission. Forward a copy of the Level 1 Screen to the PASRR Contractor (a copy must also be maintained by the nursing facility). The PASRR Contractor will perform a Level 2 Screen to determine if the person has a developmental disability and/or a serious mental illness as defined by the federal PASRR regulations and if so then whether or not the person needs nursing facility placement and if the person needs specialized services. The screening agency will notify the nursing facility, the county of responsibility and the resident or his representative, in writing of the determinations. Facility policy, titled PASRR, undated, includes: It is the policy of this facility to Complete and maintain a PASRR Level 1 screening for all new admissions, regardless of payer source. Ensure that individuals who screen positive receive a level 2 evaluation before admission unless an emergency categorical determination applies. R8 initially admitted to the facility on [DATE] and her most recent re-admission was on 2/19/25. Her diagnoses include Major Depressive Disorder and Schizoaffective disorder. R8's PASRR, dated 4/7/23, includes: Section A: Does the person have a major mental disorder: Yes. Has the person received psychotropic medications to treat symptoms or behaviors of a major mental disorder: Yes. Medication List: Aripiprazole and Escitalopram. Section B: hospital discharge exemption, 30 day maximum: No. Emergency placement- 7 day maximum: No. Respite Care- 7 days maximum: No R8's Physician Orders, for 9/1/25-9/30/25, include: Escitalopram Oxalate Tablet 5 MG (milligrams). Give 5 mg by mouth in the morning related to Major Depressive Disorder. Aripiprazole Tablet 5 MG. Give 5 mg by mouth in the morning related to Schizoaffective disorder. On 9/30/25 at 8:27 AM SW Q (Social Worker) indicated R8 should have had a level 2 screen completed. SW Q indicated she has not had training on PASRR policy and procedure yet. SW Q indicated she has been filling out PASRR 1 forms for residents after admission and she thought they should be done prior to admission. On 9/30/25 at 12:30 PM NHA A (Nursing Home Administrator) indicated R8 should have a PASRR 2 and she would make sure this was corrected today.

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	12/01/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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 did not ensure that residents received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 2 of 3 sampled residents (R29 and R4). On 9/19/25, R29 was being pushed in his wheelchair by staff when his foot came off the foot pedal and was run into by the wheelchair wheel. There is no indication that R29's foot was assessed by an RN (Registered Nurse). R4 has a diagnosis of CHF (Congestive Heart Failure) and experienced a 23 pound weight increase in a week. The facility failed to notify R4's Medical Doctor, failed to assess R4 for symptoms of complications related to CHF, failed to provide continued close monitoring of CHF exacerbation such as checking for edema and listening to lung sounds, and the facility failed to notify R4's Registered Dietician timely for consultation. Evidenced by: 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. The facility policy, entitled RN Assessment – Standard of Care, undated, states, in part: When Required: Incidents: Falls, Injuries, Bruises. Expectations: 1. Immediate Response: RN must access the resident promptly after staff report an incident/accident. 2. Comprehensive Assessment: Vital signs. pain assessment, skin assessment, mobility and functional status. 3. Documentation: RN assessment note in the medical record. Include description of event, resident's baseline, current findings, and interventions. Notification of physician and responsible party as appropriate. 4. Follow-up: Monitoring schedule based on severity. Completion of incident/accident report with RN signature. Example 1: R29 was admitted to the facility on [DATE] with diagnoses that include, in part: Multiple Sclerosis (a chronic autoimmune condition that affects the brain and spinal cord), Type 2 Diabetes Mellitus, Muscle Wasting and Atrophy multiple sites, Paraplegia unspecified, Muscle Weakness generalized, and Unspecified Abnormalities of Gait and Mobility. R29's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/5/25, indicates, in part, that R29 has a Brief Interview of Mental Status (BIMS) Score of 13 out of 15, indicating that R29 is cognitively intact. Section GG indicates that R29 uses a manual wheelchair and is dependent upon (continued on next page)

