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{N 000}	Initial Comments On 06/05/2024, 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. All 3 deficiencies are repeat deficiencies from Statement of Deficiency (SOD) JQFH11, dated 03/16/2023, SOD DZNW12, dated 06/29/2023, SOD DZNW13, dated 10/04/2023, and SOD DZNW14, dated 02/29/2024. 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 06/05/2024, Surveyor conducted a verification	{N 196}		

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

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{N 196}	Continued From page 1 visit of Statement of Deficiency (SOD) DZNW14, dated 02/29/2024. Three citations of noncompliance were identified, all 3 of which are repeat citations, as identified below: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws This requirement is being cited for a second time. See SOD DZNW14, dated 02/29/2024. N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication This requirement is being cited for the fifth time. See SOD JQFH11, dated 03/16/2023, SOD DZNW12, dated 06/29/2023, SOD DZNW13, dated 10/04/2023, and SOD DZNW14, dated 02/29/2024. N0408 DHS 83.37(1)(i) PRN Psychotropic Medication This requirement is being cited for a fifth time. See SOD JQFH11, dated 03/16/2023, SOD DZNW12, dated 06/29/2023, SOD DZNW13, dated 10/04/2023, and SOD DZNW14, dated 02/29/2024. Example 2 - Special order On 06/05/2024, Surveyor reviewed Department records for the provider and observed a "Notice and Order" letter, issued on 03/08/2024, 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:	{N 196}		

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{N 196}	Continued From page 2 "1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) of Resident 2, Resident 5, Resident 6, Resident 8, Resident 9, with a copy of Statement of Deficiency DZNW14 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 06/05/2024, Surveyor reviewed the resident roster, which documented that Residents 2, 5, 6, 8, and 9 all had services contracted through managed care organizations. On 06/05/2024, at approximately 12:00 p.m., Surveyor requested from Executive Director Z all documentation related to the above special order. In the records provided, there was no evidence that Resident 9's legal representative was provided a copy of SOD DZNW14 or a copy of the corresponding Notice and Order letter. There was also no evidence that the case managers for Residents 2, 6, or 9 were provided a copy of SOD DZNW14 or a copy of the corresponding Notice and Order letter. At approximately 12:17 p.m., Surveyor interviewed Executive Director Z. Executive Director Z confirmed that Resident 9 had an activated power of attorney for healthcare. Executive Director Z was looking through e-mails on his/her laptop during the interview, which s/he	{N 196}		

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{N 196}	Continued From page 3 reported was a shared e-mail address for whoever filled the executive director position with the provider. Executive Director Z reported that SOD DZNW14 and the Notice and Order letter were received around the time that Former Executive Director T's employment was terminated and the time that s/he transitioned into the executive director role, and so s/he wasn't sure of all the people who were all involved in the special orders. Executive Director Z reported that it was thought that Former Executive Director T sent out most of the SOD and Notice and Order letter e-mails because s/he (Executive Director Z) was only told to follow up with a couple of legal representatives and case managers who had not responded to Former Executive Director T's initial e-mails. Executive Director Z reported that with the director's e-mail, s/he was able to see previous correspondence from Former Executive Director T, but s/he wasn't sure if these were all his/her e-mails. After searching through the e-mails, Executive Director Z confirmed s/he was unable to find any evidence that Resident 9's legal representative or the case managers for Residents 2, 6, and 9 were provided SOD DZNW14 or a copy of the corresponding Notice and Order letter. 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:	{N 352}		

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{N 352}	Continued From page 4 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 2 residents reviewed received all medications in the dosages and at intervals prescribed by a practitioner. Resident 11 did not receive all doses of his/her daily polyethylene glycol as prescribed. Resident 12, who was prescribed daily Metamucil, a fiber supplement, on 05/10/2024, had yet to be administered it despite it being dispensed by the pharmacy on 05/10/2024. This is a repeat deficiency. See Statement of Deficiency (SOD) JQFH11, dated 03/16/2023, SOD DZNW12, dated 06/29/2023, SOD DZNW13, dated 10/04/2023, and SOD DZNW14, dated 02/29/2024. Findings include: Example 1 - Resident 11 On 06/05/2024, at approximately 10:33 a.m., Surveyor observed 1 of the provider's 2 medication carts with Caregiver S. Surveyor observed 1 container of polyethylene glycol 3350 powder with a pharmacy label indicating that it was prescribed to Resident 11. The manufacturer's labels on the container indicated that it contained 30 once daily doses, with a dosing of 17 grams (the cap being filled to the line) per administration. The pharmacy label on	{N 352}		

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

the container indicated that the container was dispensed on 04/03/2024 with the following instructions, "Mix 17 grams (fill cap to line) in 4-8 oz liquid, stir well and drink once daily for constipation." The bottom of the container contained a layer of powder that covered its bottom, approximately 10% full.

