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 02/29/2024

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 02/27/2024, with information obtained through 02/29/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Rivers-Fox (The), a community-based residential facility (CBRF) located in Portage, WI. As a result of the survey, 3 deficiencies were identified. Two deficiencies are repeat deficiencies from SOD JQFH11, dated 03/16/2023, SOD DZNW12, dated 06/29/2023, and SOD DZNW13, dated 10/04/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 18	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on interview and record review, the licensee did not ensure the community-based residential facility (CBRF) and its operation complied with all laws governing the CBRF. The findings include: Example 1 - Noncompliance On 02/27/2024, with information obtained through	N 196		

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

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N 196	Continued From page 1 02/29/2024, Surveyor conducted a verification visit of Statement of Deficiency (SOD) DZNW13, dated 10/04/2023. Three citations of noncompliance were identified, two of which were repeat citations, as identified below: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication This requirement is being cited for the fourth time. See SOD JQFH11, dated 03/16/2023, SOD DZNW12, dated 06/29/2023, and SOD DZNW13, dated 10/04/2023. N0408 DHS 83.37(1)(i) PRN Psychotropic Medication This requirement is being cited for a fourth time. See SOD JQFH11, dated 03/16/2023, SOD DZNW12, dated 06/29/2023, and SOD DZNW13, dated 10/04/2023. Example 2 - Special order On 02/27/2024, Surveyor reviewed Department records for the provider and observed a "Notice and Order" letter, issued on 11/28/2023, which included the following under the "SPECIAL ORDERS" heading: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that The Rivers-Fox: "1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the	N 196		

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N 196	Continued From page 2 licensee shall provide Resident 5's legal representative and case manager (if any) with a copy of Statement of Deficiency DZNW13 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the Department, to verify compliance with Order #1. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. The documentation required by Order #1 will be available to department representatives upon request." On 02/27/2024, at approximately 11:22 a.m., Surveyor interviewed Executive Director T and Regional Director (of Operations) U. Executive Director T confirmed that Resident 5 had an activated power of attorney for healthcare (POA), Person V. Surveyor requested evidence from Executive Director T and Regional Director U that Person V was provided the SOD and Notice and Order letter in accordance with the special order above. Regional Director U reported the SOD was issued prior to him/her working with the provider and so s/he wasn't aware if Person V was provided the SOD and Notice and Order letter. Regional Director U reported that s/he wanted to look for evidence to see if any other staff had provided Person V the required documents. Surveyor gave a deadline of 4:00 p.m. that day to provide the requested information. Nothing further was received. On 02/28/2024, at approximately 1:00 p.m., Surveyor interviewed Regional Director U. Regional Director U reported that s/he called Person V and Person V confirmed with him/her that s/he was not provided the SOD or the Notice and Order letter.	N 196		

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N 196	Continued From page 3 Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0408 DHS 83.37(1)(i) PRN Psychotropic Medication	N 196		
{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 that 2 of 3 residents reviewed received all medications in the dosages and at intervals prescribed by a practitioner. Resident 8 had not received his/her prescribed daily Calcium + Vitamin D supplement since 01/13/2024. Resident 8 did not receive his/her prescribed inhaler from his/her 02/20/2024 12:00 p.m. dose until his/her 02/24/2024 8:00 p.m. dose (a total of 18 missed doses). Resident 9 was not administered 1 days' worth of antibiotic medication out of his/her 10 prescribed daily doses. Resident 9 had not received his/her prescribed Florajen capsules since they were ordered on 02/14/2024. This is a repeat deficiency. See Statement of Deficiency (SOD) JQFH11, dated 03/16/2023, SOD DZNW12, dated 06/29/2023, and SOD	{N 352}		