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	525321	A. Building B. Wing	12/01/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff for all mobility needs. R29's Baseline Care Plan indicates, in part:Focus: I have a physical functioning deficit related to: Mobility impairment, Self care impairment, Diagnosis (Dx) Multiple Sclerosis (MS), paraplegia, morbid obesity, weakness, pain. I choose not to get out of bed at times. Date Initiated: 9/13/25. Interventions: . Transfer assistance of three with Hoyer unless using bariatric Hoyer. Date Initiated: 8/28/25. Revision on: 9/5/25. Unable to ambulate. Date Initiated: 8/28/25. Revision on: 9/5/25. On 9/24/25 at 10:20 AM, Surveyor interviewed R29 who stated that his left foot had been run over a couple of weeks ago by his wheelchair while being pushed by staff. R29 stated that it was an accident and wasn't the staff member's fault. R29 could not recall the name of the staff member who was pushing the wheelchair. R29 indicated that his left ankle still hurts at times. On 9/19/25 at 7:23 PM, a Progress Note is written by LPN O (Licensed Practical Nurse) in R29's EHR (Electronic Health Record) that states, [Resident Name] was outside being pushed around in wheelchair today around noon and his foot came off his footrest and hit the ground. It was somewhat bent weird and he states it hurts now. Upon initial assessment after this happened he was having mild pain which is a little worse now. He got Tylenol for the pain. I am going to recheck and reassess but as of now there is no swelling or redness. (Of note: According to N6, Wisconsin Nurse Practice Act LPNs cannot perform assessments, only gather data to report to an RN. No RN signed off on this and there is no indication if an RN was notified and completed an assessment) On 9/21/25 at 11:48 AM, a Progress Note is written by LPN O in R29's EHR that states, Reassessed ankle today. Still no signs of swelling, redness, or bruising. He is still having some pain with it so he is getting his PRN (as needed) Tylenol which helps. On 9/22/25 at 11:01 AM, a Progress Note is written by LPN P in R29's EHR that states, PT (Physical Therapy) working with resident and reporting increased pain of left ankle and calf, noted r/t (related to) an incident that occurred on 9/19/25. There is no swelling, there is faint yellow swelling on the inner aspect of his left ankle, no swelling, redness, or bruising noted to his left calf. Call placed to [Dr Name] and informed, requesting an x-ray to r/o (rule out) injury. On 9/23/25 at 1:49 PM, a Progress Note is written by LPN P in R29's EHR that states, Results of x-ray received. Left foot: two view. Results: no acute fracture, no dislocation. Conclusion: no obvious or acutely displaced fracture. On 9/23/25 at 2:38 PM, a Progress Note is written by LPN P in R29's EHR that states, Resident reports 'my ankle still hurts'. No redness, swelling or warmth present. Foot is tender with assisted movement i.e. when lifted up off bed to prop left foot on a pillow he states 'that hurts' and facial wincing. Instructed med aide to administer PRN Tylenol. On 9/23/25 at 7:08 PM, a Progress Note written by LPN T in R29's EHR states, Resident's x-ray is negative for Fx (fracture) to left ankle. Continues to c/o (complain of) pain to area. No redness or swelling noted. Tylenol given as ordered upon request. On 9/29/25 at 3:22 PM, Surveyor interviewed LPN O, who stated that she was pushing R29 outside in his Broda chair when his foot fell off the wheelchair pedal. LPN O stated that R29 does not have a lot of control over the one side of his body because he had a stroke, and he didn't feel his left leg falling (continued on next page)

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	525321	A. Building B. Wing	12/01/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out. LPN O stated that the foot slipped out of the pedal area and hit the ground as they were going forward. LPN O indicated that the foot didn't really get run over, just slipped off the pedal and hit the ground. LPN O stated that she stopped right away and set it back on the pedal. LPN O stated that they then went back inside so she could look at it. LPN O stated that she checked it out and there was no redness or swelling. LPN O stated that the next day, I assessed it and there was no bruising or swelling or redness or anything. LPN O indicated that R29 did say that it was causing him a little bit of