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
	0016610	A. BUILDING: _____ B. WING _____	R-C 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONDON RAILS AFH	4014/4016 LONDON ROAD EAU CLAIRE, WI 54701

(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 12/05/2023, Surveyor conducted a verification visit at London Rails AFH. Three of 4 deficiencies identified in Statement of Deficiency (SOD) NIWJ11, dated 08/30/2022 were corrected. One deficiency was identified and was a repeat deficiency. 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 medications were securely stored. This is a repeat deficiency. See Statement of Deficiency (SOD) NIWJ11, dated 08/30/2022.	{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
	0016610	A. BUILDING: _____ B. WING _____	R-C 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONDON RAILS AFH	4014/4016 LONDON ROAD EAU CLAIRE, WI 54701

(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 Findings include: This facility is licensed to serve up to 4 residents in the client group developmentally disabled. On 12/05/2023 at approximately 1:45 PM, Surveyor asked Caregiver A to see resident medications. Caregiver A opened an unsecured drawer in the kitchen located beneath the cupboard where medications were stored and retrieved the keys. Surveyor asked Caregiver A if the keys were always stored there. Caregiver A stated, "For as long as I've been here, at least a year. This is where we've always kept them. I'll let [House Manager (HM) B] know we have to figure something else out." Caregiver A confirmed the keychain stored in the drawer contained the key to open the cabinet and the key to open the box containing controlled medications. Three residents were home at the time of observation and had access to the kitchen where the keys were stored.	{M 458}		