STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525455	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside	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 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 observation, interview, and record review, the facility did not ensure that all residents are clinically appropriate to self-administer medications for 1 of 25 sampled residents (R49).R49 was observed to have a cup of medications left on her bedside table for her to take independently. R49 does not have an assessment for self-administration of medications indicating that she is safe to administer medications independently.Evidenced by:The facility policy titled, Self-Administration of Medication states, in part, Facility, in conjunction with the interdisciplinary care team, should assess and determine with respect to each resident whether self-administration of medications is safe and appropriate .to ensure safe and appropriate self administration, facility should educate residents to ensure that resident is able to: a) state the name, dose, strength, frequency, time, and purpose for use of his/her medications; b) understand the possible side effects of his/her medications and the he/she should notify facility staff if he/she experiences any such side effects; c) correctly administer, inject or apply his/her medications .Facility should obtain a physician order for self-administration .Facility should document in the resident's care plan whether the resident or facility staff is responsible for the storage of the resident's medications .Facility should document the self-administration of medications in the resident's care plan.R49 was admitted to the facility on [DATE]. Her most recent MDS (Minimum Data Set), includes a BIMS (Brief Interview for Mental Status) score of 15, indicating R49 is cognitively intact.It should be noted that R49 had a previous stay at the facility in which she discharged on 12/9/25 with a Return Not Anticipated noted on her discharge MDS. This was a planned discharge to another facility.During this previous stay, R49 was assessed on 3/25/25 to self-administer certain medications.On 1/15/2026 at 8:29 AM, Surveyor observed R49 in her room lying in her bed with the head of the bed elevated. R49's bedside table was over her bed. Observed on the table was a small medication cup with a red pill in it along with another small medication cup with a small spoon and what appeared to be yogurt or pudding. When asked what the red pill was, R49 stated, That is my senna. They just leave it for me. R49 stated that she gets intermittent constipation and diarrhea and is not always sure she wants to take it so they leave the pill for her and she takes it depending on how she feels. On 1/15/26, Surveyor interviewed LPN O (Licensed Practical Nurse) who stated that, in the past, R49 would get certain medications left at her bedside for self-administration, but that was for a previous stay. LPN O indicated that she (R49) used to have an order to self-administer certain medications but then discharged and since coming back, no longer had an order so she (LPN O) would not leave her any medications to self-administer, nor should any other nurse. Of note, R49's care plan does not indicate that she can self-administer medications, nor does she have any physician's orders indicating that she can self-administer medications. On 1/14/2026 at 3:10 PM, Surveyor interviewed DON B (Director of Nursing) who stated that R49 does not currently have a self-administration of medications assessment or order, but had one during a previous stay and that she was only gone from the facility a short time. When asked if R49 should had orders for self administration of medications and been reassessed and care planned again given the new admission, DON B stated, Yes.