pain, so she gave him PRN Tylenol which seemed to help. Surveyor asked LPN O if an RN had completed an assessment on R29's foot after the incident. LPN O stated that at some point that day or the next day she had somebody else look at it, she thought it had been RN K (Registered Nurse). Surveyor asked LPN O if she had notified the physician of the incident. LPN O indicated that she had not called the doctor at that time. On 9/29/25 at 3:45 PM, Surveyor interviewed LPN P about the incident involving R29's foot. LPN P stated that she found out about the incident on 9/22/25 when she worked. LPN P stated that it was the Physical Therapist (PT) who told her about the occurrence and that it actually happened on 9/19/25. LPN P indicated that it was the PT who recommended that an x-ray be obtained and that prompted her to call the doctor and order an x-ray. Surveyor asked LPN P if an RN assessment was completed. LPN P indicated that there was no redness or swelling and that there was some yellowish bruising that looked like it was old. LPN P stated that she put the incident on the 24-hour report herself so that there would be continued monitoring and reiterated that she did not know anything about the incident until the therapist informed her of it. LPN P indicated that an RN assessment should have been completed at the time of the incident. On 9/30/25 at 9:36 AM, Surveyor interviewed PT N (Physical Therapist) about the incident involving R29's foot. PT N stated that, to his knowledge, R29 was up in a Broda chair or a wheelchair when the foot got injured during transport. PT N stated that he went to see R29 for a scheduled appointment and R29 told him about it. PT N stated he assessed the ankle and found there was discomfort about the left ankle and told the RN about it. PT N indicated he recommended to get an x-ray, which they did. On 9/30/25 at 9:59 AM, Surveyor interviewed RN K (Registered Nurse) about the incident involving R29's foot. RN K indicated that she had no knowledge of the incident. Surveyor asked RN K if she had worked on 9/19/25. RN K stated that she wasn't sure but that if the schedule indicated she worked, then yes, she would have been working that day. RN K stated that no one reported anything to her about it, and she had not completed an assessment on R29's foot. RN K indicated that the first time she had heard anything about it was at this time from the Surveyor. On 9/30/25 at 10:08 AM, Surveyor interviewed DON B (Director of Nursing) about the incident involving R29's foot. DON B stated that she wasn't notified of the incident until 9/22/25 when PT N had taken a look at his foot and recommended getting an x-ray. DON B stated that was the first time she was made aware of it. Surveyor asked DON B if it would have been her expectation that an RN assessment be completed on R29's foot after the incident. DON B stated yes, that would have been her expectation and that no, it was not done in this instance. Example 2 R4 originally admitted to the facility on [DATE] with diagnoses that included Chronic Systolic Congestive Heart Failure (CHF) (the hearts left ventricle (heart chamber) cannot pump blood effectively), acute chest pressure, and expressive aphasia (partial loss in ability to express (continued on next page)

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	525321	A. Building B. Wing	12/01/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	language). R4's Physician Orders, include weekly weights on Thursday. R4's recorded weights are as follows: 6/26/25 177.07/17/25 176.37/29/25 176.3(It is important to note the missing weight for this week) 8/14/25 180.08/21/25 179.08/28/25 178.09/3/25 201.0 (No evidence of an RN assessment being completed regarding R4's 23-pound weight gain despite R4 having CHF. R4's chart does not contain evidence of monitoring for CHF exacerbation such as checking for edema and listening to lung sounds. No documentation was provided for 9/3 indicating R4's MD or RD was notified of the weight gain.) R4's recorded weight 9/4/25 201.4 R4's MD's (Medical Doctor) Note, dated 9/4/25, includes: Visit reason: Follow up on chronic problems, visit at facility. He has a history of cerebrovascular disease with expressive aphasia. active problems: Chronic HFrEF (heart failure with reduced ejection fraction). weight 9/4/25 178 pounds, blood pressure 110/60, respirations 14, pulse 74, temperature 97.2 pulse oximetry 92% . (It is important to note R4's MD Note does not include the most recent weight of 201.4.) R4's