STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016757	A. BUILDING: _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE ASSISTED LIVING	1210 W 4TH ST NEILLSVILLE, WI 54456

(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) COMPLETE DATE
N 000	Initial Comments On 10/24/2024, Surveyors conducted a licensure survey and complaint investigation at Riverside Assisted Living. Data collected through 10/29/2024. The complaint was substantiated. One deficiency was identified. Census: 22	N 000		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure adequate supervision for Resident 1. Findings include: The provider was licensed to care for 25 individuals in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 10/14/2024, the department received a	N 426		

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

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N 426	Continued From page 1	N 426		

complaint regarding supervision concerns due to a recent elopement.

On 10/24/2024 at approximately 9:10 AM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 had recently eloped and s/he sent in a self-report to the department. Administrator A stated they were unaware that Resident 1 was an elopement risk upon admission. S/he stated caregiving staff had just seen Resident 1 about 15 minutes prior to receiving a phone call stating that Resident 1 had been found up the street by a bystander. Administrator A stated that Resident 1 was taken by ambulance to Neillsville hospital and later transferred to Marshfield hospital. Administrator A stated they were currently looking for placement for Resident 1 at a facility with a locked unit. Administrator A noted that they have put a wander guard system in place to prevent Resident 1 from eloping again. S/he stated there have been no elopements since the incident on 09/04/2024.

On 10/24/2024 at approximately 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted 08/26/2024, and diagnosed with Alzheimer's, dementia, hypertension, failure to thrive, atrial fibrillation, alcoholism, and gout. Resident 1 was under guardianship.

On 10/24/2024 at approximately 10:05 AM, Surveyor reviewed Resident 1's individualized service plan (ISP), dated 08/26/2024. The ISP did not indicate that Resident 1 was an elopement risk. Resident 1's ISP did indicate that s/he was on 2-hour checks. The last documented check on 09/04/2024 was at 4:00 PM.

On 10/24/2024 at approximately 10:10 AM, Surveyor reviewed the self-report sent to the

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N 426	Continued From page 2	N 426		

department regarding Resident 1's elopement. The self-report indicated that Resident 1 left the facility on 09/04/2024 at about 5:30 PM. The facility was notified by family that Resident 1 had been found 2 blocks away at approximately 5:44 PM. The self-report indicated staff had eyes on Resident 1 last at 5:20 PM.

On 10/24/2024, Surveyor reviewed Resident 1's medical notes. Resident 1's discharge summary read: "This is a 78-year-old [fe/male] with a history of Alzheimer's dementia, a-fib (atrial fibrillation), gout, hypertension, and alcoholism, who suffered an unwitnessed ground level fall on 09/04/2024. The patient recently move [sic] into an ALF (assisted living facility) where s/he wondered out of and fell into a small pothole ... [S/he] was taken to a local emergency department where [s/he] was found to have sustained a subarachnoid hemorrhage in the right frontal and temporal region, type II odontoid fracture, complex right-sided facial fractures with features of LeFort type II/III, right facial laceration, right-sided rib fractures ... Upright x-rays performed and Neurosurgery cleared the cervical collar. Facial surgery recommended Augmentin for 1 week and follow up in 1 week outpatient ... The [resident] worked with therapies, and after discussion with ALF, it was deemed they could support the [resident's] needs. The [resident] was discharged back to [his/her] ALF with home health and a platform walker on 09/11/2024.

On 10/29/2024 at approximately 11:19 AM, Surveyor interviewed Family Member (FM) B. FM B stated they knew when they placed Resident 1 in the facility that it was not a locked unit. FM B stated Resident 1 had been doing well and they did not have concerns s/he would elope. FM B stated the facility had placed measures to prevent

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N 426	Continued From page 3 it from happening again and they have no concerns at this time. The provider did not ensure Resident 1 was adequately supervised when s/he eloped from the facility on 09/04/2024 and sustained serious injuries.	N 426		