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
	0018009	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF OREGON WI	151 NORTH BERGAMONT BOULEVARD OREGON, WI 53575

(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 11/05/2024, Surveyor conducted a complaint investigation at BeeHive Homes of Oregon, a CBRF located in Oregon, WI. As a result of the investigation, 1 violation of Chapter DHS 83 was issued. The complaint was substantiated.	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, Resident 1 did not receive prescribed medication in the dosage prescribed by a practitioner. Resident 1 received a dose of oxycodone that was double what was prescribed by Resident 1's Primary Care Physician (PCP). Findings include: On 09/25/2024, The Department received a complaint that a resident received a double dose of oxycodone on 09/24/2024. On 11/05/2024 at 10:00 AM, Surveyor reviewed facility documentation of the incident on 09/24/2024. An incident report dated 09/24/2024 confirmed that Resident 1 received 10 mg oxycodone when s/he should have received 5 mg	N 352		

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

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N 352	Continued From page 1 oxycodone. On 11/05/2024 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A confirmed that on 09/24/2024 at 7:10 PM, Resident 1 received a dose of oxycodone that was double what was prescribed by Resident 1's PCP. Administrator A stated that Resident 1 was prescribed oxycodone 5 mg, and received 10 mg oxycodone by mistake. Hospice was called and staff were instructed to monitor Resident 1. Administrator A acknowledged that Resident 1 received the 10 mg oxycodone and that Caregiver B was retrained and Nursing will be conducting more training and more frequent audits to help prevent further incidents.	N 352		