STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009712	A. BUILDING: _____ B. WING _____	C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE	258 N BEULAH ST ELLSWORTH, WI 54011

(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 12/20/2023, Surveyor conducted an abbreviated survey at Parkside. One deficiency was identified. Census: 8	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 medicine cabinets were secured, and the key available only to personnel identified by the CBRF (community based residential facility). Findings include: On 12/20/2023 at approximately 11:30 AM, Surveyor requested to observe the medication storage area in the kitchen. Program Manager (PM) A walked over to the medication cabinet, opened a drawer located next to the cabinet, and retrieved a set of keys. PM A opened the medication cabinet. Surveyor asked PM A if the keys were always stored in the unsecured drawer. PM A stated, "Staff do try to keep them on them." Surveyor asked Caregiver B (working at the time of observation) if the keys were always stored in the drawer. Caregiver B stated, "Yeah." Caregiver B further stated that s/he asked where they should be stored and stated s/he was told to place them in the drawer. Two residents were seated at the	N 419		

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

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N 419	Continued From page 1 kitchen table and another resident passed through the kitchen at the time of observation. PM A confirmed the key to open the lock box in the refrigerator was also on the keychain. PM A stated s/he would work to ensure staff secured the keys at all times. The provider did not ensure the medicine cabinets were secured when the keys were stored in an unsecured drawer next to the cabinet, available to anyone in the home.	N 419		