recorded weight 9/7/25 201.4R4's recorded weight 9/11/25 200.6 R4's Dietary Note, dated 9/16/25, includes: Significant weight change. weight gain 1 month, 3 months, 5 months is significant, desired, planned. Etiology of weight gain most likely due to improved intakes; meal intake pattern trending upward towards 76-100% . Current body weight 200.6 pounds. Body Mass Index (BMI) 27.3 normal limits for age group.9/18/25 200.2 R4's Interdisciplinary Note, dated 9/18/25, includes: weight gain is desirable. R4's recorded weight 9/25/25 200.8 On 9/25/25 at 2:46 PM during an interview RD L (Regional Registered Dietician) indicated her company started with the facility the week of 9/8/25. RD L and Surveyor reviewed R4's weights. RD L indicated there was quite a jump from 8/28/25 to 9/3/25. RD L stated, We would go off of whatever the nurse reported. I would hope they would alert us and look into it further that week. RD L indicated staff should notify the Registered Dietician of significant weight changes, notify the resident's Medical Doctor of significant weight changes, and the Registered Nurse should be assessing for other signs and symptoms, especially with a diagnosis of CHF. RD L indicated she would like to know if lungs sound are clear or if the resident presents with edema. On 9/25/25 at 10:27 AM DON B (Director of Nursing) indicated the facility had a lapse in dietician coverage. DON B indicated the facility is to notify the resident's MD and the RD of significant weight changes, especially with a resident who has a diagnosis of CHF. DON B indicated she expects to see an RN assessment with a significant weight gain and CHF that includes lung sounds and if edema is present. DON B indicated the facility did not re-educate staff on notifying the RD and the MD of significant weight changes or on RN assessments related to CHF and weight gain.

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	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivers Edge Nursing and Rehab	1000 N. Wisconsin Ave. Muscoda, WI 53573

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility did not recognize, evaluate and address the nutritional and hydration needs of 1 of 3 Residents (R35) to reduce the risk of continued weight loss, dehydration and malnutrition. R35 did not have appropriate interventions put into place to prevent continued weight loss. R35 had a weight loss of 22.6 pounds/13.9% over 1 month, indicating a severe weight loss, and a 32 pound/18.6% weight loss in 6 months, indicating a severe weight loss.This is evidenced by:Facility policy titled, Weight Monitoring, undated, states in part, Purpose: . the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range. Compliance Guidelines: Weight can be a useful indicator of nutritional status. Significant unintended changes in weight. may indicate a nutritional problem. 1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: a. Identifying and assessing each resident's nutritional status and risk factors. c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary. 4. Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. 6. Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: a. 5% change in weight in 1 month. b. 7.5% change in weight in 3 months. c. 10% change in weight in 6 months. 7. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions. e. The Registered Dietician or Dietary Manager should be consulted to assist with interventions, actions are recorded in the nutrition progress notes.R35's most recent admission to the facility was on 5/17/23, with diagnosis that include, in part: Normal Pressure Hydrocephalus (a condition where cerebrospinal fluid (CSF), the fluid that cushions the brain, accumulates in the brain causing pressure), Type 2 Diabetes Mellitus, Unspecified Protein-Calorie Malnutrition, Dysphagia (difficulty swallowing), Muscle Wasting and Atrophy, Muscle Weakness Generalized, Gastro-Esophageal Reflux Disease (GERD, a digestive disorder where stomach contents flow back up into the esophagus, causing irritation and inflammation), Depression Unspecified, Alzheimer's Disease Unspecified, and Abnormal Weight Loss.R35's most recent Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/29/25 indicates that R35 has a Brief Interview for Mental Status (BIMS) of 8 out of 15, indicating that R35 has a moderate cognitive impairment. K0100 indicates the resident did hold food in mouth/cheeks or residual food in mouth after meals and did have coughing or choking during meals or when