

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 11/24/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on staff and resident interview and record review, the facility did not report an allegation of abuse to the State Agency (SA) for 1 resident (R) (R1) of 1 sampled resident. R1 reported an allegation of staff-to-resident abuse. The facility did not report the allegation of abuse to the SA. Findings: The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, indicates: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Reporting/Response: The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services (APS), and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. On 11/24/25, Surveyor reviewed R1's medical record. R1 had diagnosis including lymphedema, type 2 diabetes, chronic pain, ongoing psychiatric follow-up for diagnosis of depression, anxiety, prolonged grief disorder, borderline personality disorder, and multiple personality disorder. R1 had a recent hospitalization for surgery with an exacerbation of psychiatric symptoms post-operatively. R1's Minimum Data Set (MDS) assessment, dated 9/12/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker. On 11/24/25 at 9:26 AM, Surveyor interviewed R1 who indicated Scheduler (SCH)-C and Driver (DRV)-D accompanied R1 to a physician appointment and argued amongst each other during the transport, including yelling at each other and using vulgar profanities. R1 indicated SCH-C and DRV-D also yelled at R1 in a threatening manner not to tell anyone about the argument which made R1 uncomfortable. R1 reported the incident to staff. R1 did not believe the facility investigated the incident because no one followed-up with R1. On 11/24/25, Surveyor reviewed the facility's grievance file which did not contain a grievance related to R1's allegation of abuse. On 11/24/25 at 12:54 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed former SCH-C and former DRV-D assisted R1 with transportation to medical appointments. DON-B indicated an argument occurred between SCH-C and DRV-D during a transport and was reported to former Nursing Home Administrator (NHA)-E. DON-B indicated NHA-E would have reported the incident to the SA. DON-B did not have any further information regarding the report. On 11/24/25 at 1:45 PM, Surveyor requested information from NHA-A regarding an argument between SCH-C and DRV-D during a medical transport for R1. On 11/24/25 at 2:37 PM, NHA-A approached Surveyor and indicated the allegation of abuse reported by R1 was not reported to the SA but should have been reported in accordance with the facility's policy and state and federal regulations.</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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on staff and resident interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 1 resident (R) (R1) of 1 sampled resident. R1 reported an allegation of staff-to-resident abuse. The facility did not thoroughly investigate the allegation of abuse. Findings include: The facility's Abuse, Neglect, and Exploitation policy, dated 7/15/22, indicates: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .V. Investigation of Alleged Abuse, Neglect, and Exploitation: A. An immediate investigation is warranted when an allegation or suspicion of abuse, neglect, or exploitation or reports of abuse, neglect, or exploitation occur. B. Written procedures for investigations include: Identifying staff responsible for the investigation, exercising caution in handling evidence that could be used in a criminal investigation .identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s), focusing the investigation on determining if abuse, neglect, exploitation, or mistreatment has occurred, the extent and cause, and providing complete and thorough documentation of the investigation . On 11/24/25, Surveyor reviewed R1's medical record. R1 had diagnoses including lymphedema, type 2 diabetes, chronic pain, ongoing psychiatric follow-up for diagnosis of depression, anxiety, prolonged grief disorder, borderline personality disorder, and multiple personality disorder. R1 had a recent hospitalization for surgery with an exacerbation of psychiatric symptoms post-operatively. R1's Minimum Data Set (MDS) assessment, dated 9/12/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker. On 11/24/25 at 9:26 AM, Surveyor interviewed R1 who indicated Scheduler (SCH)-C and Driver (DRV)-D accompanied R1 to a physician appointment and argued amongst each other during the transport, including yelling at each other and using vulgar profanities. R1 also indicated SCH-C and DRV-D yelled at R1 in a threatening manner not to tell anyone about the argument which made R1 feel uncomfortable. R1 reported the incident to staff but did not think the facility investigated the incident because no one followed-up with R1. On 11/24/25, Surveyor reviewed the facility's grievance file which did not contain a grievance for R1's allegation of abuse. On 11/24/25 at 12:54 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed former SCH-C and former DRV-D assisted R1 with transportation to medical appointments. DON-B confirmed an argument occurred between SCH-C and DRV-D during a transport. DON-B indicated the incident was reported to former Nursing Home Administrator (NHA)-E who would have investigated the incident. DON-B did not have any further information regarding the investigation. On 11/24/25 at 1:45 PM, Surveyor requested the facility's investigation for R1's allegation of abuse. On 11/24/25 at 2:37 PM, NHA-A approached Surveyor and indicated the facility did not have an investigation for R1's allegation of abuse. NHA-A indicated an investigation should have been initiated after R1 reported that R1 was yelled at by SCH-C and DRV-D and felt uncomfortable due to vulgar language that was used. NHA-A also indicated SCH-C and DRV-D should have been suspended pending results of the investigation. NHA-A indicated NHA-A interviewed staff that day (11/24/25) after becoming aware of R1's allegation of abuse and discovering arguments between SCH-C and DRV-D occurred on multiple occasions.</p>		