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not immediately notify and consult with the resident's physician when a change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 25 sampled residents (R94). R94 was sent to the ED (Emergency Department) with a change in condition. The facility did not consult with PA E (Physician Assistant) or any provider regarding R94's abnormal lab results. As evidenced by The facility policy, Change of Condition Notification, updated 1/2026, documents, in part, as follows: Purpose: Notification of a provider and family/POA (Power of Attorney) of changes in a resident's condition or health status.Procedure for Provider NotificationBetween the hours of 8:00 AM to 5:00 PM, 7 days a week, attending provider or on-call provider is to be notified of all condition or health status changes.Between the hours of 5:00 PM - 8:00 AM the attending on-call provider should be notified of any change in condition, health status or incident that (list is not inclusive-examples only):b. Abnormal lab values for the residentvii. Unusual bleedingxiii. Significant change in mental psychosocial status R94 was admitted to the facility on [DATE] with diagnoses including, but not limited to: colitis (inflammation of the large intestine), hypomagnesemia (low magnesium), anemia (blood lacks health red blood cells reducing oxygen delivery), DM type 2 (diabetes mellitus type 2), CKD (chronic kidney disease) Stage 3b, and debility. R94's admission Minimum Data Set (MDS) dated [DATE] indicates R94 has a Brief Interview of Mental Status (BIMS) of a 11 out of 15, which indicates he is moderately cognitively impaired. R94 is his own decision maker prior to being hospitalized on [DATE]. On 10/19/25 at 12:16 PM, R94's Progress Notes document as follows: Bowel Status: This writer (a Registered Nurse) noted resident was having multiple dark tarry stools. A sample was obtained for hemoccult testing with a positive test result noted. VSS (Vital Signs Stable). Charge RN notified. On 10/19/25 at 12:20 PM, a second RN (Registered Nurse) documented the following: Resident noted to have dark brown/back tarry stools this AM. Hemoccult obtained, result = positive. Resident is pleasant, cooperative, alert, and orientated per baseline. VS (Vital Signs) = WNL (within normal limits) for resident. No changes in ROM or ADL function. Charge nurse updated and Event in place. On 10/19/25 at 1:04 PM, the Charge RN (Charge Registered Nurse) documented as follows: This writer updated the physician due to dark/tarry appearing stools, medications, diagnosis' and positive hemoccult test. Provider also aware of follow up scope scheduled for the 30th of this month. New order obtained for CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) now. On 10/19/25 at 1:43 PM, R94's Progress Notes document as follows: Labs: Labs drawn from Right AC (antecubital), resident tolerated well. Labs spinning to be sent to hospital on [DATE] an order was added for Assessments - Description: Clinical Charting - Monitor for s/sx (signs/symptoms) of bleeding, GI (gastrointestinal upset), and full set of VS (vital signs) Q (every) shift x 72 hours. Document in Progress Note and attach to event. Order Date: 10/19 - 10/22/25. It is important to note R94's vital signs remained stable prior to being hospitalization on 10/21.25. On 10/19/25 at 2:30 PM, R94's Progress Notes document as follows: Respiratory status: Lung sounds clear. Intermittent cough noted. No sputum. On 10/19/25 at 3:28 PM, R94's Progress Notes document as follows: Stools: Resident noted to have 4 total loose stools on Am, 1 incontinent along with 3 continents. One medium soft incontinence stool. Resident had no GI complaints such as bloating, discomfort, or cramping. Resident no current or recent ATB use. Dx (diagnosis) of colitis. Nursing continues to monitor with labs pending at hospital, waiting for result to review with on call provider. On 10/20/25 at 8:26 AM, R94's Progress Notes document as follows: RESPIRATORY: Resident denies any SOB (shortness of breath), cough is minimal this morning and lung sounds remain clear bilaterally, resident is afebrile, will continue to monitor. On 10/20/25 at 8:30 AM, R94's Progress Notes document as follows: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	GI/Bleeding: Resident denies any GI upset including, N/V (nausea/vomiting), indigestion, or stomach cramps. Resident was incontinent of a medium soft stool, dark brown to black in color. VSS (vital signs stable), will continue to monitor. On 10/20/25 at 8:42 AM, the hospital faxed R94's test results to the facility. The tests results include, in part, as follows:Hemoglobin 8.5 (Reference Range 13.2-16.6 g/dL)Hematocrit 26.9 (Reference Range 38.3-48.6)Erythrocytes 3.07 (Reference Range 4.35-5.65)RBC (red blood cell) Distrib (Distribution) Width 17.9 (11.8-14.5)Leukocytes 9.8 (Reference Range 3.4-9.6) Neutrophils 7.75 (Reference Range 1.56-6.45)Sodium 130 (Reference Range 135-145) Chloride 130 (Reference Range 98-107) On 10/20/25 at 8:44 AM, a Charge RN (Registered nurse) sent the following email to PA E (Physician Assistant). R94 had some