swallowing medications. K0300 indicates the resident did have a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a prescribed weight loss program.R35s Comprehensive Care Plan, states, in part:Focus: Resident is at potential nutritional risk related to depression, dementia, and history of (h/o) vomiting and diarrhea which has resolved. Has altered nutritional labs related to Diabetes Mellitus (DM). Date Initiated: 10/11/17. Goal: Weight will remain free of unplanned significant weight (wt) changes. Date Initiated: 10/11/17. Revision on: 8/28/25. Interventions: Diet as ordered. Date Initiated: 10/11/17. Revision on: 10/11/17. Monitor meal consumption daily. Date Initiated: 10/11/17. Revision on: 5/13/21. Monitoring through Weight Management Committee. Date Initiated: 10/11/17. Revision on: 10/11/17. Notify MD and family/responsible party of weight change. Date Initiated: 10/11/17. Revision on: 10/11/17. Focus: Resident is at risk of malnutrition related to (r/t) advanced age, need for therapeutic and mechanically altered diet, DM (Diabetes Mellitus), unspecified protein-calorie malnutrition, dysphagia, anemia, anorexia, GERD (Gastroesophageal Reflux Disease), depression, Alzheimer's. Goal: . Resident will have no significant weight changes per MDS criteria. Weight goal: maintenance. Resident will consume and tolerate >50% of meals consistently to help maintain good skin integrity with no signs/symptoms (s/s) of dehydration or malnutrition. Date Initiated: 4/13/25. Revision on: 8/28/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Diet as ordered: controlled carbohydrate diet, mechanical soft texture, Regular (thin) consistency. Date Initiated: 10/25/17. Revision on: 4/25/24. Fortified cereal. Date Initiated: 8/10/23. Revision on: 4/30/25. Monitor meal consumption daily. Date Initiated: 10/25/17. Revision on: 5/6/22. Provide encouragement during meals. Date Initiated: 11/8/23. Weights per order, monitor skin integrity. Date Initiated: 10/25/17. Revision on: 4/30/25.R35's Physician Orders state, in part: -CCHO (Consistent Carbohydrate Diet) Mechanical Soft texture. Regular (thin) consistency may have toast cut up into small pieces for. dysphagia. Order Date: 2/27/24. No end date.-Fortified cereal in the morning for supplement. Order Date: 8/10/23. No end date.-Monthly weight one time a day starting on the 1st and ending on the 2nd every month for monthly weight. Order Date: 5/15/23. No end date.R35's weights were documented as follows:10/24/24: 170 lbs. (pounds)11/28/24: 167 lbs.12/27/24: 166.4 lbs.1/23/25: 170.8 lbs.2/17/25:170.8 lbs. 3/27/25: 171 lbs.4/2/25: 171 lbs. 5/2/25: 172 lbs.6/2/25: 162.8 lbs. (Note: This is a 9.2-pound weight loss in 1 month).7/2/25: 162.6 lbs.8/1/25: 140 lbs. (Note: This is 22.6-pound weight loss in 1 month and a 32 pound/18.6% loss since 5/2/25).8/2/25: 147.8 lbs.9/1/25: 164.8 lbs. (Note: This is a 17-pound weight gain in 1 month).9/2/25: 154.6 lbs. (Note: This is over a 10.2-pound weight loss in 1 day, no evidence of a re-weigh being completed)9/29/25: 158.4 lbs.(Of note: R35 lost 9.2 pounds in 30 days between 6/2/25 and 7/2/25 with no indication that R35's weight was rechecked for accuracy, no new orders were received from the MD, no new recommendations from the Registered Dietician (RD), and no update to R35's care plan. R35's weight loss continued with an additional 22.6-pound weight loss between 7/2/25 and 8/2/25). On 8/17/25 at 8:57 AM, a Mini Nutritional Assessment was completed for R35, which states, in part: . No decrease in food intake. No weight loss. The Resident has normal nutritional status - No care planning action is required.On 8/27/25 at 3:02 PM, a Physician Progress Note was completed for R35, which states, in part: . Patient seen for a 5% weight loss this past 30 days. Patient has had a weight loss of 160 lbs on 7/18/25 to 147.3 lbs on 8/12/25. She denies any new medications or illnesses. States not sure why she is losing weight. Weekly weight for 4 weeks and then review medications and diet.