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 _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE	**2575 S 7TH ST LA CROSSE, WI 54601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This was a complaint and partial extended survey conducted at Riverside from 01/14/25 to 01/22/25. This survey identified substandard quality of care at F600. Federal citations issued: 1 The most serious citation was F600 cited at a severity/scope level of J (Immediate jeopardy/Isolated). Census: 94 Sample size: 4	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to protect a resident's right to be free from physical abuse. The facility did not protect residents (R) from physical abuse by a staff member or protect the resident immediately after	F 600	Past noncompliance: no plan of correction required.	

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525455	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE	**2575 S 7TH ST LA CROSSE, WI 54601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1	F 600		

the abuse occurred. This affected 1 of 4 residents (R1) reviewed for abuse.

On 01/06/25, Certified Nursing Assistant (CNA) D witnessed CNA C strike R1 across the face. CNA D left CNA C alone with R1 to report the incident to nursing staff. R1 was left alone with CNA C for approximately 15 minutes. This left R1 at risk for further physical abuse from CNA C.

The facility's failure to protect vulnerable residents from physical abuse created a finding of immediate jeopardy that began on 01/06/25. Surveyor notified the Nursing Home Administrator (NHA) and Director of Nursing (DON) of the immediate jeopardy on 01/14/25 at 2:55 p.m. The immediate jeopardy was removed 01/07/25 and corrected on 01/10/25. Based on this determination, this citation is being cited as past noncompliance.

Findings include:

Facility policy and procedure titled "Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property," last reviewed on 01/08/25, states in part, " ...It is the policy of Riverside that the resident(s) will be protected from the alleged offenders(s). Procedure: Immediately upon receiving a report of alleged "abuse", the Administrator, and or designee will coordinate delivery of appropriate medical and/or psychological care and attention. Ensuring safety and well-being for the vulnerable individual are of utmost priority. Safety, security and support of the resident, their roommate, if applicable and other residents with the potential to be affected will be provided. The facility will take necessary steps to protect residents from possible subsequent

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 _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE	**2575 S 7TH ST LA CROSSE, WI 54601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2	F 600		

incidents of misconduct or injury. This should include as appropriate: 1. Procedures must be in place to provide the resident with a safe, protected environment during the investigation: A. The alleged perpetrator may immediately be removed for the resident's protection. Employees accused of alleged "abuse" may be immediately removed from the facility and will remain removed pending the results of a thorough investigation ..."

Record review identified R1 was admitted to the facility on 08/23/24 with diagnoses including, in part, Alzheimer's disease with late onset, depression, dementia with other behavioral disturbance, anxiety disorder, and cognitive communication deficit. R1's medical record identified R1 was not able to complete a Brief Interview for Mental Status assessment, which indicated R1 had severe cognitive impairment. The Resident Profile identified R1 had a history of physical and verbal agitation with cares. "Special instructions: Approaches: 1:1, redirect, reapproach, PRNs [as needed medications], retired nurse-talk about nursing. Triggers: Pain and ADL [activities of daily living] care."

Surveyor reviewed the facility incident investigation file and identified a statement provided by CNA D. CNA D stated on the night of 01/06/25, CNA D entered the 200-dementia unit to deliver supplies and see what time CNA C wanted a break. CNA D stated from the doorway of R1's room she observed CNA C was changing R1's brief. CNA D witnessed CNA C strike R1 in the face with an open backhand. R1 responded by putting her hands to her face. CNA D turned and began walking out of the unit to inform the nurse of the incident. At that time CNA C was left alone with R1.

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 _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE	**2575 S 7TH ST LA CROSSE, WI 54601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3	F 600		

The incident investigation file identified Registered Nurse (RN) E was informed of the incident at 11:15 PM by CNA D. RN E then placed calls to NHA A and DON B. RN E was not able to reach either NHA A or DON B and left messages for them. RN E then called the police to report the incident at 11:19 PM. The incident investigation file identified RN E went to the 600 unit to request help from another staff member before entering the 200 unit. When RN E entered the 200 unit, CNA C was assisting R1 in the bathroom. The investigation file indicated RN E asked CNA C if he hit R1 and CNA C confirmed he had hit R1 as a reflex.

