STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017166	A. BUILDING: _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE RIDGE ASSISTED LIVING MAYVILLE	1175 BRECKENRIDGE STREET MAYVILLE, WI 53050

(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 04/22/2025 to 04/25/2025, Surveyor conducted a complaint investigation and standard survey at Prairie Ridge Assisted Living Mayville. Eight deficiencies were identified. Two of 8 deficiencies were repeat violations. See Statement of Deficiency (SOD) 4BFW11, dated 08/15/2023. The complaint is substantiated. Census: 30	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure complete background checks were conducted upon hire for 2 of 2 employees reviewed.	N 219		

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

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N 219	Continued From page 1 The complete background check is to include the background information disclosure form (BID), the criminal history search form from the department of justice (DOJ), and the information maintained by the department of safety and professional service regarding a person's credentials (IBIS). This is a repeat violation. See Statement of Deficiency (SOD) 4BFW11, dated 08/15/2023. Findings include: On 04/22/2025, Surveyor reviewed employee records and identified the following: -Caregiver C was hired 09/16/2024. Caregiver C's record did not include a BID, DOJ and IBIS letter. -Caregiver E was hired 07/13/2024. Caregiver E's record did not include a BID, DOJ, and IBIS letter. On 04/24/2025 at 2:00 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Administrator A reported after looking through files for the last 2 days, Caregiver C's and Caregiver E's employee records could not be located. Administrator A reported s/he had been in this role for 3 weeks and was finding a lot of things to be out of compliance. Administrator A reported Caregiver C no longer works for the provider and s/he was working with Caregiver E to redo their employee file.	N 219		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a	N 220		

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N 220	Continued From page 2	N 220		

physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure documentation was obtained from a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse indicating 3 of 3 employees (Caregiver B, Caregiver C, and Caregiver E) reviewed was screened for clinically apparent communicable disease including tuberculosis (TB).

Findings include:

On 04/22/2025, Surveyor reviewed employee records and identified the following:

-Caregiver B was hired on 08/29/2024. His/her record did not include a communicable disease screen.

-Caregiver C was hired on 09/16/2024. His/her record did not include a communicable disease screen.

-Caregiver E was hired 07/13/2025. His/her record did not include a communicable disease

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N 220	Continued From page 3 screen and baseline TB test. On 04/24/2025 at 2:00 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Administrator A reported after looking through files for the last 2 days TB test requirements could not be located for the above staff. Administrator A reported Former Administrator F hired the above staff and s/he would get new testing completed.	N 220		
N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain documentation of training for 2 of 2 employees reviewed. The records for Caregiver C and Caregiver E did not contain documentation of completed training in the following requirements: orientation, all employee, and task specific. Findings include:	N 223		

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N 223	Continued From page 4 On 04/22/2025, Surveyor reviewed employee records and identified the following: The record for Caregiver C, hired 09/16/2024, did not contain evidence of training in orientation, all employee, and task specific. A review of the provider's staff schedule from January-April 2025 included the following dates where Caregiver C worked alone without completing the above training's: 01/04/2025 and 02/01/2025. The record for Caregiver E, hired 07/13/2024, did not contain evidence of training in orientation, all employee, and task specific. On 04/22/2025 at 2:18 PM, Surveyor interviewed Administrator A. Administrator A reported before s/he started the business office was broken into, and employee records went missing. Administrator A stated s/he started 3 weeks ago at this location and was still going through care plans and chart audits. Administrator A acknowledged the provider was out of compliance in regard to maintaining training documentation in employee records. Administrator A stated s/he will continue to work on brining the facility back into compliance.	N 223		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete	N 239		

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N 239	Continued From page 5 training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver D obtained all department approved training as required. Caregiver D did not have training in fire safety or first aid and choking within 90 days after starting employment. This is a repeat violation. See Statement of Deficiency (SOD) 4BFW11, dated 08/15/2023. Findings include: On 04/22/2025, Surveyor conducted a review of employee files to verify compliance with department approved training requirements. First Aid and Choking:	N 239		

