| 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 10/04/2023 |

| 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 |
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| N 000 | Initial Comments<br><br>On 09/27/2023, with information obtained through 10/04/2023 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.<br><br>As a result of the survey, 2 deficiencies were identified.<br><br>Both deficiencies are repeat deficiencies from SOD JQFH11, dated 03/16/2023, and SOD DZNW12, dated 06/29/2023.<br><br>Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed.<br><br>Census: 15 | N 000 | | |
| N 352 | 83.32(3)(h) Rights of Residents: Receive medication<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed received all medications in the dosage and at intervals prescribed by a practitioner.<br><br>Resident 5 did not receive 2 prescribed ointments from 09/01/2023 - 09/27/2023 and the limited attempts made by staff in trying to obtain his/her | N 352 | | |

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

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| N 352 | Continued From page 1 | N 352 | | |

ointments were only made on 09/26/2023 and 09/27/2023 (the day before and day of the survey.) Resident 5 did not receive 1 prescribed ointment for at least 3 days from 09/25/2023 - 09/27/2023, and staff did not attempt to refill it until it had already been documented for 1 day as being out.

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

Findings include:

On 09/27/2023, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 12/10/2021 with diagnoses including unspecified pruritus and other specified soft tissue disorders. Surveyor reviewed Resident 5's prescriptions, which included the following:

- Boudreaux's Butt Paste 16% ointment with an order start date of 05/24/2023 and instructions to "apply to sensitive areas on buttocks twice daily."

- Triamcinolone 0.1% cream with an order start date of 05/24/2023 and instructions to "apply topically to arms and legs twice daily for soft tissue disorder."

- Vitamin A&D ointment with an order start date of 05/24/2023 and instructions to "apply to sensitive areas on buttocks twice daily."

Surveyor reviewed Resident 5's medication administration record (MAR) from 09/01/2023 - 09/27/2023 and observed the following:

1. Triamcinolone 0.1% cream
- Marked as "Waiting delivery from pharm" on

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| N 352 | Continued From page 2<br>09/25/2023<br>- Marked as "other" with the annotation "none in med cart" on 09/26/2023<br>- Marked as "Waiting delivery from pharm" on 09/27/2023<br><br>2. Boudreaux's Butt Paste 16% ointment:<br>- Marked as refused on 9 occasions (mornings of 09/01/2023, 09/02/2023, 09/08/2023, and 09/22/2023; evenings of 09/03/2023, 09/07/2023, 09/10/2023, and 09/18/2023)<br>- Marked as "Waiting delivery from pharm" on 39 occasions (mornings of 09/04/2023, 09/06/2023, 09/07/2023, 09/11/2023 through 09/21/2023, 09/23/2023 through 09/25/2023, and 09/27/2023; evenings of 09/01/2023, 09/02/2023, 09/04/2023 through 09/06/2023, 09/08/2023, 09/11/2023 through 09/17/2023, 09/19/2023 through 09/26/2023)<br>- Marked as "other" on the morning administration of 09/26/2023 with no other annotations<br>- Marked as administered on 4 occasions (mornings of 09/03/2023, 09/05/2023, and 09/09/2023; evening of 09/09/2023)<br><br>3. Vitamin A&D ointment:<br>- Marked as refused on 8 occasions (mornings of 09/01/2023, 09/02/2023, 09/08/2023, 09/10/2023, and 09/22/2023; evenings of 09/07/2023, 09/10/2023, and 09/18/2023)<br>- Marked as "Waiting delivery from pharm" on 40 occasions (mornings of 09/04/2023, 09/06/2023, 09/07/2023, 09/11/2023 through 09/21/2023, 09/23/2023 through 09/25/2023, and 09/27/2023; evenings of 09/01/2023 through 09/06/2023, 09/08/2023, 09/11/2023 through 09/17/2023, 09/19/2023 through 09/26/2023)<br>- Marked as "other" on the morning administration of 09/26/2023 with no other annotations<br>- Marked as administered on 4 occasions | N 352 | | |

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| N 352 | Continued From page 3<br>(mornings of 09/03/2023, 09/05/2023, and 09/09/2023; evening of 09/09/2023)<br><br>At approximately 11:05 a.m., Surveyor interviewed Lead Caregiver L about Resident 5's ointments. Lead Caregiver L reported that a different caregiver had talked to Resident 5's pharmacy recently and they were still trying to get ahold of Resident 5's medical provider for refills.<br><br>At approximately 11:25 a.m., Surveyor interviewed Regional Director I, Community Director J, and Regional Director of Operations M. Community Director J reported that Resident 5 gets his/her prescriptions refilled from a different pharmacy other than the provider's contracted facility due to cost concerns. Community Director J reported that s/he has called the pharmacy multiple times to troubleshoot refill issues for Resident 5's ointments but gets no response. Community Director J reported that Resident Care Coordinator N called the pharmacy yesterday and the pharmacy indicated that all of Resident 5's ointments/creams would be delivered on 10/04/2023.<br><br>On 10/03/2023, at approximately 8:47 a.m., Surveyor interviewed Pharmacy Representative O from Resident 5's pharmacy. Pharmacy Representative O reported that Resident 5's Vitamin A&D ointment and Boudreaux's ointment were never filled since they were not carried by the pharmacy. Pharmacy Representative O reported that back on 08/31/2023, Care Coordinator P from the provider reached out to inquire about the filling of Resident 5's prescriptions for Vitamin A&D and Boudreaux's ointments. Pharmacy Representative O reported that Care Coordinator P was informed by pharmacy staff during that call that the | N 352 | | |

