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
	0011370	A. BUILDING: _____ B. WING _____	R-C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLF RIVER COUNTRY ADULT HOME	**13231 CTY HWY H STANLEY, WI 54768**

(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
{M 000}	INITIAL COMMENTS On 08/28/2024, Surveyor conducted a verification visit at Wolf River Country Adult Home. One deficiency was identified. This was a repeat violation. See Statement of Deficiency (SOD) K5EW11, dated 01/30/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
{M 458}	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure prescription medications were securely stored in the original container as received from the pharmacy. This is a repeat deficiency. See Statement of	{M 458}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011370	A. BUILDING: _____ B. WING _____	R-C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLF RIVER COUNTRY ADULT HOME	**13231 CTY HWY H STANLEY, WI 54768**

(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
{M 458}	Continued From page 1 Deficiency (SOD) K5EW11, dated 01/30/2024. Findings include: On 8/28/2024 at approximately 12:15 PM, Surveyor asked to see resident medications. Medications were in a locked medication cabinet, inside of a secured office. Surveyor observed weekly medication planners, filled with medications, inside the medication cabinet. Each weekly planner was labeled with the resident's name. Licensee A stated s/he popped the pills out of the original packing and prepped about a week of medications for residents ahead of time. On 8/28/2024 approximately 12:30 PM, Surveyor interviewed Licensee A about the medication storage. Licensee A stated s/he felt it was easier to prep the medications ahead of time for convenience.	{M 458}		