dark, tarry stools over the weekend. The physician was notified and gave orders for labs to be drawn. Both (staff first name) and Charge RN are having a hard time logging in the hospital records to see results. Can you look into him (R94) and tell me what the results are and if you have any new orders regarding them. On 10/20/25 at 9:05 AM, R94's Progress Notes document as follows: Lab results: Resident's labs came back within normal limits except the following: Hgb 8.5(L), Hct 26.9(L), Erythrocytes 3.07(L), RBC Distrib Width 17.9(H), Leukocytes 9.8(H), Neutrophils 7.75(H), Sodium 130(L), and Chloride 96(L). PA E (Physician Assistant) notified via email. It is important to note, the facility did not consult with the provider regarding R94's test results. On 10/20/25 at 1:47 PM, R94's Progress Notes document as follows: MULTIPLE LOOSE STOOLS: Residents continue to have multiple, incontinent stools today x5, hemoccult positive this shift, resident denies any cramping, distention, or abdominal pain. Appetite has been fair, consuming 50-75% of today's meals. Resident does have a scope scheduled for 10/30/2025, charge nurse to be notified. 10/20/25 8:54 PM RESPIRATORY STATUS: Resident has a dry cough present on this shift when trying to lay down. PRN cough drops requested and administered. Lungs diminished in all fields. Vitals within parameters. On room air and stable this shift. On 10/20/25 at 8:56 PM, R94's Progress Notes document as follows: BLEEDING: Scant black tarry stool during cares. Offers no complaints of upset stomach or other GI (gastrointestinal) issues on this shift. On 10/21/25 at 4:38 AM, R94's Progress Notes document as follows: BLEEDING/GI (gastrointestinal): No stools to observe this shift. No complaints of GI upset. Sleeping well throughout this shift. On 10/21/25 at 10:21 AM, R94's Progress Notes document as follows: GI (Gastrointestinal): Resident denies any pain or discomfort to abdomen, no N/V (nausea/vomiting), however, resident did request 2 Tums due to slight indigestion which brought resident effective relief. Resident did have 1, continent, BM this morning, which was a large, loose, greenish brown stool, abdomen does feel a bit firm and distended, will continue to monitor. On 10/21/25 at 2:07 PM, R94's Progress Notes document as follows: R94's family member called to speak with this hall nurse, states she talked to R94 on the phone and he appeared confused. Assessed resident who had his light on to use the restroom, appeared alert and orientated calling me by name and denying any pain or discomfort. R94 asked this RN (Registered Nurse) when the provider was going to see him, informed him that it will be sometimes this afternoon. Resident did refuse lunch today, stated, I am just not hungry now, offered snack and a drink, R94 accepted, will continue to monitor. On 10/21/25 at 4:03 PM, R94's Progress Notes document as follows: PA E (Physician Assistant) update: PA E in house and reviewed labs. PA E gave the following order:1) Please send to ED (emergency department) NOW. dx: increased weakness with known GI bleed and Anemia, decreased Na+ and decreased Magnesium. On 1/15/26 at 12:45 PM, Surveyor left a message for PA E (Physician Assistant) requesting a return phone call. PA E has not returned Surveyor's phone call. It is important to note, the facility has no documentation that the provider was consulted regarding R94's abnormal lab results. On 1/15/25 at 1:00 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor discussed chain of events and lab results not reported to the provider timely. Surveyor asked DON B, how soon should staff have reported R94's labs to the provider. DON B stated, staff should have reported the labs to the provider immediately. DON B stated, staff should have notified the provider via phone to avoid the delay. DON B stated this is important due to a possible GI (gastrointestinal) bleed. DON B stated this delay in notifying the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider is unacceptable. Surveyor asked DON B, what standard of practice does the facility follow for change in condition such as this. DON B stated, she is unsure if there is a specific standard of practice however, staff should learn in nursing school that these results black stools indicate a GI bleed as well as low HCT (hematocrit) and HGB (hemoglobin) need to be reported immediately. DON B stated sodium that is outside of parameters should also be reported to the provider immediately.

