STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Riverside		STREET ADDRESS, CITY, STATE, ZIP CODE 2575 S 7th St LA Crosse, WI 54601	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not ensure that 4 of 6 residents (R) reviewed for pressure injuries (PI) (R58, R89, R9, and R28) received care consistent with professional standards of practice to prevent the development of a new pressure injury and promote healing of existing PIs. R58 was admitted with multiple PIs and was at risk for PI development. R58 developed an unstageable PI. The facility did not reposition R58 for several hours. R89 was at risk for PI development. The facility failed to evaluate the effectiveness of current interventions R89 had in place. The facility did not reposition R89 for several hours and did not off-load heels and coccyx. R9 and R28 have existing PIs. R9 and R28 were not repositioned to promote healing of existing PIs or prevent pressure injuries from developing. Findings include: Example 1 R58 was admitted to facility on 01/30/24 with diagnoses which included in part: hypertension, hyponatremia, pressure injury to the right ankle stage 3, unstageable pressure injury to the right heel, stage 2 pressure injury to the sacral region, and bullous pemphigoid. R58's Minimum Data Set (MDS) assessment, dated 01/31/24, identified R58 scored 15 during a Brief Interview for Mental Status (BIMS), indicating cognition intact. MDS identified R58 required total dependent assistance of two people for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and for transfers. MDS also indicated that R58 was determined to be at risk for PIs. Surveyor reviewed R58's Braden skin risk assessment completed on 01/30/24 scored 15 at risk for pressure injury. Surveyor reviewed R58's admission skin assessment completed on 01/30/24 indicating R58 had a PI to foot stage 3, left heel unstageable PI, stage 3 PI to the right lateral bunion scabbed over at present time. (continued on next page)

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

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed Activities of Daily Living (ADL) CNA Kardex sheet: -Minimize time sitting in wheelchair to less than 2 hours at a time during meals. -Lay resident down after lunch. -Transfer Hoyer with 2 assists. -The resident is totally dependent on staff for bed mobility and repositioning and turning in bed 1-2 person assist. -Staff is to assist with turning and repositioning. Surveyor reviewed R58's IMPAIRED SKIN Care Plan: -Skin will remain intact initiated on 01/30/24, revised on 06/24/24. -CNA to observe skin during AM/HS cares report changes to nurse initiated on 01/30/24. -Pressure redistribution cushion in chair initiated on 01/30/24. -Pressure redistribution mattress initiated on 01/30/24. -Nurse to complete a systematic skin inspection on assigned bath day. Complete weekly skin assessment observation and wound management, including measurements, when appropriate initiated on 01/30/24. -Assess and record the condition of the skin surrounding the pressure ulcer initiated on 01/30/2024. -Assess the pressure ulcer for location, stage, size (length, width, and depth), presence/absence of granulation tissue and epithelization weekly initiated 01/30/2024. -Conduct a systematic skin inspection weekly. Report any signs of further skin breakdown initiated 01/30/2024. -Keep clean and dry as possible. Minimize skin exposure to moisture initiated 01/30/2024. -Keep linens clean, dry, and wrinkle free initiated 01/30/2024. -Observe and report signs of osteomyelitis (pain, redness, swelling in affected joint, muscle spasms in affected joint, chills, fever (rapid elevation), diaphoresis, tachycardia, restlessness, irritability) initiated 01/30/2024. -Observe and report signs of sepsis (fever, lassitude or malaise, change in mental status, tachycardia, hypotension, anorexia, nausea, vomiting, diarrhea, headache, lymph node tenderness/enlargement). initiated 01/30/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Podiatry and wound care appointments as scheduled initiated 01/30/2024. -Treatment: see TAR for specifics initiated 01/30/2024. -Turn and reposition routinely per protocol initiated 01/30/2024 and reviewed/revised on 06/26/24. Surveyor reviewed weekly skin assessments and noted: -On 06/20/24 a new skin event initiated and indicated pressure ulcer discovered in house acquired stage 1 pressure injury to the right ischium. Right ischium had area of non-blanchable erythema measuring 2x1.5cm with surrounding skin blanchable red measuring 5x4cm. Interventions being used or put into place indicates: *Skin will remain intact initiated on 01/30/24, revised on 06/24/24. *Turn and reposition routinely per protocol initiated 01/30/2024 and reviewed/revised on 06/26/24. *Pressure relieving gel pad on commode initiated on 06/24/24. -On 06/26/24 wound zoom documentation indicates: Right posterior iliac crest Superficial wound measuring 3.4cmx4,4cmx0.10cm. Surveyor's interview with Director of Nursing on 9/9/24 indicates on 6/20/24, the wound nurse noted a red area with a small area that was non-blanchable. Due to its indurated nature, it was monitored closely as it was not easily classifiable due to it possibly being a blister