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N 239	Continued From page 6 The record for Caregiver D, hired 09/04/2022, did not contain evidence of training or evidence of meeting an exemption for First Aid and Choking. On 04/22/2025, Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for first aid and choking. On 04/24/2025 at 2:00 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Administrator A acknowledged an understanding of the concern. Administrator A reported s/he did not hire Caregiver D but will speak to him/her and continue to audit employee records for compliance.	N 239		
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, interview, and record review, the provider did not ensure 2 of 2 resident records reviewed (Resident 4 and Resident 6) received all prescribed medications in the dosage and at intervals prescribed by a practitioner. From 10/01/2024 to 04/21/2025, Resident 4 did not receive his/her Polyethylene glycol as prescribed.	N 352		

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N 352	Continued From page 7 From 03/08/2025 to 04/21/2025, Resident 6 did not receive his/her Polyethylene glycol as prescribed. Findings include: Example 1-Resident 4 On 04/22/2025 at 11:08 AM, Surveyor observed the provider's south medication cart with Caregiver I and identified the following: -Resident 4's polyethylene glycol container noted a manufacturer's label including the container originally held 30 once-daily doses of 17 grams. The container included a pharmacy label including Resident 4's practitioner's prescription for polyethylene glycol including, "Mix 17 GM in 8 OZ of liquid and drink every evening at 6PM for constipation." The pharmacy label included a delivery date to the facility of 10/15/2024. Surveyor observed approximately 1/3 of the medication remained within the container. Caregiver I observed and verbally confirmed 1/3 of the container remained. Surveyor observed another polyethylene glycol container with the same manufacturer's label and practitioner's prescription. The pharmacy label included a delivery date to the facility on 03/07/2025. Surveyor observed the container of medication was full and had not been opened. Caregiver I observed and verbally confirmed the 2nd container was full/not opened. On 04/22/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 12/12/2022 with diagnoses including hyperlipidemia, polyp of colon, and multiple eye conditions. Resident 4's	N 352		

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N 352	Continued From page 8 most recent individual service plan (ISP) dated 11/14/2024 indicated care staff administer his/her medications. Surveyor reviewed Resident 4's October 2024 to April 2025 medication administration record (MAR) and identified the following: -Resident 4 was administered 173 doses of polyethylene glycol between 10/16/2024-04/21/2025 from a 30-dose container, based on Resident 4's practitioner's order, with 1/3 of the medication remaining in the container. Example 2-Resident 6 On 04/22/2025 at 9:36 AM, Surveyor observed the provider's north medication cart with Caregiver G and identified the following: -Resident 6's polyethylene glycol container noted a manufacturer's label including the container originally held 30 once-daily doses of 17 grams. The container included a pharmacy label including Resident 6's practitioner's prescription for polyethylene glycol including, "Mix 17 GM in 8 OZ of liquid and drink every evening." The pharmacy label included a delivery date to the facility of 03/07/2025. Surveyor observed approximately 1/4 of the medication remained within the container. Caregiver G observed and verbally confirmed 1/4 of medication remained in the container. Surveyor did not observe any other containers within the med cart for Resident 6. On 04/22/2025, Surveyor reviewed Resident 6's record. Resident 6 was admitted on 01/15/2025 with diagnoses including diabetes, chronic gastritis, and cerebrovascular accident. Resident 6's most recent ISP with an unknown date indicated care staff administer his/her medication.	N 352		

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N 352	Continued From page 9 Surveyor reviewed Resident 6's March 2025 to April 2025 MAR and identified the following: -Resident 6 was administered 43 doses of polyethylene glycol between 03/08/2025-04/21/2025 from a 30-dose container, based on Resident 6's practitioner's order, with ¼ of the medication remaining in the container. On 04/24/2025 at 2:00 PM, Surveyor interviewed Administrator A regarding Resident 4's and Resident 6's polyethylene glycol order. Administrator A acknowledged if the above medications were administered as prescribed the containers would have been emptied much earlier and requests for refills would have been sent to the pharmacy. Surveyor expressed concern with the amount still left in each container and staff continuing to document as administered. Administrator A reported s/he was assuming staff were documenting as given, without administering the medication. Administrator A stated s/he would follow up with the pharmacy to ensure no other containers were delivered. Surveyor asked for evidence to be submitted no later than 04/25/2025 at 5:00 PM. On 04/25/2025 at 4:08 PM, Administrator A sent the Surveyor the following email: "[Resident 4]: Poly powder, last delivery date was 3/7/25. [Resident 6]: Poly powder, last delivery date was March 7, 2025. Staff education has already been completed."	N 352		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and	N 388		