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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 (R50) to reduce the risk of continued weight loss. R50 did not have appropriate interventions put into place to prevent continued weight loss. R50 had an unintentional weight loss of 8.4 pounds/5.77% over 1 month, indicating a severe weight loss. This is evidenced by: Facility policy titled, Identification of Residents at Nutritional Risk, undated, states in part, Policy: Nutrition risk is determined by the presence of characteristics that are associated with an increased likelihood of poor nutritional status. This includes various non-acute or chronic diseases and conditions, unintended weight change, inadequate or inappropriate food/fluid intake, dependence, disability. Procedure: A. Special nutritional needs will be identified by the following criteria: 1. Weight status; unplanned loss or gain a. >5% WT (weight) change in 30 days. 2. Oral/nutrition intake; food: a. Leaves 25% or more at most meals. Facility policy titled, Immediate Temporary Interventions for Unintended Significant Weight Loss, dated 2017, states in part, Policy: Individuals with unintended significant/severe weight loss will receive immediate nutrition interventions to prevent further weight loss, stabilize weight, and/or assist to regain weight as appropriate. Procedure: 1. Facility staff will request temporary nutrition interventions as appropriate for significant/severe weight loss. The individual should be interviewed for preference of intervention. 2. These temporary interventions may include: a. Oral nutritional supplements one to three times a day, between meals or with medication passes. B. Other interventions such as extra milk, pudding, yogurt, milkshakes, fortified foods, or extra portions as appropriate. 5. The registered dietitian (RD) or designee will review all significant/severe weight losses monthly or more often as needed and assess nutritional status. At that time, the temporary intervention may be changed as needed. 6. The RD or designee will determine a monitoring system to evaluate the success of the interventions initiated (i.e. weekly weights, food/fluid intake studies, etc.). R50's original admission date to the facility was 3/1/18 with most recent admission to the facility being 3/11/24. R50 has diagnoses that include, in part: Hemiplegia and hemiparesis following cerebral infarction affecting right dominate side- R (right) sided weakness, Congestive heart failure, Chronic kidney disease stage 3, Type 2 diabetes mellitus, Vitamin D deficiency, Other specified disorders of bone density and structure, Osteopenia (lower than normal bone density, Aphasia (impaired ability to speak) following cerebral infarction (stroke), Vascular cognitive impairment, Other reduced mobility. R50's most recent Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/7/25 indicates that R50 has a Brief Interview for Mental Status (BIMS) of 3 out of 15, indicating that R50 has a severe cognitive impairment. K0100 indicates that R50 did not have a swallowing disorder. Section GG of the MDS indicates R50 requires set up and/or clean up assistance with eating. R50s Comprehensive Care Plan, states, in part:Problem: Nutrition strength: No nutrition dx (diagnosis) with good appetite and stable weights.Goal: Maintain weight within 145-155# (pound) range.Interventions: Approach: 1. Serve LCS (Low Calorie Sweetener) diet. 2. Offer PM and HS (bedtime) snacks and as I request. 3. Provide Vitamin C, Ca (calcium), B12 and Florajen as ordered. 4. Notify dietary if weight goes below 145#. 5. I am able to eat independently after set up but need a deep divided plate now to help maintain my independence.6. Honor my food preferences.7. Discourage extra snacking per daughter's request.Start Date: 3/12/18. Last Reviewed: 11/5/25. R50's Physician Orders state, in part: --DIET: LCS. Encourage Low sugar/Carb options at breakfast due to significant blood sugar elevation at lunch. Start Date: 7/31/22. No end date.--Weight 2x/week on M/F (Monday/Friday). Update MD if >3# in a week anytime or SOB (shortness of breath), edema (swelling), etc. Notify dietary if weight is out of goal range of 150-165 . Start Date: 9/17/24. No end date. R50's weights were documented as follows:12/12/25: 145.6 lbs. (pounds)12/15/25: 145.6 lbs.12/19/25: 145.4 lbs.12/22/25: 143.2 lbs. (Note: the electronic health system flagged this weight)12/26/25: 140.6 lbs. (Note: this is almost a 5 lbs weight loss in one week. It is greater than the 3 lbs. per week parameter and is below the 145 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	threshold. Physician orders and care plan state MD should be notified. The electronic health system flagged this weight)12/29/25: 141.9 lbs. (Note: the electronic health system flagged this weight)1/2/26: 140.0 lbs. (Note: the electronic health system flagged this weight)1/5/26: 138.0 lbs. (Note: the electronic