from bullous pemphigoid. In addition, it was found R58's daughter had brought in his previous custom-made ish-dish seat cushion R58 used prior to admission. It was sitting in his recliner at the time of the assessment. R58's daughter brought this when she took him to last wound appointment. The wound nurse immediately took this cushion away and placed the roho cushion to be used. R58's daughter was educated and took it home with her. This ish-dish is hard and would cause pressure on the ischium. On 6/24/24, R58 was admitted to the hospital with possible sepsis related to his chronic UTI. Resident has a suprapubic catheter and history of cancer. The hospital did not note the PI area during his hospital stay and it was not addressed while he was admitted there. R58 returned on 6/26/24 with a declined wound status of right hip. Upon the admission skin assessment, R58 was also found to have a new pressure injury to buttocks, suspicious of DTI. In-house provider saw the resident on 6/27/24 for follow-up. Resident was also experiencing possible extremity cellulitis and another exacerbation of bullous pemphigoid due to illness: Given patient's known bolus pemphigoid it was thought this may be related to a new flare up due to the stress of the acute illness. R58 was seen again by in-house physician on 7/2/24 to follow up on the bullous pemphigoid exacerbation and cellulitis. R58 was started on an antibiotic and Lasix for edema at that time. The wound appears to be intact but continued to be monitored as area of concern. Physician orders in part: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/26/24: ADL - Toileting: Suprapubic Catheter, Cont/Incont Bowels, Hoyer A x 2 to commode, 100% non-weight bearing to right lower extremity. Special Instructions: Encourage less than 15 minutes on commode. On 06/26/2024: Check (SpanAm Alternating) air mattress is properly inflated every shift. Special Instructions: Firmness setting to resident's comfort level Three Times A Day. On 06/26/2024: Barrier skin prep to L medial heel discoloration BID. Twice A Day. On 06/26/24: Check (ROHO) cushion placement and proper inflation every shift. Three Times A Day. -On 07/03/24 weekly skin assessment missed. -On 07/03/24 wound zoom documentation indicates: Right posterior iliac crest (ischium) wound measuring 3. 6cmx4.0cmx0.00cm. Thick discolored well adhered callous. -On 07/10/24 wound zoom documentation indicates: Right posterior ischium PI unstageable measuring 3. 4cmx3.2cmx0.00cm. -On 07/17/24 wound zoom documentation indicates: Right posterior iliac crest wound 3.4cmx3.7cmx0.20cm, Black well adhered leathery necrotic tissue covering majority of open area. **Physician orders: On 07/22/2024: Repositioning 2 hours. Every Shift. On 07/24/24 weekly skin assessment completed. On 07/31/24 weekly skin assessment completed. **Physician orders: On 08/02/24: BLE Rooke boots off at AM, on at HS. Twice A Day. On 08/02/24: Document any refusal of repositioning, sitting on commode, or up in wheelchair every shift. Special Instructions: Patient should be allowed time tilting side to side in bed between meals. Minimize time sitting in wheelchair to less than 2 hours at a time during meals. On 08/06/24: ADL - Skin: Rooke Boots to BLE at HS only, SpanAM Alt. Mat, Roho, Enc Repos Q 2 hours (REPO SHEET), Aquaphor L leg/foot & R leg daily. Physician visit note on 7/11/24 indicates that R58 was out for an appointment with his wife for several hours and was sitting on a hard surface cushion that R58's wife had provided during this outing. (continued on next page)

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/12/24, the facility completed a risk benefit agreement with R58 regarding limiting the time on the commode and educated on the risks of developing a PI, if R58 chose to sit longer on the commode. The facility added a gel cushion to the commode to prevent pressure. Physician note on 8/2/24 in part, It is reasonable to think that this was a bulllous pemphigoid blister that worsened due to resident's choice to sit on commode . Physician orders: On 08/15/24: Try to spend time up in chair limited to 1-2 hours at a time, encourage to lay down in bed between meals twice a day. -On 08/21/24 wound zoom documentation indicates unstageable PI to the posterior right ischial 2.7cmx2.9x0. 20cm, no tunneling, no undermining. On 08/26/2024: Treatment to Right ischium: Special Instructions: Offload ischium frequently. Use cushion in recliner or similar cushion. Every Shift - PRN Observations were made of resident not being repositioned for 2.5 hours on 08/26/24. On 08/26/24 at 11:01 AM, Surveyor observed R58 sitting in wheelchair, Hoyer sling underneath, and R58 watching TV. On 08/26/24 at 12:33 PM, Surveyor observed R58 sitting in wheelchair, Hoyer sling underneath and R58 watching TV. On 08/26/24 at 1:37 PM, Surveyor observed Registered Nurse (RN) T lay R58 down into bed to complete wound dressing changes. Surveyor reviewed repositioning schedule from 08/26/24 that did not have documentation of R58 refusing to be repositioned. On 08/26/24, documentation indicates R58 stayed sitting in wheelchair from 8:00AM-2:00PM. Observations were made of resident not being repositioned or toileted for 5 hours