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N 388	Continued From page 10 follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not implement Resident 5's individual service plan (ISP) as written. The provider did not record Resident 5's daily weights in accordance with his/her ISP for at least the last 79 days. Findings include: On 04/22/2025, Surveyor conducted a standard survey and identified the following: On 04/22/2025 at 8:45 AM, Surveyor observed Caregiver G perform a medication pass with Resident 5 in his/her room. Caregiver G reported Resident 5 had a low blood sugar reading in the 60's during the night, so s/he was sleeping in. Caregiver G reported Resident 5 received insulin 4x/day and had a catheter. Resident 5 was admitted to the facility on 07/10/2024 with diagnoses including type 2 diabetes, congestive heart failure, and hypertension. Resident 5 had an activated healthcare power of attorney. Resident 5's facesheet identified him/her as having these key indicators diabetes, fall risk, POA, home health (suprapubic catheter), and anticoagulant therapy. Resident 5's ISP dated 11/01/2024 documented: "Weights: Weights to be taken daily and as needed. Staff to notify Care Coordinator of weight gain/loss of 3lbs, within 48 hours. Care Coordinator will notify Primary MD with any changes of concerns via fax/phone." According to Resident 5's February to April 2025 medication administration records (MARs), the vital sections where weights are to be recorded,	N 388		

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N 388	Continued From page 11 staff did not document under this task at any point in the previous 79 days. On 04/24/2025 at 2:00 PM, Surveyor interviewed Administrator A. Surveyor stated s/he could not locate daily weights being recorded for Resident 5 per his/her ISP. Administrator A acknowledged an understanding of the concern and reported weights should be recorded on the medication administration record as a task to complete for the med passer. Surveyor requested Resident 5's documentation of daily weights for February 2025 to present. Surveyor asked for evidence to be submitted no later than 04/25/2025 at 5:00 PM. On 04/25/2025 at 4:08 PM, Administrator A sent the Surveyor the following email. "Weights: entered [his/her] care plan as daily, was not scheduled. It was checked as PRN. - Fixed."	N 388		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility had adequate staff to meet resident needs on 8 occasions between 01/01/2025-04/21/2025, when they had 1 staff member to care for 30 residents. Four residents (Resident 1, Resident 2, Resident 3, and Resident 5) all required 2 staff to assist with cares Findings include:	N 396		

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N 396	Continued From page 12 On 03/12/2025, the Department received a complaint that alleged concerns related to staffing. On 04/22/2025, Surveyor conducted a complaint investigation and identified the following: The provider is licensed to care for up to 45 residents in the client groups of advanced age, irreversible dementia/Alzheimer's, and terminally ill. On 04/22/2025 at 9:15 AM, Surveyor reviewed the resident roster with Caregiver G and noted 30 residents listed on the roster. Caregiver G reported s/he had worked full-time on the 1st shift since 2023. Caregiver G identified Resident 1, Resident 2, Resident 3, and Resident 4 as requiring 2 staff to assist with cares. Surveyor reviewed the January-April 2025 staff schedule and time punch cards which documented the provider staffed one caregiver for third shift on the following dates: 01/04/2025, 01/18/2025, 01/19/2025, 02/01/2025, 02/14/2025, 02/15/2025, 03/02/2025, and 04/03/2025. On 04/22/2025, Surveyor reviewed resident records and identified the following: -Resident 1 was admitted to the provider on 02/22/2019 with diagnoses including flaccid hemiplegia affecting right dominant side, his/her facesheet identified them as a fall risk and as receiving hospice services. Resident 1's individual service plan (ISP) dated 11/20/2024 documented: "Evacuation capabilities in an emergency: Resident will need assist of two to transfer into wheelchair. [S/he] will also need assistance to propel wheelchair to designated	N 396		

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area. Mobility/Transfers & Ambulation: Resident is a 2 assist with transfers to and from chair and wheelchair."

-Resident 2 was admitted to the provider on 04/20/2021 with diagnoses including type 2 diabetes, chronic pain, and multiple eye conditions. Resident 2's ISP dated November 2024 documented "Bathing: Resident needs complete assist of 2 to complete shower and 2 staff to complete dressing and to assist into wheelchair."