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{N 352}	Continued From page 4 DZNW13, dated 10/04/2023. Findings include: Example 1 - Resident 8 On 02/27/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 09/28/2023. Surveyor reviewed Resident 8's prescriptions, which included the following: - Calcium 600 + Vitamin D 400 tablets with an order start date of 11/26/2023 and instructions to "Take 1 tablet by mouth once daily for supplement." - Combivent Respimat Inhaler with an order start date of 12/14/2023 and instructions to "Inhale 1 puff by mouth 4 times daily every morning, noon, evening, and at bedtime for shortness of breath ..." The times for administration set on the medication administration record (MAR) were 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Surveyor reviewed Resident 8's MAR from 01/13/2024 - 02/26/2024 and observed the following: 1. Calcium 600 + Vitamin D 400 tablet - Marked as administered on 1 occasion (01/17/2024) - Marked as "pending [medical doctor] change for Medicaid" on 2 occasions (01/15/2024 and 02/08/2024) - Marked as "Pending POA" on 1 occasion (01/14/2024) - Marked as "Waiting on [medical doctor] refill" on 1 occasion (02/20/2024) - Marked as "other" on 39 occasions (01/13/2024, 01/16/2024, 01/18/2024 through 01/22/2024, 01/24/2024 through 02/07/2024, 02/09/2024	{N 352}		

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{N 352}	Continued From page 5	{N 352}		

through 02/19/2024, 02/21/2024 through 02/26/2024). The annotations with the entries marked "other" contained annotations of either "pending" or "not in med cart."

2. Combivent Respimat Inhaler marked as not administered from 12:00 p.m. on 02/20/2024 through 4:00 p.m. on 02/24/2024 due to either "Waiting on [medical doctor] refill" or "other." The annotations with the entries marked "other" contained the annotations of either "on order with pharmacy," "out of medication waiting for pharmacy to deliver," "pending," "on order," or "on order awaiting delivery."

On 02/27/2024, at approximately 11:22 p.m., Surveyor interviewed Executive Director T and Regional Director (of Operations) U. Both reported they were new with the provider and were unaware of any issues behind Resident 8 not having his/her calcium supplement on hand or the delay in receiving his/her inhaler. Executive Director T reported after looking in Resident 8's record s/he was unable to find any notes that further explained why his/her calcium supplement wasn't on hand or why there was a delay in receiving his/her inhaler. Regional Director U reported s/he could see that a regional nurse, Regional Nurse W, had entered the calcium supplement into Resident 8's MAR on 11/26/2023.

On 02/28/2024, at approximately 8:50 a.m., Surveyor interviewed Receptionist X from Resident 8's primary care provider office. Receptionist X reported there were no notes in Resident 8's medical record regarding the provider's staff not having his/her inhaler from 02/20/2024 - 02/24/2024 or his/her calcium supplement. Receptionist X confirmed there were

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{N 352}	Continued From page 6 no notes, including communication notes, regarding the provider's staff having contacted Resident 8's medical provider to alert him/her of the calcium supplement concern or of Resident 8 not having received his/her inhaler from 02/20/2024 - 02/24/2024. On 02/28/2024, at approximately 9:04 a.m., Surveyor interviewed Pharmacist Y from the pharmacy that dispensed Resident 8's medication. Regarding Resident 8's inhaler, Pharmacist Y reported that s/he could see a refill request was submitted on 02/20/2024 at 7:13 a.m. but for some reason it wasn't received by the pharmacy's electronic system until 02/23/2024 at around 7:00 p.m. Pharmacist Y reported that the pharmacy does not typically do Saturday morning deliveries (which would be 02/24/2024), and so Resident 8's inhaler wasn't delivered until the evening of 02/24/2024. Pharmacist Y reported that s/he could not find any evidence in the pharmacy's system of staff having contacted the pharmacy in attempts to troubleshoot the delay in Resident 8's inhaler refill request. On 02/28/2024, at approximately 1:00 p.m., Surveyor interviewed Regional Director U. Regional Director U reported that after Surveyor was on site s/he and Executive Director T looked into the issue with Resident 8's inhaler and confirmed that there seemed to be an issue in the transmission of the request from the provider's electronic record platform to the pharmacy. Regional Director U reported that they were going to follow up with support staff from the provider's electronic record platform company to further look into the issue. Example 2 - Resident 9	{N 352}		

