STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018879	A. BUILDING: _____ B. WING _____	R-C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIORITY PLACE LLC	8726 WEST MILL ROAD MILWAUKEE, WI 53225

(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 12/16/2025, Surveyors completed three complaint investigations, and a verification visit at Priority Place LLC. As a result, 6 of the previous 10 deficiencies were corrected. Four of the previous deficiencies were re-cited with 2 new deficiencies. Two complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 16	{N 000}		
{N 277}	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee received continuing education in all required topics. Caregiver G did not receive continuing education training for the year 2024. This is a repeat deficiency. See Statement of Deficiency 1JLV11, dated 02/18/2025.	{N 277}		

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
	0018879	A. BUILDING: _____ B. WING _____	R-C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIORITY PLACE LLC	8726 WEST MILL ROAD MILWAUKEE, WI 53225

(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 277}	Continued From page 1 Findings include: On 12/16/2025, at approximately 11:30 AM, Surveyor reviewed Caregiver G's employee file. Caregiver G was hired 04/19/2023. Caregiver G's record did not contain evidence of 15 hours of continuing education training for the year 2024. On 12/16/2025, at approximately 12:30 PM, Surveyor interviewed Licensee E and Supervisor F. Licensee E reported s/he did not know why Caregiver G's employee file did not contain continuing education training. Supervisor F reported all training courses are completed online through Relias, an online training module program. Supervisor F reported s/he could not locate Caregiver G's continuing education training online.	{N 277}		
{N 408}	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN	{N 408}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018879	A. BUILDING: _____ B. WING _____	R-C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIORITY PLACE LLC	8726 WEST MILL ROAD MILWAUKEE, WI 53225

(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 408}	Continued From page 2 psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's Individual Service Plan (ISP) included the rationale for use of an as needed (PRN) psychotropic medication. Resident 3 had a PRN order for lorazepam 0.5 milligram (mg) (every 4 hours as needed) and received the medication on 8 occasions from 10/15/2025 to12/15/2025, and there was no documentation regarding the behaviors requiring the PRN, or side effects. Resident 3's ISP did not include the rationale for use of the medication or a detailed description of behaviors which would indicate the need to administer the PRN medication. Findings include: On 12/16/2025 at approximately 11:00 AM, Surveyors reviewed Resident 3's record. Resident 3's Order Summary, dated12/16/2025, included an order for lorazepam 0.5 mg tablets with instructions to give 1 tablet orally every 4 hours as needed for prophylaxis. Review of progress notes show that lorazepam was administered on 10/29/2025, 10/31/2025, 11/02/2025, 11/04/2025, 11/05/2025, 11/07/2025, 11/12/2025, and 11/24/2025. Resident 3's ISP did not include information about Resident 3's lorazepam, including rationale for use or a detailed description of behaviors for staff to administer the PRN medication. On 12/16/2025 at 12:30 PM, Surveyors	{N 408}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018879	A. BUILDING: _____ B. WING _____	R-C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIORITY PLACE LLC	8726 WEST MILL ROAD MILWAUKEE, WI 53225

(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 408}	Continued From page 3 interviewed Licensee E regarding the administration of lorazepam to Resident 3. Licensee E stated that the lorazepam was administered when Resident 3 was having adverse behaviors. Licensee E confirmed that there was no mention of Lorazepam in the ISP nor was there a valid indication in the administration record.	{N 408}		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not maintain accurate proof-of-use records for scheduled II drugs for 2 of 2 residents. Resident 4's and Residents 5's proof of use records were not accurate. Findings include: On 12/16/2025, at approximately 9:00 AM, Surveyors reviewed the proof of use records and controlled medications. Resident 4 had an order for clonazepam 0.5 milligram (mg) tablets (tabs), with instructions to	N 409		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018879	A. BUILDING: _____ B. WING _____	R-C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIORITY PLACE LLC	8726 WEST MILL ROAD MILWAUKEE, WI 53225

(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 409	Continued From page 4 take 1.5 tabs by mouth every morning. Resident 4's proof of use record last signed on 12/14/2025 shows 8 doses remaining. The blister pack for Resident 4's clonazepam had 6 doses remaining. Resident 5 has an order for clonazepam 0.5mg tabs, with instructions to take 0.5 tabs 2 times daily at 8:00 AM and 5:00 PM. The following was identified: AM doses: Proof of use record sheet shows a dose administered on 12/08/2025, no signature for that date. On 12/12/2025 the proof of record sheet shows 11 doses remaining. The next entry on the proof of record sheet is from 12/16/2025 showing 9 doses remaining. PM doses: Proof of use record sheet shows on 12/12/2025 there were 10 doses remaining, the next entry on the proof of record sheet is from 12/15/2025 which shows 6 doses remaining, with no entries in the record sheet between 12/12/2025 and 12/15/2025. On 12/16/2025 at 10:00 AM, Surveyors interviewed Licensee E. Licensee E stated s/he was unaware of any issues with narcotics administration and documentation. Licensee E reported s/he would have the nurse that covers the facility look into it and make necessary changes.	N 409		
N 492	83.45(1)(a) Exterior areas.	N 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018879	A. BUILDING: _____ B. WING _____	R-C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIORITY PLACE LLC	8726 WEST MILL ROAD MILWAUKEE, WI 53225