-Resident 3 was admitted to the provider on 01/31/2022 with diagnoses including dementia and multiple sclerosis. Resident 3's ISP dated 12/05/2024 documented: "Bathing: ...2 person assist required for Hoyer transfer. Toilet Check: ...Resident requires complete assistance of 2 staff with toileting needs."

-Resident 5 was admitted to the facility on 07/10/2024 with diagnoses including type 2 diabetes, congestive heart failure, and hypertension. Resident 5's ISP dated 11/01/2024 documented: "Mobility/Transfers & Ambulation: Resident is wheelchair bound and requires use of EZ Stand or 2-person pivot transfers and assistance pushing [his/her] wheelchair."

On 04/22/2025 at 12:55 PM, Surveyor interviewed Caregiver G regarding staffing on the 3rd shift. Caregiver G reported there is supposed to be 2 staff on the 3rd shift due to resident's needs. Caregiver G stated earlier this year there were times, I (Caregiver G) would come in to relieve 3rd shift and only 1 staff was working. Caregiver G stated it has not happened in a while.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017166	A. BUILDING: _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE RIDGE ASSISTED LIVING MAYVILLE	1175 BRECKENRIDGE STREET MAYVILLE, WI 53050

(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 396	Continued From page 14 On 04/22/2025 at 1:10 PM, Surveyor interviewed Caregiver H. Caregiver H stated there were typically 2 staff working on the 3rd shift due to resident needs. Caregiver H stated when Former Administrator F was in charge, there were times when only 1 staff was working on the 3rd shift. On 04/24/2025 at 2:00 PM, Surveyor interviewed Administrator A regarding staffing on the 3rd shift. Surveyor shared the above dates where only 1 staff was working. Administrator A reported Former Administrator F would have been in charge of finalizing the staff schedule during this time period. Administrator A acknowledged the staff schedules and timesheets had only 1 staff working on multiple dates. Administrator A stated since s/he had arrived we are ensuring at least 2 staff working on the 3rd shift.	N 396		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017166	A. BUILDING: _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE RIDGE ASSISTED LIVING MAYVILLE	1175 BRECKENRIDGE STREET MAYVILLE, WI 53050

(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 415	Continued From page 15	N 415		

provider did not ensure proper documentation within the Medication Administration Record (MAR) for 1 of 1 resident reviewed. Resident 5's MARs did not include documentation of the number of sliding scale insulin units administered over 39 days.

Findings include:

On 04/22/2025, Surveyor reviewed Resident 5's record and identified the following:

Resident 5 was admitted to the facility on 07/10/2024 with diagnoses including type 2 diabetes, congestive heart failure, and hypertension. Resident 5's most recent individual service plan (ISP) dated 11/01/2024 indicated s/he required assistance with medication administration.

Resident 5's physician orders included the following:
"Novolog Flexpen Syringe with instructions to inject 0-11 units subcutaneously per sliding scale 4 times a day with meals and at bedtime with a start date of 03/12/2025."

Surveyor reviewed Resident 5's March and April 2025 MAR. Between 03/13/2025-04/21/2025, (39 days), staff recorded 128 blood glucose levels that would have required sliding scale insulin. There was no documentation showing how many units of insulin Resident 5 was administered.

On 04/24/2025 at 2:00 PM, Surveyor interviewed Administrator A. Surveyor shared when Resident 5's Humalog was switched to Novolog in the middle of March 2025, staff did not ensure the number of sliding scale insulin units administered was recorded in the record. Administrator A

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	0017166	A. BUILDING: _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE RIDGE ASSISTED LIVING MAYVILLE	1175 BRECKENRIDGE STREET MAYVILLE, WI 53050

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N 415	Continued From page 16 acknowledged an understanding of the concern and reported staff should be recording the number of insulin units within the MAR. Administrator A stated since s/he was newer to the building s/he would need additional time to review Resident 5's orders. Surveyor asked for evidence to be submitted no later than 04/25/2025 at 5:00 PM. On 04/25/2025 at 4:08 PM, Administrator A sent the Surveyor the following email "sliding scale units were being documented and then [Former Administrator F] changed it. It is fixed."	N 415		