on 08/27/24. On 08/27/24 at 7:51 AM, Surveyor observed staff place R58 on commode. On 08/27/24 at 8:18 AM, Surveyor observed staff transfer R58 off R58's commode. Staff observed R58 sitting on commode for 27 minutes and staff did not follow R58's care plan. On 08/27/24 at 10:27 AM, Surveyor observed R58 sitting in wheelchair with Hoyer sling underneath R58. Surveyor did not observe R58 repositioned or offered repositioning. On 08/27/24 at 12:22 PM, Surveyor observed R58 still in wheelchair with Hoyer sling underneath R58. Surveyor did not observe R58 repositioned or offered repositioning. R58 sitting in room visiting with family. On 08/27/24 at 12:48 PM, Surveyor observed R58's daughter ask Certified Nursing Assistant (CNA) M if CNA M could transfer R58 to recliner as R58 was requesting to be repositioned off bottom. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/27/24 at 1:26 PM, Surveyor observed R58's daughter come out to hallway and scan for staff. Surveyor heard R58's daughter state to R58 that when staff get a chance staff will lay R58 down soon. On 08/27/24 at 1:28 PM, Surveyor observed CNA M enter R58's room and ask R58 if everything was ok. R58 requested to be placed in recliner. CNA M and a student CNA transferred R58 via Hoyer into recliner. On 08/27/24 at 1:38 PM, Surveyor interviewed R58's daughter and asked if R58's daughter had any concerns with R58's repositioning. R58's daughter indicated that she believes the staff try to get to R58 when they have time. R58's daughter indicated she understands there is an issue with a pressure injury on R58's bottom. R58's daughter indicated that R58 wants to relieve pressure off R58's bottom but doesn't always get the help right away but that facility staff do their best. On 08/27/24 at 2:05 PM, Surveyor interviewed CNA M and asked if R58 was repositioned anytime in the day other than before placing R58 into recliner. CNA M indicated that R58 has been in wheelchair all day because R58 refuses sometimes and R58 had a visitor little before lunch time. Surveyor reviewed repositioning schedule from 08/27/24 that did not have documentation of R58 refusing to be repositioned. On 08/27/24 from 6:00 AM until 2:00 PM there was no documentation of refusing or repositioning of R58. On 08/28/24 at 7:58 AM, Surveyor interviewed CNA C and asked how the repositioning schedule charting worked for R58. CNA C indicated that if it is care planned that staff reposition residents every so often then CNAs chart on the repositioning schedule and then it gets scanned in every so often into the EHR. CNA C indicated that R58's repositioning schedule was to reposition every 1-2 hours, and up for maximum of 1-2 hours in chair. CNA C indicated that CNA C documents when R58 is repositioned on the sheet. On 08/28/24 at 9:21 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation was for repositioning R58. DON B indicated that all residents should be repositioned every two hours. Surveyor asked DON B if DON B has a repositioning policy in place. DON B indicated the facility does not have a repositioning policy, but that expectation is for staff to follow standards of practice and reposition every 2 hours. DON B indicated that R58 sometimes refuses but that when this occurs staff should document the refusal in the Electronic Health Record (EHR). Surveyor indicated to DON B that upon review of the repositioning schedule and Surveyor's observations, Surveyor found missing documentation on repositioning or refusals for R58. Surveyor indicated to DON B that Surveyor observed R58 sitting in wheelchair for up to 5 hours without being off loaded off R58's bilateral ischiums and coccyx. Surveyor asked DON B if R58's PI on the right ischium could have been avoidable. DON B indicated that originally facility thought the PI on the right ischium was from sitting on commode for long periods of time. The facility initiated limited time on the commode to 15 minutes, but R58 is his own person and insists on sitting longer at times. A risk benefit education has been done with R58. DON B indicated that staff should have offered; if R58 refused, then staff are to document this. DON B indicated the facility implemented a gel cushion for the commode as well and increased the repositioning frequency. DON B indicated that staff are still to offer or reposition every 1-2 hours with R58 while R58 is up in wheelchair, recliner or lying in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at 2:05 PM, Surveyor interviewed DON B and Nursing Home Administrator (NHA) A and asked if there was any other information to provide with observations of no repositioning for R58 and evidence of off-loading during Surveyor's observations from 08/26/24 and 08/27/24. DON B indicated that at this time there was no other information to provide. Example 2 R89 was admitted to facility on 08/01/24 with diagnoses which included in part: acute respiratory failure with hypoxia, right heart failure, hypertension, and acute kidney failure. R89's Minimum Data Set (MDS) assessment, dated 08/07/24, identified R89 scored 15 during a Brief Interview for Mental Status (BIMS), indicating cognition intact. MDS identified R89 required total dependent assistance of two people