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{N 352}	Continued From page 7 On 02/28/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 08/05/2022. Surveyor reviewed Resident 9's prescriptions, which included the following: - Clindamycin 300 mg capsules with a start date of 01/17/2024 and instructions to "Take 1 capsule by mouth 3 times daily for 10 days." - Florajen Acidophilus capsule with a start date of 02/14/2024 and instructions to "Take 1 capsule by mouth 3 times daily." Surveyor reviewed Resident 9's MAR from 01/13/2024 - 02/27/2024 and observed the following: - Clindamycin capsules were marked for administration at 8:00 a.m., 2:00 p.m., and 8:00 p.m. The first date/time of administration was 2:00 p.m. on 01/17/2024. Staff initialed off on administering each dose of Resident 9's Clindamycin from that time through 8:00 a.m. on 01/26/2024, with 1 exception of the 2:00 p.m. dose on 01/18/2024. Surveyor observed that a total of 26 doses across 9 total days were administered, as opposed to a total of 30 doses across 10 days as prescribed by Resident 9's medical provider. After the 8:00 a.m. dose on 01/26/2024, staff documented not administering Resident 9's Clindamycin due to the medication ending. - Florajen capsules were not administered since the start date of 02/14/2024, with staff documenting annotations of either: "Pending POA," "Pending [medical doctor] change for Medicaid," or "other." Entries on 02/17/2024 and 02/18/2024 documented that the medication was not in the medication cart.	{N 352}		

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{N 352}	Continued From page 8 On 02/28/2024, at approximately 1:00 p.m., Surveyor interviewed Regional Director U. Regional Director U reported s/he was not sure what happened with Resident 9's Florajen capsules. Regional Director U reported that Executive Director T was out and so s/he was not able to get clarification from him/her. Regional Director U acknowledged Surveyor's concern that Resident 9 did not receive his/her fully prescribed doses of Clindamycin and reported s/he was unaware of this. Regional Director U reported s/he was unsure why Resident 9 was prescribed antibiotics and so s/he would have to find additional information. Nothing further was received. On 02/29/2024, at approximately 1:17 p.m., Surveyor interviewed Caregiver S. Caregiver S reported that Resident 9 was prescribed several courses of antibiotics over the past couple of months on and off due to an infection in his/her feet. Caregiver S reported s/he couldn't recall if it was an infection in both feet or just Resident 9's left foot. Caregiver S stated, "The infection was pretty bad," and clarified that Resident 9's foot had green pus coming out of open areas on it. Caregiver S reported that Resident 9 has had wound care on and off for his/her feet. When asked about Resident 9's Florajen, Caregiver S reported that on a previous day where s/he was passing medications, s/he noticed that the Florajen capsules were not in the medication cart. Caregiver S reported that s/he thought the capsules would maybe be stored in the refrigerator so s/he looked there and could not find them. Caregiver S reported that s/he recalled speaking to a manager about it, who s/he thought was maybe Regional Nurse W. Caregiver S reported that s/he asked why Resident 9 was prescribed Florajen capsules and the person who	{N 352}		

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{N 352}	Continued From page 9 s/he spoke with replied that they weren't sure but would look into it. Caregiver S reported that s/he did not receive any additional information about the capsules. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{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 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 that the individual service plans (ISPs) for 4 of 4 residents reviewed who were prescribed as needed (PRN) psychotropic	{N 408}		

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{N 408}	Continued From page 10	{N 408}		

medications included the rationale for use and a detailed description of the behaviors indicating the need for their use.

Resident 5's ISP did not include any information about his/her PRN Quetiapine use.

Resident 6's ISP did not include any information about his/her PRN Clonazepam use.

Resident 2's ISP did not include a detailed description of the behaviors indicating the need for his/her PRN Quetiapine use.

Resident 7's ISP did not include any information about his/her PRN Lorazepam use.

This is a repeat deficiency. See Statement of Deficiency (SOD) JQFH11, dated 03/16/2023, SOD DZNW12, dated 06/29/2023, and SOD DZNW13, dated 10/04/2023.