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prescriptions for those ointments could not be filled. Pharmacy Representative O reported that a refill request for Resident 5's Triamcinolone cream was received via phone call on 09/26/2023 (1 day after it was already out and 2 days from when it was last administered) and a refill was sent out that same day. Pharmacy Representative O reported that on 09/27/2023 (day Surveyor was on site) staff from the provider called about Resident 5's Triamcinolone cream and had asked about the other ointments, to which pharmacy staff replied that there were no current prescriptions on file for Resident 5's zinc oxide or Vitamin A&D ointments. Representative O reported that on 09/28/2023 (day after Surveyor was on site) the pharmacy received a request for generic 16% zinc oxide ointment (the same active ingredient as in the Boudreaux's ointment) but they were only able to get 20% zinc oxide ointment, which was then sent out and anticipated to arrive on 10/04/2023. Pharmacy Representative O reported that pharmacy staff have to make entries every time communication is received on behalf of a customer, which would include when the provider's staff call. Pharmacy Representative O confirmed that other than the communications described above there was no other communication from the provider's staff regarding Resident 5's ointments.

On 10/04/2023, at approximately 1:00 p.m., Surveyor interviewed Nurse Q, a registered nurse from the Resident 5's primary care provider office. Nurse Q reported s/he did not receive any communication from the provider's staff nor could find any communication notes in Resident 5's chart indicating that staff attempted to reach out with concern that Resident 5 was not receiving his/her prescribed ointments until 09/26/2023 (the day before survey). Nurse Q reported that s/he

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| N 352 | Continued From page 5<br>wasn't surprised that this was an issue because his/her experience with staff is that they have not been good about communication.<br><br>On 10/04/2023, at approximately 1:00 p.m., Surveyor interviewed Regional Director of Operations M. Regional Director M reported that s/he has been working on auditing medications and medication records for residents and following up on medications that either haven't been received or have been refused for extended periods. Regional Director of Operations M agreed with Surveyor's concern that staff had documented administering Resident 5 his/her Vitamin A&D Boudreaux's ointments as well as documented his/her refusals when it didn't seem they had any evidence of even having the ointments for at least the month of September | N 352 | | |
| N 408 | 83.37(1)(i) PRN psychotropic medication.<br><br>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 | N 408 | | |

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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 2 of 2 residents reviewed who were prescribed as-needed (PRN) psychotropic medications included the rationale for use and a detailed description of the behaviors indicating the need for their use.

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

Findings include:

Example 1 - Resident 2

On 09/27/2023, at approximately 9:15 a.m., Surveyor reviewed the medication cart with Lead Caregiver L. Surveyor observed the following PRN psychotropic medications:

- 1 card of Quetiapine 100 mg tablets prescribed to Resident 2. The pharmacy label on the card contained instructions to "Take 1/2 tablet (50 mg) by mouth twice daily as needed for schizoaffective disorder..." The card showed 3 medication bubbles punched out of the card with dates of "8-23," "08-31," and "9-13" handwritten next to the entries.

On 09/27/2023, 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

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current ISP, not dated, did not contain information about his/her PRN Quetiapine use. Surveyor reviewed Resident 2's medication administration record (MAR) from 09/01/2023 - 09/27/2023, and observed the following entry on 09/13/2023 at 12:11 p.m. documenting the administration of his/her PRN Quetiapine: "Reason? agitation."

At approximately 11:25 a.m., Surveyor interviewed Regional Director I, Community Director J, and Regional Director of Operations M. Regional Director I reviewed Resident 2's ISP and confirmed s/he could not find the rationale for use or detailed description of behaviors indicating the need for Resident 2's PRN Quetiapine. All 3 acknowledged Surveyor's concern that this information continued to be missing from Resident 2's ISP since the last survey. Nothing further was said.

Example 2 - Resident 5

On 09/27/2023, at approximately 9:15 a.m., Surveyor reviewed the medication cart with Lead Caregiver L. 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 1/2 tablet (25 mg) by mouth once daily as needed." The card was full with no tablets punched out.

On 09/27/2023, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 12/10/2021 with diagnoses including unspecified dementia and anxiety disorder. Resident 2's current ISP, dated 05/23/2023, did not contain information about his/her PRN Quetiapine use.

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| N 408 | Continued From page 8<br><br>At approximately 11:05 a.m., Surveyor interviewed Lead Caregiver L. Surveyor asked Lead Caregiver L if s/he knew when s/he was supposed to administer Resident 5's PRN Quetiapine. Lead Caregiver L replied that s/he wasn't sure what his/her Quetiapine was for.<br><br>At approximately 11:25 a.m., Surveyor interviewed Regional Director I, Community Director J, and Regional Director of Operations M. Regional Director I reviewed Resident 5's ISP and confirmed s/he could not find the rationale for use or detailed description of behaviors indicating the need for Resident 2's PRN Quetiapine. Nothing further was said. | N 408 | | |