for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and for transfers. MDS also indicated that R89 was determined to be at risk for PIs. Surveyor reviewed physician orders: -Check ROHO cushion placement and proper inflation every shift. -Check Span AM air mattress is properly inflated every shift. Special instructions pump to resident's firmness preference. -Encourage to float heels. -Encourage to turn and reposition every two-four hour with care. Surveyor reviewed R89's Braden skin risk assessment completed on 08/01/24 scored 13 at moderate risk for pressure injury. Surveyor reviewed R89's admission skin assessment completed on 08/01/24 indicating R89 had gluteal crease and buttocks with incontinence associated dermatitis with fungal involvement. Surveyor reviewed Activities of Daily Living (ADL) CNA Kardex sheet: -Roho cushion. -Encourage to float heels. -Encourage to turn and reposition every two-four hour with care. -Bed mobility assists of two. Surveyor reviewed R58's IMPAIRED SKIN Care Plan: -Skin will remain intact initiated on 08/01/24. -CNA to observe skin during AM/HS cares report changes to nurse initiated on 08/01/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pressure redistribution cushion in chair initiated on 08/01/24. -Pressure redistribution mattress initiated on 08/01/24. -Nurse to complete a systematic skin inspection on assigned bath day. Complete weekly skin assessment observation and wound management, including measurements, when appropriate initiated on 08/01/24. Observations were made of R89 not being repositioned for 4 hours on 08/27/24. On 08/27/24 at 7:29 AM, Surveyor observed R89 lying in bed supine at a 45-degree angle directly on the coccyx and R89's heels directly on the bed. R89 was sleeping soundly in bed. Surveyor did not observe staff offer or reposition R89. On 08/27/24 at 9:25 AM, Surveyor observed R89 lying in bed supine at a 45-degree angle directly on the coccyx and R89's heels directly on the bed. R89 had just finished eating breakfast. Surveyor did not observe staff offer or reposition R89. On 08/27/24 10:27 AM, Surveyor observed R89 lying in bed supine at a 45-degree angle directly on the coccyx and R89's heels directly on the bed. LPN S entered to give morning medications. Surveyor did not observe staff offer or reposition R89. On 08/27/24 at 11:29 AM, Surveyor observed LPN S and Hospice nurse roll R89 to the right side and perform peri cares. LPN S noted that the slit on R89's coccyx/sacrum area was a new slightly opened area. Surveyor observed the bilateral coccyx area had redness and superficial breakdown. LPN S applied [NAME] and capisopom as ordered and repositioned R89 back to R89's back. Surveyor observed R89 placed back on back and heels directly on R89's bed. On 08/27/24 at 11:35 AM, Surveyor interviewed LPN S and asked LPN S what process LPN S follows for proceeding with a new finding of skin breakdown for R89. LPN S indicated that LPN S would review orders and progress notes to see if the current treatments being completed presently covers the skin breakdown observed to R89's sacrum/coccyx area. LPN S indicated two weeks ago when he was assessing R89's bottom that the breakdown was not there. LPN S indicated that LPN S will be checking the EHR for skin breakdown changes and report to charge wound nurse as soon as possible and begin standing orders and daily assessments. Surveyor asked what LPN S's expectation for repositioning R89 is. LPN S indicated that R89 should be repositioned off the coccyx area every 2 hours and heels floated. LPN S indicated that LPN S did not reposition R89 off R89's bottom and did not elevate R89's heels at this time as LPN S is unsure the last time R89 was repositioned. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at 1:36 PM, Surveyor interviewed DON B and asked about expectation for alternating mattress. DON B indicated that the alternating mattress is based on resident's comfort for pressure levels and there is no set parameters or expectations of use. Surveyor asked DON B if R89 had weekly skin assessments completed since admission on 08/01/24 as Surveyor could only find 08/01/24, 08/09/24, and 08/24/24. Weekly skin assessment was not completed for 08/15/24. DON B indicated that the weekly assessment on 08/15/24 was missed. Surveyor asked DON B when the facility noted a suspected DTI on the left inner heel area and why this was not assessed again on the weekly skin assessments since admission. DON B indicated that there has been a staffing crisis and turnover and that the further assessment of the suspicious DTI on left inner heel has been missed. Surveyor asked DON B what interventions other than redistribution mattress on bed and cushion in chair was in place to prevent further breakdown for R89. DON B indicated that is expectation that R89 be repositioned every 2 hours as the standards of practice. On 08/28/24 at 2:05 PM, Surveyor interviewed DON B and Nursing Home Administrator (NHA) A and asked if there was any other information to provide with observations of no repositioning for R89. DON B indicated at this time there was no other information to provide. 