STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018246	A. BUILDING: _____ B. WING _____	R-C 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN OAKS ASSISTED LIVING	21600 WETS CLEVELAND AVENUE NEW BERLIN, WI 53146

(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 06/05/2024, Surveyor conducted a verification visit at Golden Oaks Assisted Living. One deficiency was identified. The deficiency was a repeat violation, see Statement Of Deficiency XSHT11 dated 12/12/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 13	{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 observation, record review and interview, the provider did not ensure the right to receive prescribed medications as ordered by the physician. Resident 1's physician ordered midodrine was to be held when his/her systolic (top number) blood pressure was > (greater than) 120 and administered when systolic blood pressure was < (less than) 120. Staff administered Resident 1's midodrine when systolic blood pressure was >120 and held it when systolic blood pressure was <120. This is a repeat deficiency. See Statement of	{N 352}		

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

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{N 352}	Continued From page 1 Deficiency XSHT11 dated 12/12/2023. Findings include: According to drugs.com, " ...Midodrine works by constricting (narrowing) the blood vessels and increasing blood pressure. Midodrine is used to treat low blood pressure (hypotension) that causes severe dizziness or a light-headed feeling, like you might pass out..." (Source: https://www.drugs.com/mtm/midodrine.html (retrieval date 06/07/2024)). On 06/05/2024, Surveyor reviewed Resident 1's record. S/he was admitted 10/13/2023. Physician orders included Midodrine10 MG 1 tablet 3 times daily hold if SBP >120, avoid within 4 hours of bedtime. Medication Administration Record (MAR) dated 04/01/2024-06/05/2024: Staff documented they did not administer Resident 1's Midodrine when systolic blood pressure was < (less than) 120 on the following dates: 04/01/2024 7:33 AM BP 101/73 Notation- "bp low" (Caregiver B) 04/05/2024 4:52 PM BP 108/71 Notation- no pass per vitals" (Caregiver D) 04/06/2024 7:30 AM BP 114/72 Notation- "bp low" (Caregiver B) 04/09/2024 4:12 PM BP 117/79 Notation- "bp" (Caregiver D) 04/12/2024 7:18 AM BP 115/70 Notation "115/70" (Caregiver B) 04/15/2024 7:02 AM BP 115/70 (Caregiver B) 04/19/2024 7:02 AM BP 115/71 Notation- "low bp" (Caregiver B) 04/20/2024 7:12 AM BP 110/78 Notation- "bp	{N 352}		

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{N 352}	Continued From page 2 low" (Caregiver B) 04/20/2024 11:21 AM BP 111/70 Notation- "bp low" (Caregiver B) 05/24/2024 11:27 AM BP 111/64 Notation- "hold per vitals" (Administrator A) 06/04/2024 8:25 AM BP 114/76 (tablet remained in bubble pack (Photo 1)) (Caregiver B) Staff documented administration of Resident 1's Midodrine when systolic blood pressure was >120 on the following dates: 04/01/2024 12:03 PM BP 123/71 (Caregiver B) 04/02/2024 8:04 AM BP 125/74 (Caregiver B) 04/05/2024 12:16 PM BP 125/79 (Caregiver B) 04/06/2024 11:00 AM BP 125/78 (Caregiver B) 04/06/2024 3:27 PM BP 129/74 04/07/2024 7:27 AM BP 132/76 (Caregiver B) 04/09/2024 7:20 AM BP 135/80 (Caregiver B) 04/11/2024 8:33 AM BP 128/72 04/12/2024 11:56 AM BP 132/81 (Caregiver B) 04/22/2024 11:59 AM BP 128/72 04/23/2024 4:24 PM BP 123/84 (Caregiver D) 04/24/2024 4:24 PM BP 126/77 04/26/2024 8:40 AM BP 125/75 04/26/2024 11:29 AM BP 123/85 04/27/2024 8:20 AM BP 125/74 04/30/2024 8:35 AM BP 122/83 (Caregiver B) 05/07/2024 3:35 PM BP 137/73 05/08/2024 3:52 PM BP 129/78 05/09/2024 4:04 PM BP 125/76 05/11/2024 4:20 PM BP 128/76 05/13/2024 4:23 PM BP 123/62 05/17/2024 3:45 PM BP 130/86 05/20/2024 4:29 PM BP 138/68 05/21/2024 3:50 PM BP 141/79 (Caregiver B) 05/22/2024 7:40 AM BP 126/68 (tablet missing from AM bubble pack (Photo1)) (Caregiver D) 05/24/2024 3:29 PM BP 124/66 05/27/2024 3:29 PM BP 135/88 05/29/2024 3:09 PM BP 124/69	{N 352}		

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{N 352}	Continued From page 3 06/03/2024 4:04 PM BP 131/72 Individual Service Plan (not dated or signed): In the area of Medication Management-"FULL ASSIST ...[Resident 1] depends on staff to administer and monitor medication management. Resident's Desired Goals & Outcomes: To continue receiving all scheduled and PRN [as needed] medications per physician orders ..." On 06/05/2024 at approximately 10:45 AM, Surveyor inspected Resident 1's AM midodrine bubble pack (start date 05/21/2024) with Caregiver B. The tablet from slot 05/22/2024 was missing (Photo 1) when BP was 126/68 (Caregiver D), and the tablet in slot 06/04/2024 remained in slot when BP was 114/76 (Caregiver B). On 06/05/2024 at approximately 10:45 AM, Surveyor interviewed and reviewed May 2024 MAR with Caregiver B. Caregiver B stated s/he had administered Resident 1's Midodrine when systolic blood pressure was >120 and held it when systolic BP was <120 because s/he was confused by the > symbol. Caregiver B stated s/he recently was told by RN I that > meant "greater than" and then s/he then wrote "hold over 120" on the bubble pack (Photo 1). On 06/50/2024 at 11:18 AM, Surveyor reviewed Resident 1's MAR and discussed concern of staff's incorrect administration of midodrine with Administrator A. Administrator A stated staff should have known what the > symbol meant. Administrator A stated Caregiver B had received his/her medication administration training. Administrator A stated s/he had not been monitoring medications until Consultant J showed him/her how to recently. Administrator A stated	{N 352}		

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{N 352}	Continued From page 4 caregivers were to notify him/her when they were confused about anything but had not.	{N 352}		