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
	0018030	A. BUILDING: _____ B. WING _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW AT JOHNSON CREEK (THE)	1 HARTWIG DRIVE JOHNSON CREEK, WI 53038

(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 AMENDED SOD: Resent to facility 09/22/2023. Did not recieve on 08/21/2023 incorrect email addresses. No changes to this SOD other than the date sent and sent to correct email addresses. On 07/12/2023, with information obtained through 07/14/2023, the Bureau of Assisted Living, Southern Regional Office, conducted two complaint investigations at View at Johnson Creek (The), a community-based residential facility (CBRF) located in Johnson Creek, WI. As a result of the survey, 1 deficiency was identified. The deficiency is a repeat deficiency from Statement of Deficiency (SOD) 9BVI11, dated 01/12/2023. One of 2 complaints was substantiated and 1 of 2 complaints was unsubstantiated. Census: 53	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 that 1 of 2 residents	N 352		

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

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reviewed received all of their prescribed medications at intervals prescribed by a practitioner.

Resident 1 did not receive 4 of his/her prescribed medications on 06/27/2023.

This is a repeat deficiency. See Statement of Deficiency (SOD) 9BVI11, dated 01/12/2023.

Findings include:

On 07/12/2023, Surveyor conducted a complaint investigation into concerns regarding the appropriate withholding of resident medication.

On 07/12/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 07/30/2020, where s/he resided until 07/07/2023, with diagnoses including depression and Vitamin D deficiency. Resident 1's prescriptions included the following:

- Escitalopram 10 mg tablet: "Take 1 tablet by mouth once daily."
- Famotidine 20 mg tablet: "Take 1/2 tablet (=10mg) by mouth every other day."
- Vitamin B-12 1000 mcg tablet: "Take 1 tablet by mouth once daily."
- Vitamin D3 50 mcg (2000 unit) tablet: "Take 1 tablet by mouth once daily."

Surveyor reviewed Resident 1's medication administration record (MAR) for June 2023 and observed that on 06/27/2023 his/her Escitalopram, Famotidine, Vitamin B-12, and Vitamin D3 were marked as not administered due to "Resident in [emergency room]."

Surveyor then reviewed Resident 1's observation

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notes from 04/04/2023 - 07/07/2023, and observed the following correlating entries:

- 06/27/2023 (6:00 a.m.): "Writer received a call from facility at 5:15am, stating that [Resident 1] had witnessed fall and hit [his/her] head...Writer advised staff to call [emergency medical services] to take [Resident 1] to [emergency department] for evaluation..."
- 06/27/2023 (10:00 a.m.): "[Resident 1] presented back to facility via [emergency medical transport]...[Resident 1] arrived back to the facility around 9:45 a.m."

On 07/12/2023, at approximately 11:30 a.m., Surveyor interviewed Director of Operations A. Director of Operations A reported s/he thought it was per the state regulations that medications could only be administered up to 1 hour before or 1 hour after the time as indicated in the MAR, and that since the administration time on Resident 1's MAR indicated for the above medications to be given at 8:00 a.m. but Resident 1 did not return to the facility until 9:45 a.m., they were held. Surveyor reviewed Resident 1's physician orders for the above medications with Director of Operations A, who confirmed the orders as written. Director of Operations A denied that the holding of Resident 1's 4 medications on 06/27/2023 was directed by a pharmacist or medical provider. Director of Operations A reported s/he thought staff had to follow the times of administration as indicated on the MAR because the times were set by the pharmacist.

On 07/13/2023, at approximately 8:33 a.m., Surveyor interviewed Pharmacist B. Pharmacist B confirmed that the times input for the daily medications on the MAR were typically set by a default but that providers were still recommended

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N 352	Continued From page 3 to follow the physician orders for medication administration. Pharmacist B reported that there did not seem to be adequate reasoning for staff withholding the administration of Resident 1's Escitalopram, Famotidine, Vitamin B-12, and Vitamin D3 on the morning of 06/27/2023, especially considering that Resident 1 had returned to the facility at approximately 9:45 a.m. that morning.	N 352		