46694 Example 3 R9 was admitted on [DATE] from an acute care hospital stay with the following diagnoses, in part, pressure ulcer of right lower back, Kyphosis (is a condition where your spine curves outward more than it should). R9's Braden risk assessment score of 11.0 which indicated R9 was at risk for development of a pressure injury. R9's admission baseline care plan identified R9 had a stage 3 PI to left mid back with interventions in place to reposition every 2-4 hours, a ROHO cushion for R9's buttocks and a waffle cushion for R9's back. R9's admission Minimum Data Set (MDS) assessment, dated 06/03/24, identified R9 was at risk for development of a pressure injury and had a stage 3 pressure injury. On 08/26/24, Surveyor observed R9 sitting in R9's Broda chair from 9:54 AM until 2:01 PM without being repositioned. On 08/27/24, R9 was brought out to the hallway at 9:35 AM where R9 ate breakfast. At 11:48 AM, R9's lunch tray was brought, and no repositioning was offered. On 08/28/24, Surveyor observed R9 from 9:28 AM until 11:20 AM. Resident was not repositioned during that time. At 11:30 a.m., R9's significant other came, and they went to the dining room. On 08/28/24, Surveyor reviewed wound zoom notes for R9. Wound changes on 06/12/24 the mid back PI measured 1.6cm X 1.1cm and on 06/19/24 the same wound measured 2.4cm X 1.9cm with an increase of 2. 2cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor asked Assistant Director of Nursing (ADON) L for an explanation for this increase in surface area. ADON L informed Surveyor that R9 required an iron infusion on 06/17/24 which R9 had to sit in a standard wheelchair instead of the broda chair for an extended amount of time. Example 4 R28 was admitted on [DATE] with diagnoses, in part, Lewy Body dementia (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function), obesity and Parkinsonism. R28's Braden risk assessment score of 14 dated 07/20/24 indicated R28 had a moderate risk for development of a pressure injury. R28's Minimum Data Set (MDS) assessment, dated 07/26/24, identified R28 was at risk for development of a pressure injury and had no unhealed pressure injuries. R28's medical chart, dated 08/04/24 at 4:24 PM, states in part, Writer observed what appears to be a deep tissue injury (DTI) on left buttock measuring 1cm X 1cm. R28's care plan states in part, Possible DTI to left buttock discovered 8/04/24 at 14:00 Discoloration-Non-blanchable purple area to left buttock 1 X 3cm No blood loss wound edges not applicable .Immediate measures taken cleansed area, topical ointment, other- reposition side/side. On 08/27/24, Surveyor observed R28 from 8:15 AM until 12:44 PM; resident remained on the right side in bed no offloading observed with SPAN air mattress on level 3 alternating. On 08/28/24 at 2:08 PM, Surveyor interviewed RN J about the start of R28's DTI. On 08/04/24, R28 was willing to go in bed as opposed to the recliner. Chamosyn was ordered to R28's skin with cares and instituted documentation of refusals of repositioning. On 08/05/24, labs drawn indicated mild dehydration from poor oral intake. This was just prior to R28's UTI. R28's mobility decreased. The SPAN air mattress was instituted on 08/09/24. R28 has documented repositioning refusals on 08/09/24, 08/10/24 and 08/14/24. 49353

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181 Based on observation, interview and record review, the facility did not prepare, distribute, and serve food in accordance with professional standards for food service safety. Staff touched ready to eat foods with contaminated gloves when preparing and serving toast to two residents (R66 and R57). Staff carried uncovered food trays in the hallway for R62, R393, R43, R20, R42, R392 and R73. Findings include: Example 1 Facility policy and procedure entitled, Bare Hand Contact with Food and Use of Plastic Gloves, stated in part, .3. Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 4. Hands are to be washed when entering the kitchen and before putting on the single-use gloves (before beginning to work with food) 6. Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed . On 08/27/24 at 6:49 AM, Surveyor observed Certified Nursing Assistant (CNA) O preparing and serving breakfast from the kitchenette on the 200 unit. Surveyor observed CNA O put on gloves and take a piece of bread out of the bag and place it in the toaster. CNA O did not wash hands or use hand sanitizer before putting on the gloves. Surveyor observed CNA O fill two glasses with juice and touched multiple items, cupboard doors, and surfaces in the kitchenette with the same gloves on. CNA O then took the toast out of the toaster with the same gloves on, opened a drawer and took out a knife, buttered the toast, cut it in half, and served it to R66. CNA O then took another piece of bread and placed it in the toaster with the same gloves on that had touched multiple surfaces in the kitchenette and dining area. Surveyor observed CNA O take off the contaminated gloves, wash hands, and put on clean gloves before taking the toast out of toaster. CNA O buttered the toast and served it to R57. On 08/27/24 at 1:48 PM, Surveyor interviewed Culinary Services Manager (CSM) D and described the observation of breakfast service by CNA O on the 200 unit. Surveyor asked CSM D if CNA O was following