STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016453	A. BUILDING: _____ B. WING _____	R-C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LSS BARRON AREA RESIDENTIAL	806 29 1/2 BARRONETT, WI 54813

(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 03/07/2025, Surveyor conducted a verification visit at LSS Barron Area Residential Treatment. One violation was identified. This is a repeat deficiency. See Statement of Deficiency (SOD) OVVY12, dated 03/26/2024, and SOD OVVY11, dated 02/09/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 5	{N 000}		
{N 410}	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify Resident 1's prescribing practitioner, nurse, or pharmacist when Resident 1 did not take his/her prescribed medication for 2 or more consecutive days.	{N 410}		

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

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{N 410}	Continued From page 1	{N 410}		

This is a repeat violation. See Statement of Deficiency (SOD) OVVY12, dated 03/26/2024 and SOD OVVY11, dated 02/09/2023.

Findings include:

The provider is licensed to care for 8 residents in the client groups alcohol/drug dependent and correctional clients.

On 03/07/2025 at 10:10 AM, Surveyor interviewed Program Supervisor (PS) A. PS A said the provider's medication services had not changed since the previous survey. During the previous survey, PS A explained that residents self-administered medications but medications were stored in the staff office. PS A said residents were responsible for requesting their medications at the appropriate times, taking the medications per physician orders, and ordering/refilling their medications. PS A said staff monitored and documented if residents complied with their medication orders; if residents did not take their medications consistently, the provider notified the resident's physician.

Surveyor reviewed Resident 1's record with PS A. Resident 1 was admitted to the facility on 01/06/2025. His/her February and March medication logs indicated Resident 1 was prescribed the following:
- Propranolol TID (3 times daily). Between 02/06/2025 and 03/03/2025, Resident 1 was supposed to take 10 mg of the medication TID and on 03/04/32025 the medication increased to 20 mg TID.
- Prazosin 2 mg tablet at bedtime.
- Suboxone 8-2mg tablet. Between 02/06/2025 and 03/03/2025, Resident 1 was supposed to

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{N 410}	Continued From page 2 take this medication 1 time daily, and on 03/04/2025, the order changed to 1/2 dose BID (two times daily). - Lamotrigine ER. Between 02/06/2025 and 03/03/2025, Resident 1 was supposed to take 50 mg 1 time daily and on 03/04/32025 the medication increased to 100 mg 1 time daily. Staff documented Resident 1 took his/her medications inconsistently. For instance, between 02/06/2025 and 03/07/2025, Resident 1 did not take his/her medications for 2+ consecutive days on these dates: - Propranolol: 02/26/2025 through 02/27/2025. Resident 1 also only took this medication as prescribed (3 times daily) 3 times. - Prazosin: 02/22/2025 through 02/23/2025 and 02/26/2025 through 03/01/2025 - Suboxone: 02/25/2025 through 02/27/2025 and 03/01/2025 through 03/03/2025 - Lamotrigine ER: 02/26/2025 through 02/27/2025 At approximately 11:00 AM, PS A stated s/he failed to notify Resident 1's physician when Resident 1 missed consecutive days of a medication. PS A discussed the changes the provider made to their monitoring system since the last survey. PS A stated the overnight shift was tasked with reviewing the medication logs and documenting on a medication check sheet if residents took their medications as prescribed or if there were issues. PS A and Surveyor reviewed the February and March medication check sheets and found staff were not checking the medication logs consistently, and they were not catching issues on days that they were checking. PS A was not aware of this system breakdown until s/he and Surveyor reviewed the medication check sheets and medication logs. PS A discussed needing to re-educate staff on the system.	{N 410}		

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