Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018330	A. BUILDING: _____ B. WING _____	R-C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS-FOX (THE)	611 E ALBERT STREET PORTAGE, WI 53901

(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 06/27/2023, with information obtained through 06/29/2023, the Bureau of Assisted Living, Southern Regional Office, conducted 2 verification visits for Statement of Deficiency (SOD) DZNW11, dated 04/12/2023, and SOD JQFH11, dated 03/16/2023, at Rivers-Fox (The), a community-based residential facility (CBRF) located in Portage, WI. As a result of the survey, 2 deficiencies were identified. Both deficiencies are repeat deficiencies from SOD JQFH11, dated 03/16/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 8	{N 000}		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner for 2 of 2 residents reviewed. Resident 3 did not receive his/her sliding scale	N 352		

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

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insulin as ordered.

Resident 4 did not receive his/her prescribed Midodrine and Furosemide in accordance with his/her physician orders on 19 occasions from 06/01/2023 - 06/27/2023.

This is a repeat deficiency. See Statement of Deficiency (SOD) JQFH11, dated 03/16/2023.

Findings include:

On 06/27/2023, Surveyors conducted two verification visits.

Example 1 - Resident 3

Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 01/03/2018 with diagnoses including major depressive disorder, Alzheimer's and diabetes. Surveyor reviewed Resident 3's prescription for novolog flexpen 100 units/ml to inject subcutaneously per sliding scale 3 times daily before meals: 151-200=2UN; 201-250=4UN; 251-300=6UN; 301-350=8UN; 351-400=10UN; >401=12UN.

Surveyor reviewed Resident 3's June 2023 medication administration record (MAR) which documented the following occurrences when the insulin administered did not follow physician's orders:

06/06/2023 12:24 p.m. BS 342, 10 units administered. Order indicates 8 units needed.
06/07/2023 12:08 p.m. BS 195, 0 units administered. Order indicates 2 units needed.
06/12/2023 9:36 a.m. BS 203, 2 units administered. Order indicates 4 units needed.
06/16/2023 7:20 a.m. BS 203, 0 units

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administered. Order indicates 4 units needed. No Pass Reason: Waiting on delivery from Pharmacy.
06/16/2023 12:17 p.m. BS not documented. No Pass Reason: Waiting on delivery from Pharmacy.
06/16/2023 5:05 p.m. BS 340, 0 units administered. Order indicates 8 units needed. No Pass Reason: Waiting on delivery from Pharmacy.
06/17/2023 12:20 p.m. BS 172, 0 units administered. Order indicates 2 units needed. No Pass Reason: Waiting on delivery from Pharmacy.
06/18/2023 4:25 p.m. BS not documented. No Pass Reason: Waiting on delivery from Pharmacy.
06/19/2023 4:33 p.m. BS 208, 0 units administered. Order indicates 4 units needed. No Pass Reason: Waiting on delivery from Pharmacy.
06/20/2023 5:00 p.m. BS 239, 0 units administered. Order indicates 4 units needed. No Pass Reason: Waiting on delivery from Pharmacy.

At 11:51 a.m., Surveyor interviewed Caregiver K, who was administering medications during the time of the survey. Surveyor asked Caregiver K if s/he has ever had issues with Resident 3's medication not being available for administration. Caregiver K stated yes, that Resident 3's novolog ran out last week and s/he did not receive any sliding scale insulin for a few days while the facility waited for the pharmacy to send more.

At approximately 1:20 p.m., Surveyor shared the above concerns with Administrator C, Regional Manager I, and House Manager J. Administrator C and House Manager J were aware that

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N 352	Continued From page 3 Resident 3's novolog had run out and that s/he had not received his/her sliding scale insulin as ordered. Example 2 - Resident 4 On 06/27/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 11/20/2020 with diagnoses including hypertensive chronic kidney disease and localized edema. Resident 4's prescriptions include the following: - Midodrine 5 mg tablet (1 tablet twice daily). The initial order from 04/24/2023 instructed staff to hold the medication if Resident 4's systolic blood pressure was greater than 130 mmHg. An updated physician order was provided on the evening of 06/21/2023 for the medication to be held if Resident 4's systolic blood pressure was less than 90 mmHg or greater than 170 mmHG. - Furosemide 40 mg tablet (1 tablet daily as needed). Physician orders dated 06/08/2023 ordered the medication to only be administered if Resident 4's weight was above 290 lbs. Updated physician orders dated 06/23/2023 ordered that the medication was to only be administered if Resident 4's weight was above 280 lbs. At approximately 12:20 p.m., Surveyor reviewed Resident 4's Furosemide medication card with Caregiver K. A pharmacy label on the card showed a dispense date of 06/06/2023. Surveyor observed 9 tablets punched out of the card. One was not dated, but the other tablet packs had hand-written dates next to them, which indicated administrations on the following dates: 06/09/2023, 06/12/2023, 06/13/2023, 06/16/2023,	N 352		

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06/17/2023, 06/18/2023, 06/26/2023, and 06/27/2023. Caregiver K showed Surveyor how s/he charted the administration of Resident 4's Furosemide in the provider's electronic record system. Surveyor observed that the instructions in the electronic system documented, "Resident must be weighed once daily prior to breakfast. If the resident weights[sic] >290 Pounds[sic] staff are to administer 40 MG Furosemide (PRN Drawer). GIVE 40 mg furosemide as needed if [s/he] weighs more than 280 lbs." Surveyor asked Caregiver K about the discrepancy in the electronic instructions in Resident 4's weight parameters (280 lbs versus 290 lbs). Caregiver K reported that it was confusing and confirmed that the instructions related to weight parameters were unclear. Caregiver K reported s/he wasn't sure why the weight parameters were different in the same instruction set but that s/he used 280 lbs as his/her parameter because that was what Resident 4's care team instructed him/her to do.

