STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012395	A. BUILDING: _____ B. WING _____	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	1015 ELM ST PLATTEVILLE, WI 53818

(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 06/15/2026, with information gathered through 06/16/2026, Surveyor conducted an abbreviated licensing survey at Park Place Assisted Living, a CBRF in Platteville, WI. One deficiency of Chapter DHS 83 was identified. Census: 32	N 000		
N 414	83.37(2)(c) Medication administration not supervised Medication administration not supervised by a registered nurse, practitioner or pharmacist. When medication administration is not supervised by a registered nurse, practitioner or pharmacist, the CBRF shall arrange for a pharmacist to package and label a resident ' s prescription medications in unit dose. Medications available over-the-counter may be excluded from unit dose packaging requirements, unless the physician specifies unit dose. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure medications were packaged in unit dose when the medication administration was not supervised by a registered nurse (RN), practitioner, or pharmacist. Findings include: On 06/15/2026 at approximately 10:50 AM, Surveyor observed the medication carts with RN Care Coordinator B. Surveyor requested access to the narcotic boxes to review the controlled substances. RN Care Coordinator B opened the boxes, and Surveyor observed 3 bottles of liquid	N 414		

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

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N 414	Continued From page 1	N 414		

morphine. Two bottles were unopened, 1 for Resident 1, and 1 for Resident 2. The third bottle was opened and was labeled as Resident 3's. The bottles were the same size for each resident, originally filled with 30 mL, and each was dosed at 100mg/5mL.

At 10:55 AM, Surveyor reviewed the proof of use sheets for each of the medications. Resident 1's proof of use sheet did not have any documented administration of the morphine, and the amount left was documented as 30 mL. Resident 2's proof of use sheet did not have any documented administration of the morphine, and the amount left was documented as 30 mL. Resident 3's proof of use sheet documented 1 dose (0.25 mL/ 5mg) of morphine as administered, and the amount left was 29.75 mL.

At approximately 11:00 AM, Surveyor interviewed RN Care Coordinator B. Surveyor asked about nursing supervision in the facility and RN Care Coordinator B stated there was 1 nurse designated to assisted living, 1 designated to memory care, and that the administrator was also a nurse. S/he stated there was nurse presence Monday-Friday from roughly 8:00 AM - 4:00 PM, and occasionally later into the evening. RN Care Coordinator B also stated there was a nurse on call 24 hours a day/ 7 days a week. Surveyor asked if the facility provided training to the medication passers on drawing a liquid medication into a syringe for administration, and s/he was unsure. Surveyor asked how the med passers verify count for the liquid morphine. RN Care Coordinator B stated they look at the side of the morphine bottle to visually see which measurement line the liquid was at, and they look at previous counts and administration to validate the count. Surveyor showed RN Care Coordinator

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N 414	Continued From page 2 B Resident 3's bottle of morphine, which appeared to be sitting just above the 30 mL line. Surveyor verified with RN Care Coordinator B that s/he saw the same thing which s/he confirmed. The morphine bottles had fine lines as a visual guide to measure the volume remaining in the bottles. However, there were only 10 lines, so each line was an indication of 3 mL equaling the 30 mL in a full bottle. Surveyor asked if the count for the liquid morphine was an estimate or if there was another way to measure the exact remaining amount, and RN Care Coordinator B stated it was an estimate. RN Care Coordinator B stated s/he was unaware the medication needed to be in unit dose packaging. At approximately 1:50 PM, Surveyors interviewed Administrator A regarding the bottles of liquid morphine. Surveyor asked if s/he was aware of any training for the facility's med passers regarding the administration of liquid morphine from a bottle, using a syringe to draw the dose. Administrator A stated they do training as RNs with the med passers, but there is no documentation for that specific training. Administrator A stated the facility has used liquid morphine and their med passers have drawn the doses themselves for a long time, and that no one had brought this up in the past as a concern.	N 414		