STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310328	A. BUILDING: _____ B. WING _____	R-C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CCLS OAKDALE DRIVE	1606 OAKDALE DR WAUKESHA, WI 53186

(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 07/17/2024, Surveyors conducted a verification visit at CCLS Oakdale Drive. One deficiency was identified. One of 1 deficiency was a repeat violation (see statement of deficiency (SOD) X3ND12, dated 09/20/2023). All other violations from SOD X3ND12, dated 09/20/2023 were substantially corrected. Under statutory provisions of Wis. Ch. 50, a $200 revisit fee is being assessed. Census: 6	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 6 received prescribed medications in the dosage and intervals prescribed by a practitioner. Resident 6 missed 3 doses of scheduled psychotropic medications between 06/26/2024 and 06/28/2024. This is a repeat violation. See statement of	{N 352}		

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
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{N 352}	Continued From page 1 deficiency (SOD) X3ND12, dated 09/20/2023. Findings include: On 07/17/2024 at 9:05 AM, Surveyors toured provider's medication cabinet and observed 2 individual bubbles from Resident 6's medication bubble packs, in the bottom of Resident 6's medication storage bin. Surveyors examined the bubbles and 1 read "June 26th 8 A, Guanfacine ER 2 mg, Fluoxetine 40 mg" and the other read "June 28th 8 P, Risperidone 0.5 m". These bubbles had not been opened or punctured, and still had the original medications in them. On 07/17/2024, Surveyors reviewed Resident 6's record and observed the following: Resident 6 admitted to the provider on 08/30/2023 with diagnosis of obsessive-compulsive disorder (OCD), anxiety, mood disorder, suicidal ideation, adjustment disorder, attention deficit hyperactivity disorder (ADHD), and autistic disorder. Resident 6's physician orders documented: "Fluoxetine 40 mg with start date of 09/08/2023 to be taken once daily with reason for use indicated as antidepressant. Guanfacine 2 mg with start date of 09/13/2023 to be taken once daily for ADHD. Risperidone 0.5 mg with start date of 02/28/2024 to be taken three times daily with reason for use indicated as antipsychotic." Resident 6's June 2024 medication administration record (MAR) documented both 06/26/2024 8 AM doses of Guanfacine ER 2 mg and Fluoxetine 40 mg and 06/28/2024 8 PM dose of Risperidone 0.5 mg were charted as administered.	{N 352}		

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{N 352}	Continued From page 2 Resident 6's individual service plan (ISP) dated 09/01/2023 and documented: "medications administered by staff." On 07/17/2024 at 9:20 AM, Surveyors interviewed Program Director B and asked what happened with the 2 bubbles that were still in the medication bin for Resident 6. Program Director B confirmed provider staff was to administer Resident 6's medications per the ISP. Program Director B stated staff must not have administered the medications and a medication error exists. Program Directed B stated s/he would follow-up with staff regarding the medication errors.	{N 352}		