On 06/05/2024, Surveyor reviewed Resident 11's record. Resident 11 was admitted to the provider on 06/15/2022 with diagnoses including dementia. Resident 11's prescriptions included polyethylene glycol 3350 powder with the same instructions that Surveyor observed on the above container. Surveyor reviewed Resident 11's medication administration records (MARs) from 04/01/2024 - 06/05/2024 and observed that on 04/01/2024, Resident 11's polyethylene glycol powder was documented as not being administered due to "Waiting on [medical doctor] to refill." From 04/04/2024, the day after Resident 11's polyethylene glycol was dispensed, through 06/05/2024, staff initialed off on administering Resident 11's polyethylene glycol powder every day except for 04/17/2024, when Resident 11 was documented as being out at the hospital - a total of 62 administrations. Surveyor observed that 44 of these administrations occurred after the provider's last survey period of correction ended on 04/22/2024.

At approximately 12:45 p.m., Surveyor interviewed Executive Director Z. Executive Director Z confirmed understanding Surveyor's concern that staff documented administering 62 daily doses of polyethylene glycol to Resident 11 when his/her container only contained 30 daily doses. Executive Director Z reported that s/he wasn't sure why staff would not be administering Resident 11's polyethylene glycol in accordance

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{N 352}	Continued From page 6	{N 352}		

with his/her prescription. Executive Director Z reported that Nurse BB audited medication carts but s/he wasn't sure when the most recent audit was done.

Example 2 - Resident 12

On 06/05/2024, at approximately 10:33 a.m., Surveyor observed 1 of the provider's 2 medication carts with Caregiver S. Surveyor observed 1 container of Metamucil fiber supplement with a pharmacy label indicating that it was prescribed to Resident 12. The pharmacy label on the container indicated that it was dispensed on 05/10/2024 with the following instructions: "Take 6.8 g by mouth once daily." The container had yet to be opened, with the seal intact on the container opening.

On 06/05/2024, Surveyor reviewed Resident 12's record. Resident 12 was admitted to the provider on 11/19/2021 with diagnoses including vascular dementia, constipation, and "personal history of other diseases of the digestive system." Surveyor reviewed Resident 12's MARs from 05/01/2024 - 06/05/2024. There was no entries or record of his/her Metamucil administration. Surveyor reviewed two "After Visit Summary" documents for recent medical appointments Resident 12 had, which documented the following:

- One "After Visit Summary" dated 05/10/2024, which contained instructions to "Take metamucil 6.8 grams daily." The document indicated that this was a new prescription that started that day.

- One "After Visit Summary" dated 05/20/2024, which documented that one of the concerns being addressed was Resident 12 having abdominal pain. The medication list included in the summary

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{N 352}	Continued From page 7 showed Resident 12's Metamucil powder as an active medication. Surveyor reviewed Resident 12's observation notes from 05/01/2024 - 06/05/2024 and observed the following entries: - 05/08/2024 (2:15 a.m.): "This resident returned back from the [emergency room]. [S/he] has a lot [sic] of gas. [S/he] is to fallow [sic] up with [primary care provider] in 2 days. (around). Staff let the [registered nurse] and Director know of this..." - 05/09/2024 (7:45 a.m.): "Resident has an illeius which will cause [him/her] to have abdominal pain and constipation. The [emergency room] has done everything they can do. Resident has a [primary care appointment]. Resident will need to take [as needed (prn)] miralax and Tylenol to help with these issues." - 05/09/2024 (8:15 p.m.): "Resident said [s/he] is still having right side abdomen pain. PRN pain medication given and constipation medication given." - 05/10/2024 (12:45 p.m.): "Reached out to me about no payment for Metamucil. They are okay with waiting for payment!" At approximately 12:45 p.m., Surveyor interviewed Executive Director Z. Executive Director Z confirmed s/he was unable to find evidence that Resident 12's Metamucil had been entered into his/her electronic record, including in his/her MAR. Executive Director Z reported s/he was unsure what was going on with the prescription and was reaching out to Nurse BB via text message for more information. Executive	{N 352}		

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{N 352}	Continued From page 8 Director Z then reported that per text message received from Nurse BB, the Metamucil order from Resident 12's medical provider was received but they were waiting to figure out coverage/payment information involving Resident 12's managed care organization covering the cost of the supplement. Executive Director Z reported that it was unclear how they were still waiting for coverage of the supplement since it was already delivered. Executive Director Z then reported that per an additional text message received from Nurse BB, Nurse BB was not informed by staff that the Metamucil had been delivered.	{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.	{N 408}		

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{N 408}	Continued From page 9	{N 408}		

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 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.