(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 492	Continued From page 5 Exterior areas. The CBRF shall maintain the yard, any fences, sidewalks, driveways and parking areas of the CBRF in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain the main parking lot area and emergency exit sidewalks of the community based residential facility (CBRF). The facility parking lot and emergency exit door sidewalks were not free of ice and snow. Findings include: The provider is licensed to care for 24 residents in the client groups advanced aged, traumatic brain injury, physically disabled, terminally ill, emotionally disturbed /mental illness, alcohol/drug dependent, correctional clients, and developmentally disabled. On 12/16/2025, at approximately 8:40 AM, Surveyor observed the facility parking lot, and 2 emergency exit sidewalks covered in ice and snow. The condition created an unsafe environment and increased the risk of slips and falls for residents at the facility. On 12/16/2025, at approximately 12:30 PM, Surveyor interviewed Licensee E. Licensee E reported s/he hired a snow removal company, and the company waited a few days to conduct the snow removal. Licensee E reported s/he was aware of the ice and snow in the parking lot, and s/he was not aware of the department's code to maintain the parking areas and sidewalks. Licensee E reported s/he would contact someone to have the parking lot and exit sidewalks cleared.	N 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018879	A. BUILDING: _____ B. WING _____	R-C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIORITY PLACE LLC	8726 WEST MILL ROAD MILWAUKEE, WI 53225

(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 499}	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were stored in a secure area. Surveyor observed cleaning compounds unsecured in the kitchen area. This had the potential to affect 16 of 16 residents in the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) 1JLV11, dated 02/18/2025. Findings include: The facility was licensed on 07/01/2025 to serve up to 24 residents, in the client groups advanced aged, traumatic brain injury, physically disabled, terminally ill, emotionally disturbed /mental illness, alcohol/drug dependent, correctional clients, and developmentally disabled. On 12/16/2025, at approximately 10:15 AM, Surveyor toured the facility and observed the following cleaning compounds unsecured in the kitchen area: -(1) 64 ounce jug of bleach -(3) 30 count containers of Weiman Stainless Steel Wipes -(4) 12 ounce cans of Weiman Stainless Steel Spray -(1) Bottle of Member's Mark Oven Grill and Fryer Cleaner	{N 499}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018879	A. BUILDING: _____ B. WING _____	R-C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIORITY PLACE LLC	8726 WEST MILL ROAD MILWAUKEE, WI 53225

(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 499}	Continued From page 7 -(1) 29 ounce bottle of Dettol Liquid Handwash Surveyor observed residents moving freely through the facility. On 12/16/2025, at approximately 12:30 PM, Surveyor interviewed Licensee E and Supervisor F. Licensee E reported s/he was aware of the department code to keep all chemicals securely stored. Supervisor F reported s/he would ensure all chemicals were securely stored in a locked cabinet located in the kitchen.	{N 499}		
{N 526}	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster drills were conducted semi-annually for 2025. There were no other emergency or disaster drills conducted in 2025. This is a repeat deficiency. See Statement of Deficiency (SOD) 1JLV11, dated 02/18/2025. Findings include: The facility was licensed on 07/01/2025 to serve up to 24 residents, in the client groups advanced aged, traumatic brain injury, physically disabled, terminally ill, emotionally disturbed /mental illness, alcohol/drug dependent, correctional clients, and developmentally disabled.	{N 526}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018879	A. BUILDING: _____ B. WING _____	R-C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIORITY PLACE LLC	**8726 WEST MILL ROAD MILWAUKEE, WI 53225**

(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 526}	Continued From page 8 On 12/16/2025, at approximately 11:00AM, Surveyor reviewed safety records. The safety files did not contain evidence of other emergency or disaster drills for 2025. On 12/16/2025, at approximately 12:30 PM, Surveyor interviewed Licensee E and Supervisor F regarding the missing drills. Licensee E confirmed the code requirement and reported no additional other evacuation drills were completed for the year 2025. Licensee E and Supervisor F did not have a reason as to why other evacuation drills were not completed semi- annually for the year 2025.	{N 526}		