Findings include:

Example 1 - Resident 5

On 02/27/2024, at approximately 8:54 a.m., Surveyor observed 1 of the provider's 2 medication cards with Caregiver R. Surveyor observed the following PRN psychotropic medications:

- 1 card of Quetiapine 50 mg tablets prescribed to Resident 5. The pharmacy label on the card contained instructions to, "Take ½ tablet (25 mg) by mouth once daily as needed." The card was full with no tablets punched out.

On 02/27/2024, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider

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{N 408}	Continued From page 11 on 12/10/2021 with diagnoses including unspecified dementia and anxiety disorder. Resident 5's current ISP, not dated, did not contain information about his/her PRN Quetiapine use. Example 2 - Resident 6 On 02/27/2024, at approximately 8:54 a.m., Surveyor observed 1 of the provider's 2 medication cards with Caregiver R. Surveyor observed the following PRN psychotropic medications: - 1 card of Clonazepam 0.5 mg tablets prescribed to Resident 6. The pharmacy label on the card contained instructions to, " ...May take 1 tablet by mouth once daily as needed for acute agitation ..." The label indicated that 28 tablets were dispensed in the card on 12/05/2023. Surveyor observed 4 tablets in the card, with the remaining 24 punched out. Each punched out pack had a date and initials handwritten next to it. On 02/27/2024, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 09/08/2023. There was no diagnosis information in Resident 6's record. Resident 6's current ISP, not dated, did not contain information about his/her PRN Clonazepam use. Example 3 - Resident 2 At approximately 9:31 a.m., Surveyor observed the 2nd medication cart with Caregiver S, and observed the following PRN psychotropic medications: - 1 card of Quetiapine 100 mg tablets prescribed to Resident 2. The pharmacy label on the card	{N 408}		

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{N 408}	Continued From page 12	{N 408}		

contained instructions to "Take 1/2 tablet (50 mg) by mouth twice daily as needed for schizoaffective disorder..." The label indicated that 15 tablets were dispensed in the card on 07/13/2023. Surveyor observed that the 15 tablets were packed as half tablets in 30 individual packs in the card. Surveyor observed 18 half-tablets in the card, with the remaining 12 half-tablets punched out. Each punched out pack had a date and initials handwritten next to it.

On 02/27/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 06/17/2022 with diagnoses including schizophrenia and bipolar disorder. Resident 2's current ISP, not dated, documented the following regarding his/her Quetiapine use: "Using psychotropic medications related to specific behaviors: Quetiapine is ordered for anxiety and". Surveyor observed that the sentence appeared to be cut off. There was no detailed description of Resident 2's behaviors indicating the use for his/her PRN Quetiapine.

Example 4 - Resident 7

At approximately 9:31 a.m., Surveyor observed the 2nd medication cart with Caregiver S, and observed the following PRN psychotropic medications:

- 1 card of Lorazepam 0.5 mg tablets prescribed to Resident 7. The pharmacy label on the card contained instructions to "Take 1 tablet by mouth four times daily as needed for anxiety / agitation." The label indicated that 28 tablets were dispensed in the card on 11/29/2023. Surveyor observed 26 tablets in the card, with the 2 remaining tablets punched out. Each punched out pack had a date and initials handwritten next to it.

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 02/29/2024

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 408}	Continued From page 13 On 02/27/2024, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 09/05/2023. There was no diagnosis information in Resident 7's record. Resident 7's current ISP, not dated, did not contain information about his/her PRN Lorazepam use. INTERVIEW: On 02/27/2023, at approximately 10:11 a.m., Surveyor reviewed the above ISPs with Executive Director T. Executive T confirmed that s/he could not find any information about Resident 5's PRN Quetiapine, Resident 6's PRN Clonazepam, and Resident 7's Lorazepam use in each of their respective ISPs. Executive Director T agreed with Surveyor that the information regarding Resident 2's PRN Quetiapine use appeared to be incomplete with the sentence being unfinished and no detailed description of behaviors warranting its use. At approximately 11:22 a.m., Surveyor interviewed Executive Director T and Regional Director (of Operations) U. Regional Director U reported that there had been a lot of turnover with the provider's staff, including management, and so there was limited relay of information from the last Statement of Deficiency (SOD). Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 408}		