health system flagged this weight)1/9/26: 138.8 lbs. (Note: the electronic health system flagged this weight)1/12/26: 137.2 lbs. (Note: the electronic health system flagged this weight) (Note: Despite the electronic health system flagging on 12/22/25 that R50 went below the 145-155 lbs. goal range indicated on R50's care plan, below the 150-165 lbs. goal range indicated in R50's physician orders, and R50 sustaining a greater than 3 lbs. weight loss in one week, there is no indication that R50's weight was rechecked for accuracy, the physician and Registered Dietician (RD) were not notified, nor was R50's care plan updated with any new interventions. R50's ?s unintentional weight loss continued to a severe weight loss of greater than 5%). R50's documented meal intakes from 12/12/25 to 1/14/26 indicate the following:Refused or marked as none for intake = 11 times1-25% = 43 times26 - 50% = 25 times51 - 75% = 13 times76 - 100% - 7 times (Note: R50 consumed less than 25% of most meals. Additionally, R50 had a greater than 5% unplanned weight loss in one month. Both indicators of someone who is nutritionally at risk). A Progress Note in R50's chart completed on 12/26/25 states, in part: This DON (Director of Nursing) spoke with.POA (Power of Attorney) at 1420.informed since 12/19/25 [Resident Name]'s weight is down 5 pounds - did not eat this AM and has been in bed today so far. DR P (Doctor) notified and ordered chest x-ray with no acute findings. Informed of influenza in building and [Resident Name] declines swab - so not sure what she may have at this time. Discussed Tamiflu prophylaxis with [POA] and she was in agreement. (Note: Despite the progress note indicating that the physician was notified on 12/26/25 of R50 having possible influenza, there is no indication that R50's recent unintentional weight loss was discussed. Nor is there any indication that the physician or the registered dietician was notified on 12/22/25 when R50's weight loss first triggered in the electronic health system). On 1/13/26 at 9:39 AM, Surveyor observed R50 eating breakfast on a tray in her room. Surveyor observed that R50 had only eaten a few bites of her breakfast. R50 declined to be interviewed by Surveyor. On 1/14/26 at 9:08 AM, Surveyor interviewed CNA F (Certified Nursing Assistant) about R50's unintentional weight loss. CNA F stated R50 eats in her room most of the time and that R50 can feed herself with staff set up. CNA F indicated that R50 will often pick at her food and will sometimes refuse meals, depending on her mood. CNA F stated that she was unsure if R50 had lost any weight, and that R50 did not receive any nutritional supplements. CNA F indicated that it is the CNA's responsibility to take the resident's weight on bath days and to note the weight on a sheet on a clipboard that the nurse then enters the weight into the electronic health record. CNA F stated that she would let the nurse on duty know if any resident had changes to their weight or meal intakes. CNA F indicated that she had not notified the nurse of any weight loss for R50. On 1/14/26 at 9:18 AM, Surveyor interviewed LPN G (Licensed Practical Nurse) about R50's unintentional weight loss. LPN G indicated that R50 does not eat much most of the time and will refuse an entire meal on rare occasions. LPN G stated that R50 does not always want the food on the tray and will just consume the liquids. LPN G stated that she thought R50 had lost a few pounds recently, but that her weight was coming back up. Surveyor asked LPN G if R50 had any weight loss parameters. LPN G indicated that R50's order was to notify the physician of a 3 lbs. weight loss in a week, and that her goal weight is 150-165 lbs. Surveyor asked LPN G if she had notified the physician of R50's recent unintentional weight loss. LPN G stated that the charge nurse sees the red flags in the system and then they are the ones to notify the doctor. LPN G indicated that she had never notified the physician or the charge nurse about R50's recent weight loss. On 1/14/26 at 9:40 AM, Surveyor interviewed LPN/Charge Nurse H about R50's recent unintentional weight loss. Charge Nurse H stated that the staff will alert her and then she reviews and compares the weights for the past month. Charge Nurse H stated that she would send the PA (Physician's Assistant) a note letting her know of the weight change and ask if she had any recommendations such as starting the resident on a nutritional supplement. Charge Nurse H also (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that she would have a chat with the resident, based on intake, to find out why they are eating less. Surveyor asked Charge Nurse H if this process had been followed for R50's recent unintentional weight loss. Charge Nurse H stated that R50's POA had been notified and that she didn't want R50 on any supplements. Charge Nurse H stated that they were encouraging R50 to eat and offering her more