

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/17/2025
NAME OF PROVIDER OR SUPPLIER  River's Bend Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  960 S Rapids Rd Manitowoc, WI 54220	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50479</p> <p>Based on staff interview and record review, the facility did not ensure a Power of Attorney for Healthcare (POAHC) was notified of a fall for 1 resident (R) (R2) of 4 sampled residents.</p> <p>R2 had a witnessed fall on 12/4/24. R2's POAHC (POAHC-G) was not notified of the fall in a timely manner.</p> <p>Findings include:</p> <p>The facility' Fall Prevention and Management Guidelines policy, dated 7/18/24, indicates: When any resident experiences a fall, the facility will .Notify the physician and family/responsible party. Review the resident's care plan and update with any new interventions put in place to try to prevent additional falls .</p> <p>On 2/17/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including dementia, ischemic stroke, pulmonary hypertension, and chronic diastolic heart failure. R2's Minimum Data Set (MDS) assessment, dated 12/4/24, indicated R2 had intact cognition. R2 had a POAHC that was activated on 11/23/24.</p> <p>R2's care plan, dated 11/30/24, indicated R2 was at risk for falls.</p> <p>R2 had a witnessed fall on 12/4/24 when R2 was walking with a Certified Nursing Assistant (CNA) and R2's hips gave out. R2 was lowered to the floor and sustained an abrasion on the upper back.</p> <p>On 2/17/25 at 1:56 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who completed an incident report on the fall. LPN-D indicated LPN-D notified R2's Hospice agency of the fall but confirmed POAHC-G was not notified.</p> <p>On 2/17/25 at 1:52 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated nursing staff should report a fall to a resident's POAHC within several hours of the incident.</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/17/2025
NAME OF PROVIDER OR SUPPLIER  River's Bend Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  960 S Rapids Rd Manitowoc, WI 54220	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50479</p> <p>Based on staff interview and record review, the facility did not individualize and revise the comprehensive plan of care for 1 resident (R) (R2) of 4 sampled residents.</p> <p>R2's plan of care did not indicate R2's activities of daily living (ADL) needs. In addition, R2's plan of care was not updated after a fall on 12/4/24.</p> <p>Findings include:</p> <p>The facility's Fall Prevention and Management Guidelines policy, dated 7/18/24, indicates: .When any resident experiences a fall, the facility will .review the resident's care plan and update with any new interventions put in place to try to prevent additional falls .</p> <p>The facility's Change in Condition of the Resident policy, dated 12/2016, indicates: When a resident presents with a possible change of condition .update the plan of care as needed .</p> <p>On 2/17/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including dementia, ischemic stroke, pulmonary hypertension, and chronic diastolic heart failure. R2's Minimum Data Set (MDS) assessment, dated 12/4/24, indicated R2 had intact cognition. R2's Power of Attorney for Healthcare (POAHC) was activated on 11/23/24.</p> <p>On 2/17/25 at 10:29 AM, Surveyor interviewed R2's POAHC (POAHC-G) who indicated POAHC-G visited R2 every day in the late morning. POAHC-G indicated R2's breakfast tray was covered and untouched when POAHC-G arrived. POAHC-G alleged staff did not provide meal tray set up and dining assistance.</p> <p>R2's care plan, dated 11/30/24, indicated: ADL self-care deficit .related to: Inadequate oral intake related to history of poor oral intake as evidenced by self reported weight loss of 30-40 pounds and varied intake since admission. R2 is at nutrition risk related to Hospice care. Intervention: Eating (specify-independent, assist of 1, setup, supervision). The care plan did not indicate the level of assistance R2 required for dining and was not individualized for R2.</p> <p>R2's medical record indicated R2 had a witnessed fall on 12/4/24 when R2 was walking with a Certified Nursing Assistant (CNA) and R2's hips gave out. R2 was lowered to the floor and sustained an abrasion on the upper back.</p> <p>On 12/16/24, the facility's Interdisciplinary Team (IDT) reviewed R2's fall. The IDT recommended an intervention to have 2 staff assist R2 during ambulation.</p> <p>R2's care plan indicated: At risk for falls due to: (specify) .Interventions/tasks: Ambulation/locomotion: with device (specify-cane, walker, wheelchair, Broda chair) .Transfer: Assist of 1 with gait belt. R2's care plan indicated R2 required the assistance of 1 person with a gait belt for transfers but did not specify the type of assistive device R2 required for ambulation. Surveyor also noted R2's care plan was not updated with the IDT's recommendation to have 2 staff assist R2 with ambulation.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/17/2025
NAME OF PROVIDER OR SUPPLIER  River's Bend Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  960 S Rapids Rd Manitowoc, WI 54220	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/17/25 at 1:52 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated a resident's care plan should specify the resident's level of assistance required for ADLs and fall prevention strategies.</p>