safe food handling during the observation of preparing and serving toast. CSM D stated, no, staff was supposed to change gloves anytime they touch a potentially contaminated surface, or use a tongs before touching a ready to eat food. 49353 Example 2 On 08/27/24 at 11:43 AM, Surveyor observed certified food service cart located at the beginning of resident 500 hallway, between rooms [ROOM NUMBERS]. Surveyor observed CNA C deliver the hot lunch meal trays to residents eating in their rooms in the 500 unit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor observed CNA C remove hot meal trays from food service cart, remove the covers from main course plate and remove the covers on the cold drinks that included milk and juice. Surveyor observed CNA C carry the uncovered food trays down the hallway, past multiple rooms and people, and delivered the trays to R62, R393, R43, R20, R42, R392 and R73.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181 Based on observation, interview and record review, the facility did not 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. During the 4-day survey Surveyors had multiple observations of staff not following the Centers for Disease Control (CDC) guidance for Personal Protective Equipment (PPE) use during a COVID-19 outbreak. This had the potential to affect all 18 residents residing on the dementia unit. Surveyor observed staff not performing hand hygiene after changing soiled gloves during cares for R64. Findings include: According to CDC Infection Control Guidance: SARS-CoV-2 [COVID-19] last updated 06/24/24, in reference to use of masks or respirators, .If they are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned . The CDC guidance also includes, .Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all patient care encounters . On 08/26/24 at 9:32 AM, Surveyor entered the 200-dementia unit. Surveyor noted a sign on the outside door to the unit that stated COVID outbreak. N95 masks required for staff and visitors. On 08/26/24 at 9:40 AM, Surveyor interviewed Licensed Practical Nurse (LPN) S who stated there were four residents who tested positive for COVID-19 over the weekend, and one more resident was found to be positive this AM. LPN S stated due to the residents having dementia and wandering, they are unable to keep all of the positive residents quarantined to their rooms. LPN S stated it was also difficult to get those confused residents to comply with wearing a mask, so they were having all staff wear N95 respirators on the unit and trying to assist the residents with frequent hand hygiene. On 08/26/24 at 10:30 AM, Surveyor observed signs outside R64's door stating droplet and contact precautions. Surveyor observed R64 wandering around the hall and dining area touching multiple surfaces. Surveyor observed R64 had a runny nose and was frequently wiping nose with hands. Record review identified R64 had a diagnosis of Alzheimer's disease and had tested positive for COVID-19. On 08/26/24 from 9:30 AM to 12:45 PM, Surveyor had multiple observations of LPN S and Certified Nursing Assistant (CNA) O and CNA U donning and doffing PPE for rooms that were identified as droplet and contact precautions due to COVID-19. Surveyor observed staff wearing a surgical mask over the N95 before entering the droplet precautions rooms. Then when they left the room, they would remove the surgical mask and put a new surgical mask over the N95 without changing the N95. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/24 at 1:29 PM, Surveyor observed R47 walking down the hallway with walker independently. R47 was not wearing a mask. R47 was pleasantly confused. Record review identified R47 had a diagnosis of vascular dementia and tested positive for COVID-19 on 08/24/24. The record stated R47 was placed on enhanced droplet precautions. On 08/26/24 at 1:35 PM, Surveyor interviewed LPN S and asked what the facility policy was for N95 use in droplet precaution rooms. LPN S stated they were not sure if this was following facility policy, but LPN S was using the surgical mask to cover the N95 to save it or keep it clean. LPN S stated they did not change the N95 when leaving the droplet precaution rooms, just the surgical mask over top. Surveyor asked LPN S if they had a shortage of N95 masks, or were in a contingency plan for PPE due to shortages. LPN S did not think there was a shortage of N95 masks. On 08/27/24 at 6:24 AM, Surveyor observed CNA R exit R47's room. Surveyor noted there was a sign outside the door that said droplet plus contact precautions. Surveyor observed CNA R had a surgical mask on over N95 respirator and goggles on when exiting the room. CNA R removed the goggles and placed in the top drawer of the PPE cart outside the door. CNA R did not wipe off the goggle with a sanitizer wipe before placing them in the drawer. CNA R did not change the surgical mask or N95 after leaving the room. On 08/27/24 at 7:04 AM, Surveyor observed CNA R and CNA O prepare to enter R64's room to provide morning cares for R64. Surveyor observed both CNAs use hand sanitizer and put on a gown and gloves outside the door. CNA O already had an N95 mask on and no surgical mask over the N95. CNA R had an N95 mask with a