snacks. (Note: No snacks had been charted for R50). On 1/14/26 at 2:06 PM, Surveyor interviewed RD I (Registered Dietician) who stated that she was familiar with R50. Surveyor asked RD I if she was aware of R50's recent unintentional weight loss. RD I stated that R50's significant weight loss was news to her. RD I stated she had not been notified of R50's recent unintentional weight loss, and she would expect staff to notify her so that she could monitor the weight loss and follow up with recommendations. RD I indicated that either the nursing staff or the dietary manager should notify her of resident weight loss so that she could see the resident and evaluate what needed to be done to mitigate further weight loss. RD I indicated that, according to R50's chart, R50's recent unintentional weight loss could be attributed to a respiratory infection she had, however it did not appear that R50's meal intakes were affected. RD I stated that she is at the facility every Friday and she would have expected to be notified of R50's unintentional weight loss so that she could start some supplements or troubleshoot how to get more calories in R50's diet. On 1/14/26 at 3:00 PM, Surveyor interviewed DON B (Director of Nursing) about R50's recent unintentional weight loss. Surveyor asked DON B if R50 was at risk for impaired nutritional status. DON B indicated that R50 had been having some weight loss recently, and that a care conference was scheduled with R50's POA to determine her goals of care. Surveyor asked DON B if R50's recent unintended weight loss of 5.77% in one month would be considered severe. DON B stated yes, she would consider that severe weight loss. DON B indicated that RD I is in the building every Friday and residents with weight concerns are discussed. Surveyor asked DON B if the registered dietician should have been notified about R50's severe unintentional weight loss. DON B stated yes, she would have expected staff to notify the registered dietician of R50's severe weight loss. Despite R50's severe unintentional 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 R50's severe weight loss as a significant change in condition, and the RD was not notified, which led to further weight loss.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. This affected 2 of 3 medication carts.Surveyor observed R2's latanoprost eye drops on the medication cart with no open date during medication storage task.Surveyor observed R47's brimonidine eye drops on the medication cart with no open date during medication storage task.Evidenced by:The facility policy entitled Medication Administration, dated 1/2026, states, in part: . Purpose: The following guidelines have been established for the staff to assure the safe administration of all medications, without jeopardizing the health and safety of all residents.Procedure: Medication therapy at Riverside is administered only in accordance with written orders of the resident's attending physician or designee, consulting physicians or Riverside's Medical Director. Telephone orders may be obtained from these physicians by licensed nursing staff only.8. The expiration/beyond the use date on the medication label must be checked prior to administration. When opening a multi-dose container, the date opened shall be recorded on the container. Example 1:R2 admitted to the facility on [DATE] and has diagnoses that includes primary open-angle glaucoma (a chronic eye disease damaging the optic nerve, often due to slow clogging of the eye's drainage canals, leading to increased eye pressure and gradual painless peripheral vision loss).R2's Quarterly Minimum Data Set Assessment, dated [DATE], shows R2 has a Brief Interview of Mental Status score of 15 indicating R2 is cognitively intact.R2's Physician Orders, dated [DATE], states, in part: . Start Date: [DATE] End Date: Open Ended. latanoprost drops, 0.005%; amount: 1 drop in both eyes, ophthalmic (eye). Special instructions: Place one drop in both eyes at bedtime. For: primary open-angle glaucoma. At Bedtime; bedtime. R2's EMAR (electronic medication administration record) for month of [DATE] shows R2 received latanoprost eye drops [DATE]-[DATE]. Order on EMAR reads: latanoprost drops; 0.005%; amount to administer: 1 drop in both eyes; ophthalmic (eye). Frequency: at bedtime. Special Instructions: Place 1 drop in both eyes at bedtime for: primary open-angle glaucoma.On [DATE], at 9:51AM, Surveyor observed R2's Latanoprost 0.0005% eye drops opened and undated during the medication storage observation with CMA C (certified medication aide). The manufacturer's expiration date on the bottle was [DATE]. At this time Surveyor asked CMA C what the facility process is for dating eye drops. CMA C indicated the process is upon opening a new bottle of eye drops, date the bottle. Surveyor asked CMA C what the expiration date of R2's latanoprost eye drops was, CMA C indicated there is no open date, so it is