STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012325	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRU GROUP HOME INC BROWN DEER MANOI	8238 N 44TH ST BROWN DEER, WI 53209

(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 06/12/2023, Surveyor completed 4 complaint investigations at CRU Group Home INC Brown Deer Manor. As a result, 2 deficiencies were identified and 4 complaints were unsubstantiated. Two of 2 deficiencies were repeat deficiencies. See Statement of Deficiency H4X911, dated 04/22/2021. Census: 7	N 000		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 medication cabinet doors locked and the key was available only to personnel who passed medications. This is a repeat deficiency. See Statement of Deficiency H4X911, dated 04/22/2021. Findings include: On 06/12/2023, at 10:00 AM, Surveyor observed medications were stored in a cabinet in the kitchen, which was equipped with 2 doors with key locking mechanism on each one. The cabinet doors were unlocked. The cabinet contained medications for all 7 residents in the home. Medications included: acetaminophen 325 milligrams (mg), acetaminophen extended release 650 mg, Advair, alendronate 35 mg, allopurinol 100 mg,	N 419		

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

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N 419	Continued From page 1	N 419		

amlodipine 5 mg, atorvastatin 20 mg, atorvastatin 40 mg, aspirin chew 81 mg, aspirin 325 mg, buspirone 3 mg, calcium 600 mg, carvedilol 12.5 milligrams (mg), Cerovite Senior, clopidogrel 75 mg, doxazosin 2 mg, escitalopram 20 mg, folic acid 1 mg, gabapentin 300 mg, Latuda 80 mg, lisinopril 10 mg, lisinopril 20 mg, lisinopril 40 mg, levetiracetam 500 mg, melatonin 3 mg, meloxicam 7.5 mg, meloxicam 15 mg, metoprolol tartrate 50 mg, metformin 500 mg, mirtazapine 30 mg, omeprazole 20 mg, oxcarbamazepine 300 mg, pantoprazole 40 mg, pravastatin 20 mg, pregabalin 50 mg, quetiapine 25 mg, Rexulti 3 mg, risperidone 3 mg, robafen cough syrup, senna-s 8.6-50 mg, sertraline 100 mg, siltussin cough syrup, vitamin B12 1000 micrograms (mcg), vitamin C 500 mg, vitamin D3 2000 international units, and vitamin D3 25 mcg.

On 06/12/2023, at 10:20 AM, Surveyor interviewed Caregiver B regarding the medication cabinet. Caregiver B confirmed s/he administered morning medications to the residents. Caregiver B reported s/he "got caught up" when Surveyor inquired about the unlocked cabinets. Caregiver B engaged the locks and placed the key to the cabinets on the counter in a ceramic dish, directly beneath the cabinets, within reach of visitors and residents.

On 06/12/2023, between 10:20 AM and 12:30 PM, Surveyor observed the key to the medication cabinet remained stored on the counter, in a ceramic dish.

While at the facility, Surveyor observed 3 residents moving freely throughout the facility, including where the medication cabinets were located.

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N 419	Continued From page 2 On 06/12/2023, at 12:30 PM, Surveyor interviewed Operations Manager (OM) A regarding the medications being unlocked and the key being available to anyone who went into the kitchen. OM A confirmed the medication cabinet was to be locked and the key to remain with staff. OM A informed Caregiver B to keep the key in her/his pocket. OM A reported s/he reminded staff repeatedly the key to the medication cabinet was to always remain on their person.	N 419		
N 420	83.37(3)(d) Medication storage: refrigeration Refrigeration. Medications stored in a common refrigerator shall be properly labeled and stored in a locked box. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all medications were securely stored in the common refrigerator for 1 of 1 refrigerator. Resident 1 and Resident 3 required insulin and their surplus medication was stored in an unlocked box in the refrigerator. Resident 2's, Resident 3's, Resident 4's, and Resident 5's prescription eye drops were stored in an unlocked bag. This is a repeat deficiency. See Statement of Deficiency H4X911, dated 04/22/2021. Findings include: On 06/12/2023, at 10:25 AM, Surveyor observed the common refrigerator. There was a black box and a black bag stored on the bottom shelf. The box was equipped with a combination lock. When Surveyor pressed the button, the box opened.	N 420		

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N 420	Continued From page 3 Inside the box contained insulin pens for Resident 1 and Resident 3. Surveyor observed 1 Humalog insulin pen and 10 Lantus insulin pens labeled with Resident 1's name on the boxes inside the box. There were 9 Lantus insulin pens and 2 Novolog insulin pens with Resident 3's name on the boxes inside the box. The black bag contained a zipper and locking device, neither were engaged. Surveyor observed 8 bottles of latanoprost eye drops labeled with Resident 2's, Resident 3's, Resident 4's, and Resident 5's names. There was one caregiver on duty upon Surveyor's arrival and residents were observed moving freely throughout the facility. On 06/12/2023, at 10:25 AM, Surveyor interviewed Caregiver B regarding the unlocked medication box in the common refrigerator. Caregiver B confirmed the medication box was unlocked. Caregiver B reported the code to the box had not been set. Caregiver B stated, "The codes not set. The nurse does that." Caregiver B was not sure when the box was purchased but they had it for the past few months. On 06/12/2023, at 12:10 PM, Surveyor interviewed Operations Manager (OM) A and Registered Nurse (RN) C. OM A confirmed the medication box should have been locked. OM A reported the lock box was purchased a "couple of months ago." OM A reported s/he did not know why the medication bag was not locked. OM A reported s/he provided reminders to staff "all the time" to keep medications locked. RN C reported it was the house manager's responsibility to ensure the medications were always locked. RN C reported s/he would retrain staff to ensure the medications were locked.	N 420		

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