(Of note: This note indicates that R35 was seen by the MD 25 days after her severe weight loss. There is no order in R35's Physician Orders for weekly weights, nor were weekly weights obtained.)On 9/24/25 at 2:45 PM, Surveyor interviewed R35 and asked her about the food at the facility. R35 indicated that it really wasn't to her liking. Surveyor asked R35 if she had had a weight loss. R35 indicated that she may have lost some weight but was unsure how much.On 9/25/25 at 2:57 PM, Surveyor interviewed RD L (Regional Dietitian), who stated that she started with the facility on 9/8/25. Surveyor asked RD L what her expectations would be with a resident who had severe weight loss. RD L stated that it would be her expectation that staff get a re-weight right away and notify the dietician or the doctor so that a cause of the weight loss could be determined, and a conversation could be had about supplementation or treatment to mitigate further weight loss.On 9/29/25 at 9:18 AM, Surveyor interviewed CNA I (Certified Nursing Assistant) about R35's weight loss. CNA I stated that the CNAs obtain the weights and give them to the nurses to enter into the Electronic Health Record (EHR). CNA I stated that R35 has never been a big eater, and that even though they try to prompt her, they can't make her eat. CNA I stated that the family brings in snacks for R35, and that she likes her sweets, which she prefers to eat over the facility meals.(Of note, a review of R35's meal intakes indicate that most of the time R35 eats 75-100% of her meals).On 9/29/25 at 9:20 AM, Surveyor interviewed CNA J about R35's weight loss. CNA J stated that R35 doesn't like most of the meals served by the facility, and that sometimes she refuses meals and will eat the snacks in her room or not at all. CNA J stated that R35's weight changes could be in part that there is not consistency in the way that some of the staff get the weights. CNA J stated that sometimes R35 could be weighed with her wheelchair pedals on and sometimes off. Surveyor asked CNA J if R35 had foot pedals for her wheelchair. CNA J stated no, R35 did not usually use foot pedals and didn't even have any in her room.On 9/29/25 at 10:19 AM, Surveyor interviewed RN K (Registered Nurse) about R35's weight loss. RN K stated that she would have the staff reweigh a resident who (continued on next page)

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	525321	A. Building B. Wing	12/01/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had a big change from the last weight. Surveyor asked RN K if the EHR system would flag if a resident had a big change in weight. RN K stated yes, the system would flag and then she would have the staff recheck the weight. Surveyor asked RN K what the process would be if a resident had a significant weight loss. RN K stated that the doctor might want the weights monitored for a week and then the doctor would tell them to get in touch with the dietician to change their diet and increase their calories. RN K indicated that they would also look at what the cause of the weight loss might be. Surveyor asked specifically about R35's weight loss. RN K looked in the facility's EHR, and noted that she had a weight loss from 160 pounds to 140 pounds. RN K stated that in that instance she would have the staff reweigh her, but that it didn't look like that had been done. RN K noted that R35 had a significant weight loss from the time that she came into the facility.On 9/29/25 at 10:35 AM, a Dietary Progress Note was entered into R35's EHR by RD L, which states, in part: . She triggers for a significant weight loss of 6.1% overnight 9/1 to 9/2, she also triggers a significant weight gain of 5.4% in 30 days, this is following a significant weight loss noted in August. Unclear reason for weight loss in August at this time. All weight fluctuations possibly related to variable meal intake. Recommend a reweight to confirm 9/2 weight. Significant weight changes are not desirable or planned. Recommend adding fortified pudding daily (qd) with lunch and reweigh. Resident is at risk for malnutrition r/t (related to) advanced age, therapeutic diet, mechanically altered diet, need for fortified foods, significant weight changes.(Of note, this would indicate a severe weight loss not a significant loss.)On 9/29/25 at 11:33 AM, Surveyor interviewed DON B (Director of Nursing) about R35's weight loss. Surveyor asked DON B what the process was if a resident had a significant or severe weight loss. DON B indicated that they discuss them at weekly Nutrition at Risk (NAR) meetings. Surveyor asked DON B who was responsible for monitoring the weights. DON B stated both the dietician and nursing, and if there is a discrepancy in weights the doctors also need to be notified. DON B stated when the nurses are entering the weights they should be looking to see if there is a change from the previous weight. DON B indicated that if there is a significant change in weight it would flag in EHR. Surveyor asked DON B who was responsible