A witness statement from CNA F noted sometime between 11:15 PM to 11:30 PM, RN E informed CNA F what had occurred on the 200 unit and requested assistance. When the police arrived, CNA F went to the 200 unit and informed RN E. RN E requested CNA F stay with CNA C while RN E spoke with the police. The police report identified the officer arrived at the facility at 11:36 PM.

The police report identified the officer interviewed CNA D, who witnessed the abuse, in a common area of the building, then went to R1's room with RN E. The officer observed redness around R1's lips and two cuts on the top and bottom lip on the right side. The cuts were still bleeding. The officer then interviewed CNA C in a common area near R1's room. During the interview CNA C informed the officer CNA C did hit R1 in the face. When the officer asked CNA C to clarify what he meant, CNA C raised "his right arm and open right hand upwards" mimicking his action towards R1. CNA C stated he was frustrated with R1 because she

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 _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE	**2575 S 7TH ST LA CROSSE, WI 54601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4	F 600		

was in the way while he was changing her. CNA C was arrested and removed from the building by the officer.

On 01/14/25 at 1:10 PM, Surveyor attempted a telephone interview of CNA D who witnessed the incident. Surveyor left a voicemail message requesting a call back. No call back has been received at the time of this writing.

On 01/15/25 at 8:05 AM, Surveyor conducted a telephone interview with RN E. RN E stated on the night of 01/06/25, CNA D approached her at the nursing station outside of the 200 unit at approximately 11:15 PM. CNA D appeared very upset and informed RN E she had just witnessed CNA C hit R1 in the face. RN E immediately attempted to call both NHA A and DON B and left messages for both, and then called the police department to report the incident. RN E then went to the 600 unit to request help from CNA F. RN E then entered the 200 unit and found CNA C assisting R1 on the toilet in her room. RN E stated she was unsure of the time, but estimated it was not more than 10 minutes between the time she was informed of the incident and when she entered the unit. RN E stated CNA C was not left alone on the unit or with residents after the time she entered the unit. RN E stated when the police arrived, CNA F came to the unit to inform her. RN E requested CNA F stay with CNA C on the 200 unit while she spoke to the police.

On 01/15/25 at 8:56 AM, Surveyor conducted a telephone interview with CNA F. CNA F stated on the night of 01/06/25, he was assigned to work on the 600 unit. CNA F was not sure of the time, but sometime after 11:00 PM, RN E informed him of the incident on the 200 unit. RN E asked CNA F

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 _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE	**2575 S 7TH ST LA CROSSE, WI 54601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 5	F 600		

to come to the 200 unit to let her know when the police arrived. CNA F stated when the police arrived, CNA F entered the 200 unit to inform RN E. CNA F stated when he entered the unit, CNA C was in the resident's bathroom with R1, and RN E was not in the resident's room. RN E asked CNA F to stay with CNA C while RN E spoke with the police. CNA F stated he then assisted CNA C to finish assisting R1 with cares and got her back in bed. CNA F stated CNA C was never left alone with residents after he entered the unit.

It is of note RN E was informed that CNA C hit R1 in the face at 11:15 PM and CNA C was still alone with R1 in her bathroom when CNA F entered the unit at 11:36 PM when the police arrived.

After CNA C was removed from the facility, CNA F and another CNA were instructed to begin immediate skin assessments of all residents to check for signs of abuse for all residents on the 200 unit. DON B and assistant arrived in the building at approximately 1:00 AM on 01/07/25 and started immediate education for all staff in the building on the need to immediately protect residents from suspected abuse.

The facility's failure to protect vulnerable residents from physical abuse created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The immediate jeopardy was removed on 01/07/25 when staff was educated on the need to immediately protect residents from suspected abuse.

The immediate jeopardy was corrected on 01/10/25 after the facility completed the following:

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 _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE	**2575 S 7TH ST LA CROSSE, WI 54601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6 Educated all staff on immediate protection of residents Educated on the abuse policy Interviewed all staff and residents about any concerns with abuse Completed skin assessments on all residents and any unknown injuries to assess for any signs of abuse Assessed non-interviewable residents for any psychosocial outcomes Completed dementia training on how to deal with aggressive behaviors Completed caregiver stress education, and signs of caregiver burnout Completed abuse drill scenarios to determine how staff should respond if witnessing abuse Based on this determination, the citation is issued as past noncompliance.	F 600		