surgical mask over the N95. Neither CNA put on goggles or eye protection before entering the room. CNA O assisted R64 to wash face and upper body while CNA R assisted with feet and legs. CNA R removed gloves and gown and used hand sanitizer before leaving the room to get more supplies. CNA R returned to the room with a gown, gloves, N95, and goggles on. CNA R did not have a surgical mask over the N95 when re-entering the room. After finishing R64's upper body, CNA O removed the gloves, and put on clean gloves. Surveyor noted CNA O did not wash hands or use hand sanitizer before putting on clean gloves. CNA O washed and dried R64's bottom and removed the old incontinent brief and threw it away. CNA O applied barrier cream to R64's bottom, removed gloves, and put on clean gloves without washing hands or using hand sanitizer. CNA O put a clean brief on R64, and CNA O and CNA R assisted R64 to dress and transfer to a wheelchair. CNA O removed gloves and washed hands in bathroom. CNA O came out with a brush and assisted R64 to brush hair with no gloves on. CNA O returned to bathroom, washed hands, and applied clean gloves. CNA O applied powder to right side of R64's neck. CNA O assisted R64 to the bathroom in wheelchair, removed gloves and put on clean gloves without using hand sanitizer between. CNA O assisted R64 to brush teeth. CNA R removed gown and gloves, used hand sanitizer, and left the room. CNA R did not remove the goggles or N95 before leaving the room. CNA R returned to the room with gown and gloves, an N95 with surgical mask over the N95, and goggles on. CNA R handed a plastic cup to CNA O who helped R64 rinse mouth. Both CNAs removed gowns and gloves and washed hands. CNA O put a gait belt around R64 and assisted her to stand. CNA R removed the surgical mask over N95, left the same N95 and goggles on, and assisted R64 to walk to the dining room. CNA R did not use hand sanitizer when leaving the room. CNA O removed the N95 in the room, carried trash and linen bags to hampers in the hall. CNA O used hand sanitizer and put on a new N95 mask and walked to dining room. Surveyor observed CNA R wearing an N95 and goggles assisting residents in the dining room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/27/24 at 7:38 AM, Surveyor observed Food Service Aide (FSA) N enter the unit wearing a surgical mask with plastic eye shield on the mask. FSA N stated they could not find an N95, and asked the CNA O if it was okay to wear that mask to check the kitchenette. CNA O stated it was their risk. Surveyor observed FSA N walk past multiple residents in the hallway and dining room to get to and from the kitchenette. On 08/27/24 at 8:07 AM, Surveyor observed CNA O use hand sanitizer and put on a gown and gloves. CNA O put a surgical mask over the N95 CNA O was already wearing and prepared to enter room [ROOM NUMBER]. Surveyor noted a sign outside the room that stated droplet plus contact precautions. Surveyor asked CNA O which resident in the room was on precautions. CNA O stated it was R13 who was on precautions due to COVID-19. CNA M stated they were going to assist R13 go to the bathroom and get washed up and dressed for the day. CNA O did not put goggles on before entering room. On 08/27/24 at 9:05 AM, Surveyor observed LPN P administer medications to R13. Surveyor noted a droplet plus contact precautions sign outside the door to R13's room. LPN P used hand sanitizer and donned a gown, gloves, goggles, and surgical mask over the N95 that LPN P was already wearing. After administering the medications, LPN P removed the gown, gloves, and surgical mask in the room and exited the room with the same N95 on. Surveyor interviewed LPN P who stated they were instructed to keep their N95 on at all times and put a surgical mask over the N95 when going in droplet precaution rooms. LPN P stated they remove the surgical mask when exiting the room and keep the same N95 on. On 08/27/24 at 9:36 AM, Surveyor interviewed Registered Nurse (RN) E who is the facility's infection preventionist. Surveyor explained multiple observations of staff inconsistently using goggles when entering droplet precaution rooms and staff not sanitizing the goggles after leaving those rooms. RN E stated everyone should be wearing goggles when entering droplet precaution rooms. RN E stated the multi-use goggles should be sanitized after use. RN E stated they have the surgical masks with the plastic eye protection attached, and they would prefer staff use those over their N95 instead of the multi-use goggles. Surveyor asked RN E what guidance they were following for N95 use in their COVID-19 unit. RN E stated they follow CDC guidance for N95 use. Surveyor asked if it was CDC guidance to wear a surgical mask over the N95 and not change the N95. RN E stated because the unit was a closed dementia unit and they were unable to keep all of the COVID-19 positive residents quarantined in their rooms, they were having the staff keep their N95s on and using a surgical mask over to decrease their risk with removing the N95s multiple times. Surveyor clarified that they were not doing this due to a supply issue and were not specifically following CDC guidance. RN E stated this was correct, they had modified the guidance and have staff wear the surgical masks over the N95 to reduce the frequency of changing the N95s on the outbreak unit. RN E stated all staff should remove the N95 when leaving the unit. Surveyor explained the observations of CNAs removing and putting on clean gloves during morning cares for R64 without performing hand hygiene between glove changes. RN E stated that was not following the facility policy. RN E stated staff should perform hand hygiene after every time they remove contaminated gloves. On 08/27/24 at 2:45 PM, Surveyor observed R47 propel self in wheelchair down the hall from room to sitting area at the end of the 200 hall. R47 was not wearing a mask. Surveyor observed R47 coughing and wiping nose with the back of hand. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at 8:41 AM, Surveyor observed FSA Q exit the 400 unit with a rolling metal cart with beverages on it. FSA Q removed the surgical face mask they were wearing and put on an N95. FSA Q did not use hand sanitizer before or after doing the mask change. FSA Q carried the surgical mask that had been removed in one hand and pushed the metal cart into the 200 unit. At 8:45 AM, FSA Q exited the 200 unit with the rolling cart. FSA Q was still holding a surgical mask in one hand. FSA Q removed the N95 and placed it on the rolling cart. FSA Q put the surgical mask on that they were holding in one hand. FSA Q took the N95 from the cart and threw it away in the trash. FSA Q pushed the rolling metal cart down the hall. FSA Q did not use hand sanitizer before or after any of the mask changes observed. FSA Q did not wipe the metal cart with a sanitizer wipe placing the used N95 on the cart during mask change. On 08/28/24 at 9:16 AM, Surveyor observed FSA Q exit the 400 unit with a surgical mask on. FSA Q walked to PPE bin outside 200 unit, took out N95 mask and put it on over the surgical mask they were already wearing. FSA Q did not use hand sanitizer. FSA Q entered the 200 unit. At 9:24 AM, FSA Q exited the 200 unit and removed the N95 mask and threw it in the trash. The surgical mask that FSA Q was wearing under the N95 came off at the same time. FSA Q put that same surgical mask back on and then used hand sanitizer. Surveyor asked if FSA Q had received training on PPE use and hand hygiene. FSA Q stated yes they were trained, but it was a long time ago. 43352 Example 2 R25 was admitted to the facility on [DATE] and has diagnoses that include, methicillin-resistant staphylococcus aureus (MRSA), acute respiratory failure, dysphagia, and anxiety disorder. There is a sign on the outside of R25's door that reads contact precautions. The facility's policy titled, Infection Surveillance & Outbreak Prevention, with an updated date of 07/23/24 reads in part, Contact precautions mandatory PPE includes gown and gloves. On 08/28/24 at 12:58 PM, Surveyor observed CNA G come out of R25's room with a lift and was wiping it down with a sanitizing wipe. Surveyor observed CNA G come out of R25's room wearing no PPE. After wiping down lift Surveyor observed CNA G go back into R25's room with only gloves on. CNA G had a sanitizing wipe and was observed wiping down R25's chair remote. CNA G then removed their gloves, picked up some washcloths from R25's room with bare hands, and CNA G pushed the scale chair out of the room along with holding the washcloths. CNA G walked down to the beginning of the hall and into the kitchenette area to get R25 something to drink. CNA G returned to R25's room with a drink, entered the room and did not put on any PPE. CNA G then exited R25's room. Surveyor interviewed CNA G and asked who CNA G used the scale chair for. CNA G indicated for R25. Surveyor asked CNA G if they did anything with the chair before they brought it into the hallway. CNA G indicated they wiped it down. Surveyor then asked CNA G how they know if a resident is on precautions. CNA G indicated there are bins on the outside of the room and during shift report they are updated. Surveyor asked CNA G if they have had any recent training on infection control. CNA G indicated a couple of months ago. Surveyor asked CNA G if they knew the difference between enhanced barrier precautions and contact precautions. CNA G indicated that contact precautions was if you are coming into contact with someone. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at about 1:11 PM, Surveyor interviewed CNA F and asked how they know if someone was on precautions. CNA F indicated there is a sign on the outside of the door that tells you what kind of precautions. Surveyor asked CNA F if a resident is on contact precautions and you are bringing them a glass of water would you have to put on PPE. CNA F indicated any contact at all they would put on PPE. Surveyor asked CNA F if they have had any recent infection control training. CNA F indicated they get yearly training through Relias and about 2 months ago they went through a CNA boot camp that covered things like infection control, the different types of precautions and what to wear. On 08/28/24 at 3:19 PM, Surveyor interviewed RN E, who is also the infection preventionist and repeated the above observation of CNA G and asked if CNA G used appropriate PPE. RN E indicated no.