for monitoring meal intakes and appetite. DON B stated the CNAs fill out the meal intake sheets daily, then they come to her, and she would monitor intakes and outputs. Surveyor asked DON B if she would expect a reweigh if someone had a 20-pound weight change from the previous month. DON B stated yes, she would expect the nurse to ask the CNAs for a reweigh or if the dietician would order a reweigh the CNAs should get that right away. Surveyor asked DON B if she would expect the doctor to be notified of such a large weight loss. DON B stated yes, if a significant weight loss or weight gain, she would expect the doctor to be called. Surveyor asked DON B if she was aware of R35's weight loss. DON B indicated that it was brought up and discussed at the NAR meeting last Thursday. Surveyor asked DON B if she considered R35's weight loss to be significant. DON B stated yes, and that she should have been reweighed for accuracy and the dietician or doctor notified. Despite R35's severe unintended weight loss, the facility failed to obtain reweights to ensure accuracy, failed to evaluate her care plan and implement interventions to prevent further decline. The facility failed to recognize R35's severe weight loss as a significant change in condition, and the MD and RD were not notified, which led to further weight loss.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident's drug regimen was free from unnecessary medications for 3 of 5 residents reviewed for unnecessary medications (R7, R1, and R3). R7 is on sleep medication and the facility failed to assess and document sleep pattern and routinely monitor the medication. R1 is on sleep medication and the facility failed to assess and document sleep pattern and routinely monitor the medication. R3 is receiving Ambien for sleep disorder. The facility failed to complete a sleep assessment and have continued monitoring for sleep behaviors. Evidenced by: The facility policy, Hypnotic Medication, no date, states, in part;.It is the policy of this facility to: Use hypnotic medications only when clinically necessary and after non-drug interventions have been attempted and documented.Prior to initiating a hypnotic: Assess and document sleep pattern, contributing factors (pain, environment, anxiety, caffeine, medications), and non-drug interventions tried. Document reason for medication and measurable goals. Obtain informed consent from resident or legal representative.Nursing monitors: Effectiveness and side effects each shift. Fall risk and morning sedation. Example 1 R7 was admitted to the facility on [DATE] with a diagnosis including major depressive disorder, altered mental status, mild cognitive impairment, dementia, and insomnia. R7's orders state, in part;.Amitriptyline HCL Oral Tablet, Give 100mg by mouth at bedtime related to insomnia.Trazodone HCL Oral Tablet, Give 2 tablet by mouth at bedtime related to insomnia. On 9/30/25 at 1:23PM, Director of Nursing B (DON) indicated if a resident is on a hypnotic medication the resident should have a sleep assessment completed as well as routine monitoring. The facility failed to complete sleep assessments prior to residents starting hypnotic medications as well as provide routine monitoring. Example 2 R1 was admitted to the facility on [DATE] with diagnoses that include atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), acute kidney failure, anxiety, and insomnia. R1's physician orders state in part Zolpidem Tartrate Oral Tablet 5 mg (milligrams)- Give 1 tablet by mouth at bedtime for insomnia with a start date of 7/21/25. On 9/30/25, Surveyor requested documentation of R1's sleep assessment. No sleep assessment was (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided. On 9/30/25 at 1:23PM, Director of Nursing B (DON) indicated if a resident is on a hypnotic medication the resident should have a sleep assessment completed as well as routine monitoring. Example 3 R3's physician orders state Ambien Oral Tablet 10 mg (milligrams). (Zolpidem Tartrate) Controlled drug Give 10 mg by mouth at bedtime for sleep disorder. On 9/30/25, Surveyor requested documentation of R3's sleep assessment. No sleep assessment was provided. On 9/30/25 at 1:23 PM, Director of Nursing B (DON) indicated if a resident is on a hypnotic medication the resident should have a sleep assessment completed as well as routine monitoring. The facility failed to complete sleep assessments prior to residents starting hypnotic medications as well as provide routine monitoring.