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
	0012043	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE RIDGE OF PLOVER MEMORY CARE	**2841 MAPLE DRIVE PLOVER, WI 54467**

(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 A desk review complaint investigation was conducted for Maple Ridge of Plover Memory Care on 04/24/2025. Surveyors had been on-site at this facility on 04/16/2025 for a verification visit at which all deficiencies were corrected. The State Agency received this complaint on 04/21/2025 for an incident that occurred on 04/01/2025. This resident was no longer on-site as of 04/02/2025. All paperwork regarding this incident was reviewed. The complaint was unsubstantiated with no deficiencies identified. Census: 19	N 000		

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