unknown. CMA C indicated the eye drops would be good for 42 days after opening. Surveyor asked CMA C what she'll do with the latanoprost bottle. CMA C indicated remove from cart and reorder the latanoprost eye drops from pharmacy.Example 2:R47 admitted to the facility on [DATE] and has diagnoses that include nonexudate age-related macular degeneration (right eye) (characterized by gradual central vision loss due to retinal deterioration), exudative age-related macular degeneration (left eye) (severe form where abnormal, leaky blood vessels grow under the retina, releasing fluid and blood, causing rapid central vision loss) and primary open-angle glaucoma (slow painless damage to the optic nerve, leading to gradual irreversible peripheral vision loss). R47's Quarterly Minimum Data Set Assessment, dated [DATE], shows R47 has a Brief Interview of Mental Status score of 00 indicating R47 has severe cognitive impairment. R47's Physician Orders dated [DATE] states in part: . Start Date: [DATE]. End Date: Open Ended. Alphagen P (brimonidine) drops; 0.1%. Amt (amount): 1 drop; ophthalmic (eye). Special Instructions: Place 1 drop into right eye twice daily. Dx (diagnosis): Macular degeneration. Separate drops by 5 minutes. Twice a day; morning, evening.R47's EMAR (electronic medication administration record) for month of [DATE] shows R47 received brimonidine eye drops [DATE]-[DATE]. Order on EMAR reads: Alphagan P (brimonide) drops; 0.1%; Amount to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525455	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer: 1 drop; ophthalmic (eye). Frequency: Twice a day. Special Instructions: Place 1 drop into right eye twice daily. Dx: Macular degeneration. Separate drops by 5 minutes. Start/End Date: [DATE]- open ended. On [DATE] at 10:31 AM, Surveyor observed R47's Brimonidine tartrate 0.1% eye drops opened and undated during the medication storage observation with CMA N (certified medication aide). The manufacturer's expiration date on the bottle was 12/26. The bottle did not have an open date marked on the bottle. At this time Surveyor asked CMA N what the facility process is for dating eye drops. CMA N indicated the process is upon opening a new bottle of eye drops, date the bottle with an open date. Surveyor asked CMA N what the expiration date is of R47's eye drops. CMA N indicated it is expired now without knowing the open date. CMA N indicated the eye drops would be good for 42 days after opening. Surveyor asked CMA N what she will do with the brimonidine bottle. CMA N indicated remove from cart and reorder the brimonidine eye drops from pharmacy.On [DATE] at 3:00 PM, Surveyor interviewed DON B (Director of Nursing) and asked what the facility process is for dating eye drops. DON B indicated when a new bottle is opened, the nurse is to date the bottle with the open date to determine the expiration date. DON B indicated Natural Tears, and such go by manufacturer's expiration date. Latanoprost is good for 28 days after opening. DON B indicated she would need to check to be sure. Surveyor informed DON B of observation of R2's latanoprost eye drops with no open date. DON B indicated she would expect an open date to be on the bottle. Surveyor informed DON B on the observation of R47's brimonidine eye drops on the medication cart with no open date. DON B indicated they should have had an open date on the bottle. DON B indicated the undated bottles should not be on the medication cart in circulation for use without an open date.

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	525455	A. Building B. Wing	01/15/2026

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **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 for 1 of 13 resident (R6) reviewed for hospice. R6 was receiving hospice services, and the facility failed to obtain hospice documentation. Evidenced by: The facility policy titled Hospice Plan of Care, dated 7/1/96, with last review date of 1/2026, states, in part: Purpose: Hospice Staff and the nursing home staff will establish one individualized Plan of Care for the Hospice resident/family in the nursing home setting. The Plan of Care will be developed by both staff - Hospice and nursing home. Procedure:. 