| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020088 | A. BUILDING: _____ B. WING _____ | C 02/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRAIRIE VIEW MANOR | 111 COMMERCIAL DR FOOTVILLE, WI 53537 |

| (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 |
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| N 000 | Initial Comments<br><br>On 02/19/2025, the bureau of assisted living southern regional office conducted 2 complaint investigations at Prairie View Manor a CBRF located in Footville, WI.<br><br>As a result of this survey, 1 violation of DHS Chapter 83 was issued.<br><br>One complaint was substantiated.<br><br>Census: 48 | N 000 | | |
| N 432 | 83.38(1)(h) Medication administration.<br><br>As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs.<br><br>This Rule is not met as evidenced by:<br>Based on record review & interview, the provider did not ensure Resident 1 received adequate medication administration to appropriate to meet his/her needs.<br><br>On 01/18/2025, Resident 1 was handed his/her morning pills in a cup. Resident 1 dropped the cup of pills. Resident 1 could not summon facility staff and called 911. When EMTs (emergency medical technicians arrived at 12:38 PM, they | N 432 | | |

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

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| N 432 | Continued From page 1<br>observed pills on Resident 1's floor and chair.<br><br>FINDINGS INCLUDE:<br><br>On 02/05/2025, the Department received a complaint regarding facility services.<br><br>On 02/19/2025, Surveyor arrived at facility for a complaint investigation.<br><br>On 02/19/2025, Surveyor reviewed Resident 1's EMS (emergency medical service) incident report #25-026. The report was dated 01/18/2025. The report documented EMS was called at 12:38 PM, arrived on scene at 12:28 PM, and dispatching from the scene at 12:38 PM. The narrative section of the reported documented, "[EMTs] were dispatched to [Facility Address] [Resident 1's Room Number] for a non-injury fall victim. The patient need (sic.) help into [his/her] wheelchair and care staff was not responding to [his/her] calls for help. units (sic.) arrived on scene and found the patient sitting in a chair in [his/her] room. [S/He] stated [s/he] had not fallen but was not able to reach [his/her] wheelchair and care staff were not responding to [his/her] room upon calling for help. EMS assisted the patient with [his/her] wheelchair ...The patient stated that Care staff have [his/her] pills to [him/her] but left the room before [s/he] took them and [s/he] had spilled them all over [himself/herself], the patient requested EMS gather [his/her] spilt pills for [him/her]. EMS gathered the pills in [his/her] chair and gave them to the patient, care staff was asked to assist the patient with [his/her] medication ..."<br><br>On 02/19/2025 at 11:45 AM, Surveyor interviewed Resident 1. Resident 1 reported facility had improved on call light response times and | N 432 | | |

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| N 432 | Continued From page 2 | N 432 | | |

medication administration in the last month. Resident 1 reported Administrator A was a very caring and present. Resident 1 did recall a morning a caregiver had given his/her morning pills in a cup and left the room. Resident 1 stated s/he had fallen asleep with the cup of pills in his/her hand and when s/he woke up the pills spilled all over the place. Resident 1 reported having difficulty summoning staff that morning with his/her call light. Resident 1 stated s/he was forced to call 911 because s/he needed his/her medications and help with a transfer.
On 02/19/2025 at approximately 12:00 PM, Surveyor observed a medical technician administer Resident 1's noon pill. Surveyor observed the medical technician administer the noon pill in a spoon with applesauce, then watch Resident 1 swallow the pill with applesauce.

On 02/19/2025, Surveyor reviewed Resident 1's facility face sheet. Resident 1 was admitted to the facility on 11/22/2024.

On 02/19/2025, Surveyor reviewed Resident 1's January 2025 medication administration record (MAR). On 01/18/2025, Medical Technician D documented s/he had administered Resident 1's 8:00AM medications. Resident 1's diagnoses included but were not limited to: schizotypal disorder, depression, generalized anxiety disorder, and multiple sclerosis. Resident 1 scheduled medication orders were for the following intervals: 8:00 AM, 4:00 PM, and 8:00 PM.

On 01/18/2025, Medical Technician D documented s/he had administered the following medications to Resident 1 at 8:00 AM:
1.) Atorvastatin 20 mg (milligram) tablet
2.) Baclofen 5 mg tablet

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| N 432 | Continued From page 3<br>3.) Calcium Citrate 200 mg tablet<br>4.) Cetirizine 10 mg tablet<br>5.) Furosemide 20 mg tablet<br>6.) Gabapentin 400 mg tablet<br>7.) Sertraline 100 mg tablet<br>8.) Vitamin D3 25 MCG (microgram) tablet<br>9.) Vitamin E 1,000 units capsule<br>10.) Cefrozil 500 mg tablet<br><br>On 02/19/2025 at 12:30 PM, Surveyor discussed the above concern with Administrator A and Director B. Administrator A stated facility had recently started administering Resident 1's pills in applesauce. Administrator A stated s/he had not been made aware of Resident 1's being found on the floor on 01/18/2025. Director B stated Medication Technician D was no longer working for the facility. Administrator A and Director B reported a recent turnover in staff and reported an improvement in recent weeks. Administrator A and Director B acknowledged Resident 1's pills 8:00 AM pills were not administered to him/her until approximately 12:30 PM on 01/18/2025. | N 432 | | |