The ISPs for Residents 2, 6, and 7 did not include a detailed description of the behaviors indicating the need for their PRN Quetiapine, Clonazepam, and Lorazepam, respectively.

This is a repeat deficiency. See Statement of Deficiency (SOD) JQFH11, dated 03/16/2023, SOD DZNW12, dated 06/29/2023, SOD DZNW13, dated 10/04/2023, and SOD DZNW14, dated 02/29/2024.

Findings include:

Example 1 - Resident 5

On 06/05/2024, at approximately 10:34 a.m., Surveyor observed 1 of the provider's 2 medication cards with Caregiver S. Surveyor observed the following PRN psychotropic medications:

- 2 cards 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 cards were full with no tablets punched out.

On 06/05/2024, Surveyor reviewed Resident 5's

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record. Resident 5 was admitted to the provider on 12/10/2021 with diagnoses including unspecified dementia and anxiety disorder. Resident 5's current ISP, dated 06/05/2024, did not contain information about his/her PRN Quetiapine use.

Example 2 - Resident 2

At approximately 10:51 a.m., Surveyor observed the 2nd medication cart with Caregiver AA, and 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 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 16 half-tablets in the card, with the remaining 14 half-tablets punched out. Each punched out pack had a date and initials handwritten next to it, 2 of which were annotated with "3-7" and "3-12." Surveyor observed that these 2 dates were after the last survey on 02/27/2024.

On 06/05/2024, 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, dated 06/05/2024, 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

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detailed description of Resident 2's behaviors indicating the use for his/her PRN Quetiapine.

Example 3 - Resident 6

At approximately 11:26 a.m.., Surveyor observed 1 of the provider's 2 medication cards with Caregiver S. Surveyor observed the following PRN psychotropic medications:

- 3 cards of Clonazepam 0.5 mg tablets prescribed to Resident 6. The pharmacy label on each of the cards contained instructions to, " ...May take 1 tablet by mouth once daily as needed for acute agitation ..." The pharmacy labels on the cards indicated that 1 card of 30 tablets was dispensed on 03/26/2024, 1 card of 30 tablets was dispensed on 04/24/2024, and 1 card of 30 tablets was dispensed on 05/22/2024. Two of the cards appeared full (60 tablets total). The card dispensed on 05/22/2024 had 2 tablets punched out with handwritten initials and dates of "5-29" next to one and "5/31" next to the other.

On 06/05/2024, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 09/08/2023 with diagnoses including unspecified dementia with anxiety and paranoid schizophrenia. Resident 6's current ISP, dated 06/05/2024, documented the following regarding his/her Clonazepam use: "Resident currently takes PRN Clonazepam 0.5 mg once daily as needed for acute agitation and anxiety." There was no detailed description of Resident 6's behaviors indicating the use for his/her PRN Clonazepam.

Example 4 - Resident 7

At approximately 11:33 a.m., Surveyor observed

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{N 408}	Continued From page 12 the 2nd medication cart with Caregiver AA, 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. On 02/27/2024, Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider on 09/05/2023 with diagnoses including anxiety. Resident 7's current ISP, dated 06/05/2024, documented the following regarding his/her Lorazepam use: "Using psychotropic medications related to specific behaviors: See [medication administration record (MAR)] for medications. Taking Quetiapine for agitation, Trazadone for insomnia, and PRN Lorazepam as needed for anxiety and agitation." There was no detailed description of Resident 7's behaviors indicating the use for his/her PRN Lorazepam. INTERVIEW: On 02/27/2023, at approximately 12:45 p.m., Surveyor reviewed the above ISPs with Executive Director Z. Executive Director Z confirmed that s/he could not find any information about Resident 5's PRN Quetiapine in his/her ISP. Executive Director Z 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.	{N 408}		

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 06/05/2024

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 Executive Director Z confirmed with Surveyor that there was no detailed description of the behaviors indicating the need for Resident 2's PRN Quetiapine, Resident 6's PRN Clonazepam, and Resident 7's PRN Lorazepam in each of their respective ISPs. Executive Director Z reported that the last SOD was issued around the time that Former Executive Director T terminated employment and s/he (Executive Director Z) transitioned into the administrator role. Executive Director Z reported that there had been conversations with management staff about psychotropic medications but s/he was unaware that the ongoing concern was carried over from the last survey. Executive Director Z reported that s/he was aware of the behaviors that some of the above residents demonstrated but that s/he would have to talk with staff about others. Executive Director Z reported that s/he would work on updating residents ISPs with all the necessary information regarding PRN psychotropic medications. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws	{N 408}		