At approximately 12:45 p.m., Surveyor interviewed House Manager J about Resident 4's Furosemide order as it was documented in the electronic system. House Manager J reported s/he made a mistake and when Resident 4's weight parameters changed to 280 lbs by his/her physician on 06/23/2023 s/he must have missed updating it in the system.

Surveyor reviewed Resident 4's MAR for June 2023 and observed the following 19 discrepancies between the MAR and his/her prescriptions:

- 06/06/2023 (8:17 a.m.): Blood pressure recorded as 143/98 (within hold parameters), Midodrine documented as administered
- 06/09/2023: Weight recorded as 280.6 lbs

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N 352	Continued From page 5 (within hold parameters), Furosemide documented as administered - 06/11/2023: Weight recorded as 280.6 (within hold parameters), Furosemide documented as administered - 06/12/2023: Weight recorded as 283.4 lbs (within hold parameters), Furosemide documented as administered - 06/13/2023: Weight recorded as 284.6 lbs (within hold parameters), Furosemide documented as administered - 06/16/2023: Weight recorded as 285.6 lbs (within hold parameters), Furosemide documented as administered - 06/16/2023 (7:23 a.m.): Blood pressure recorded as 145/94 (within hold parameters), Midodrine documented as administered - 06/16/2023 (2:43 p.m.): Blood pressure recorded as 121/83 (within administration parameters), Midodrine documented as held - 06/17/2023: Weight recorded as 286.6 lbs (within hold parameters), Furosemide documented as administered - 06/17/2023 (7:24 a.m.): Blood pressure recorded as 168/108 (within hold parameters), Midodrine documented as administered - 06/18/2023: Weight recorded as 281.4 lbs (within hold parameters), Furosemide documented as administered - 06/18/2023 (7:52 a.m.): Blood pressure recorded as 136/81 (within hold parameters), Midodrine documented as administered - 06/19/2023 (2:45 p.m.): Blood pressure recorded as 129/82 (within administration parameters), Midodrine documented as held - 06/21/2023: Weight recorded as 282.6 lbs (within hold parameters), Furosemide documented as administered - 06/24/2023 (7:42 a.m.): Blood pressure recorded as 131/61 (within administration	N 352		

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N 352	Continued From page 6 parameters based on updated physician parameters), Midodrine documented as held - 06/24/2023 (1:48 p.m.): Blood pressure recorded as 160/101 (within administration parameters based on updated physician parameters), Midodrine documented as held - 06/25/2023 (7:03 a.m.): Blood pressure recorded as 124/94 (within administration parameters based on updated physician parameters), Midodrine documented as held - 06/25/2023 (1:35 p.m.): Blood pressure recorded as 151/105 (within administration parameters based on updated physician parameters), Midodrine documented as held - 06/26/2023 (7:54 a.m.): No blood pressure recorded. Medication documented as held but entry annotation documented, "Blood pressure was normal." At approximately 1:20 p.m., Surveyor interviewed Administrator C, Regional Manager I, and House Manager J. Regional Manager I reported s/he was aware of some of the medication administration errors related to Resident 4's parameters, which s/he reported occurred because some staff had difficulties interpreting the order parameters. Regional Manager I reported that management was working on educating staff to correctly read and interpret prescription instructions.	N 352		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the	N 408		

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behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 2's individual service plan (ISP) did not include the rationale for the use of quetiapine as needed and a description of the behaviors which indicate the need for the administration of PRN psychotropic medication.

This is a repeat deficiency. See Statement of Deficiency (SOD) JQFH11, dated 03/16/2023.

Findings include:

On 06/27/2023, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the provider on 06/17/2022 with diagnoses including morbid obesity, schizophrenia, and bipolar disorder. Surveyor reviewed Resident 2's physician order for quetiapine tab 50 mg to take twice daily as needed for schizoaffective disorder.

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N 408	Continued From page 8 Surveyor requested Resident 2's current ISP from House Manager J. Resident 2's ISP, no date noted, did not include the rationale for the use of PRN quetiapine 50 mg or a detailed description of the behaviors which would indicate the use of it. At approximately 1:20 p.m., Surveyor shared the above concerns with Administrator C, Regional Manager I, and House Manager J. Regional Manager I reviewed Resident 2's ISP and acknowledged PRN quetiapine was not included and stated s/he would make sure the ISP is updated to include the rationale for use and description of behaviors.	N 408		