STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510307	A. BUILDING: _____ B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANSEN'S GROUP HOME	1190 17TH ST BARRON, WI 54812

(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 08/14/2023, Surveyor conducted an abbreviated survey at Hansens Group Home. Data was collected through 08/15/2023. Three violations were identified. Census: 22	N 000		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an onsite annual medication administration and medication storage	N 404		

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

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N 404	Continued From page 1 system review was completed by a physician, pharmacist, or registered nurse. Findings include: The provider is licensed to care for 7 residents in the client group developmentally disabled. On 08/14/2023, Surveyor requested the Annual Medication Regimen Review. At approximately 9:30 AM, Surveyor interviewed Licensee A. Licensee A stated the pharmacist did review the medications at the pharmacy. Licensee A stated s/he did not have any documentation that an onsite medication review was completed. At approximately 1:30 PM, Licensee A stated s/he was not aware that an onsite review was needed. Licensee A stated the pharmacist signed the resident medication administration record (MAR) and s/he thought that was adequate. The provider did not ensure an annual onsite medication administration and medication storage system review was completed.	N 404		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for	N 406		

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N 406	Continued From page 2 disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure expired prescription medications were destroyed in compliance with federal, state, and local standards or laws. Six expired medications were found in the provider's medication cabinet. The expired medications were stored next to medications that were not expired. Findings include: The provider is licensed to care for 7 residents in the client group developmentally disabled. On 08/14/2023, Surveyor observed the following expired medications in the medication cabinet: -1 bubble packed card of Acetaminophen prescribed to Resident 1, expired 10/04/2022. -1 bubble packed card of Docusate Sodium prescribed to Resident 1, expired 01/19/2019. -1 bottle of Refresh Tears prescribed to Resident	N 406		

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N 406	Continued From page 3 1, expired 05/24/2019. -1 tube if Triamcinolone Cream prescribed to Resident 1, expired 10/04/2022. -1 tube Voltaren Gel prescribed to Resident 1, expired 03/09/2015. -1 tube double antibiotic cream prescribed to Resident 1, expired 03/06/2018. At approximately 12:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he checks the medications monthly and must have missed checking these medications as they were tucked back in the cabinet. Licensee A stated s/he would destroy the medications as soon as possible. The provider did not destroy expired medications in accordance with federal, state, and local standards of the law.	N 406		
N 417	83.37(3)(a) Medication storage: original containers. Original containers. The CBRF shall keep medications in the original containers and not transfer medications to another container, unless the CBRF complies with all of the following: 1. Transfer of medications from the original container to another container shall be done by a practitioner, registered nurse, or pharmacist. Transfer of medication to another container may be delegated to other personnel by a practitioner, registered nurse or pharmacist. 2. If a medication is administered by CBRF employees and the medication is transferred from the original container by a registered nurse, or practitioner or other personnel who were delegated the task, the CBRF shall have a legible label on the new container that includes, at a minimum, the resident ' s name, medication	N 417		

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N 417	Continued From page 4	N 417		

name, dose and instructions for use. The CBRF shall maintain the original pharmacy container until the transferred medication is gone.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure medications were kept in the original container for 2 of 2 residents reviewed.

Findings include:

The provider is licensed to care for 7 residents in the client group developmentally disabled.

On 08/14/2023 at approximately 12:15 PM, Surveyor observed Licensee A complete a mock AM medication pass for Resident 1. Surveyor observed a paper medication cup sitting in Resident 1's medication box with 2 oblong pills. One was 2 shades of blue and 1 was white. Surveyor asked Licensee A what the paper cup of medications was for. Licensee A stated that when s/he passed AM medications, s/he punched out the medications for the evening medication pass. Licensee A showed Surveyor the bubble pack cards for the evening medication pass. The cards read:
-"[Resident 1] Propranolol ER [extended release] 120 MG [milligram]: Take 1 capsule by mouth 2 times a day
-[Resident 1] Glucosamine/Chondroitin 500/400 MG [milligram]: Take 1 capsule by mouth 2 times a day." Surveyor observed the pills in the bubble packs were the same pills in the medication cup. The bubble of medication was punched out for 08/14/2023 on both cards.

Surveyor observed a second paper medication cup with Resident 2's name written in black marker. The cup contained 4 pills: two oblong

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N 417	Continued From page 5 orange, 1 white round, and 1 white oval. Licensee A showed Surveyor the bubble pack cards for the evening medication pass. The cards read: -"[Resident 2] Phenytoin 100 MG [milligram]: Take 2 capsules by mouth at bedtime -[Resident 2] Atorvastatin 40 MG [milligram]: Take 1 tablet by mouth daily -[Resident 2] Doxazosin 4 MG [milligram]: Take 1 tablet by mouth daily." Surveyor observed the pills in the bubble pack were the same pills in the medication cup. Surveyor observed the bubble of medication was punched out for 08/14/2023 on all 3 cards. Licensee A stated s/he was not a registered nurse. The provider did not ensure medications were kept in the original container for 2 of 2 residents.	N 417		