1. Nursing home resident becomes Hospice. a. Hospice will meet with family and resident for admission assessment and collaborate with nursing home staff. R6 was admitted to the facility on [DATE] with diagnoses that include, in part: Acute kidney failure, Type 2 diabetes mellitus, and Chronic Obstructive Pulmonary Disease. R6's most recent MDS (Minimum Date Set) dated 12/29/25 states that R6 has a BIMS (Brief Interview of Mental Status) of 4 out of 15, indicating that R6 has severe cognitive impairment. The MDS also indicates that R6 is dependent on staff for toileting and transfers, requires substantial/maximal assistance for lower body dressing, and partial/moderate assistance for upper body dressing, personal hygiene, and rolling in bed. R6 is a bilateral lower extremity amputee. R6 was admitted to hospice services on 12/22/25 with primary hospice diagnosis of metastatic cholangiocarcinoma (cancer that has spread to other parts of the body). R6's hospice admission note indicated that an [Hospice Name] binder was provided to the facility. On 1/14/26 at 3:39 PM, Surveyor asked to review R6's hospice binder that was kept at the nurse's station. Surveyor observed that R6's hospice binder was empty. R6's Comprehensive Care Plan states, in part: Problem: I am enrolled in [Hospice Name] as of 12/22/25.Goal: Both Hospice and Riverside staff will provide collaborative, necessary care to meet the needs of the resident.Interventions: Work collaboratively in developing the resident's plan of care. Discontinue facility standing orders. Inform Hospice of any condition change or need that the resident has. Keep the resident as comfortable as possible. Update responsible party and MD as needed.Start Date: 12/22/25. Edited on: 1/2/26. On 1/14/26 at 3:31 PM, Surveyor interviewed LPN J (Licensed Practical Nurse) and asked about R6's hospice services. LPN J stated that when the hospice nurse comes to the facility, they will talk to the charge nurse and will also stop to talk to the floor nurse to see how R6 is doing that particular day. LPN J stated that she will reach out to the hospice on call with any changes or medication needs. Surveyor asked LPN J where the hospice care plan was included in R6's medical record. LPN J stated that a paper copy was kept in a binder at the nurse's station/HUC (Health Unit Coordinator) desk. On 1/14/26 at 3:35 PM, Surveyor interviewed CNA K (Certified Nursing Assistant) about R6's hospice services. CNA K stated that the facility CNAs do one shower a week and the hospice aide will come in and do the other shower. Surveyor asked CNA K where she would locate R6's hospice care plan in the medical record. CNA K stated that there were hospice binders at the nurse's station. On 1/14/26 at 3:39 PM, Surveyor interviewed HUC L (Health Unit Coordinator) about R6's hospice services. HUC C stated that she typically scans the hospice notes and care plan into the resident's electronic medical record. Surveyor asked HUC L to show where these documents were kept in the electronic medical record. HUC L accessed R6's chart and indicated where the electronic notes should be but noted that R6 did not have any hospice notes in his electronic medical record. Surveyor asked to see R6's hospice binder. HUC L retrieved R6's hospice binder, but upon opening the binder observed that there was nothing in the binder. HUC L stated that she could call hospice if she needed any records. On 1/14/26 at 3:39 PM, Surveyor interviewed LPN/Charge Nurse H about R6's hospice services. Surveyor asked Charge Nurse H about R6's hospice binder being empty and lack of hospice documentation in R6's electronic medical record. Charge Nurse H showed Surveyor a paper copy of R6's physician order to admit to hospice and stated (continued on next page)

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	525455	A. Building B. Wing	01/15/2026

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she didn't know if hospice would give them any documentation unless they were making any changes. On 1/14/26 at 4:16 PM, Surveyor interviewed DON B (Director of Nursing) about R6's hospice services. Surveyor asked DON B who was responsible for communicating with hospice and obtaining hospice documentation. DON B stated that the charge nurses do that. Surveyor asked DON B how staff would access the hospice care plan and documentation. DON B indicated that there were hospice binders for each hospice patient at the nurse's station. Surveyor asked DON B if the hospice care plan was included in the resident medical record. DON B stated that the HUCs would scan them into the resident's electronic medical record. Surveyor shared with DON B the observations that were made with Charge Nurse H and HUC L, and that R6's hospice binder was empty and there was no hospice documentation in his electronic medical record. DON B stated this information should be a part of R6's medical record and she would reach out to hospice to make sure they were getting that information to the facility. On 1/15/26 at 11:13 AM, Surveyor interviewed Hospice RN M (Registered Nurse). Hospice RN M stated that he had seen R6 3-4 times and that he likes to fax all his notes to the facility after he sees his patient. Hospice RN M stated that he was notified on 1/14/26 that the facility was not receiving the hospice documentation from them. Hospice RN M stated that he was not sure what happened but that it was some kind of miscommunication. Hospice RN M stated that the care plan, visit notes, and IDT (Interdisciplinary Team) meetings should all be part of R6's medical record, and that going forward the plan was to fax them to the facility weekly.