STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012042	A. BUILDING: _____ B. WING _____	R-C 11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE RIDGE OF PLOVER	2831 MAPLE DRIVE PLOVER, WI 54467

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{N 000}	Initial Comments On 11/10/2025, Surveyors conducted a verification visit. As a result of the survey, two (2) of the three (3) previous deficiencies were corrected, one (1) repeat deficiency was identified and one (1) new deficiency was identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 16	{N 000}		
N 432	83.38(1)(h) Medication administration. 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. This Rule is not met as evidenced by: Based on observation, interviews and record review, the provider did not provide medication services, including procedures to assure the accurate administering of all medications, to meet the needs of residents. In 1 of 1 medication cart of the facility, opened insulin pens were discovered in the med cart without a resident name, pharmacy label or date when the pen was opened or expired.	N 432		

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

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N 432	Continued From page 1 Findings include: Division of Quality Assurance Insulin Storage Guide publication dated 06/2023 indicated, "...Insulin is available from the drug manufacturers in two basic packages-vials and pens. General insulin storage requirements are as follows: ...5. Check Storage guideline specific to the insulin formulation. This is usually in the product package insert..." ~Review of the Humalog KwikPen Manufacturer's Insert revised 05/2025 indicated, "When stored at room temperature, Humalog KwikPen can only be used for a total of 28 days, including both not in-use (unopened) and in-use (opened) storage time..." ~Review of the Lantus Solostar Manufacturer's Insert dated 2022 indicated, "After 28 days, throw your opened Lantus pen away---Even if it still has insulin in it." ~Review of the Admelog Solostar Manufacturer's Insert dated 2024 indicated, "Only use your pen for up to 28 days after its first use. Throw away the Admelog SoloStar pen you are using after 28 days, even if it still has insulin left in it." ~Review of the Tresiba FlexTouch Pen Manufacturer's Insert revised 07/2022 indicated, "The Tresiba FlexTouch Pen you are using should be thrown away after 56 days if it is refrigerated or kept at room temperature, even if it still has insulin left in it and the expiration date has not passed." On 11/10/2025 at 12:20 PM, Surveyor observed the facility's medication cart with Supervisor G. A blue colored plastic box with the number "4" written on top with a black marker, contained an opened Humalog KwikPen and an opened Lantus Solostar pen. Both insulin pens contained no	N 432		

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N 432	Continued From page 2	N 432		

resident name, pharmacy label or dates to confirm when the pens were opened or expired. Supervisor G verified the insulin pens in the blue plastic box marked with the number "4" were opened and prescribed for Resident 2. Supervisor G also confirmed the insulin pens did not contain the resident's name, a pharmacy label or date when the pens were opened or expired. Surveyor observed a second blue colored plastic box with the number "15" written on top with a black marker in the medication cart. The box contained an opened Tresiba Flextouch Pen and an opened Admelog SoloStar pen. Both insulin pens contained no resident name, pharmacy label or dates to confirm when the pens were opened or expired. Supervisor G verified the insulin pens in the blue plastic box marked with the number "15" were opened and prescribed for Resident 3. Supervisor G confirmed the insulin pens did not contain the resident's name, a pharmacy label or date when the pens were opened or expired. Supervisor G stated, "Staff should be labeling the insulin pens with the resident's name and date the pen was opened.

On 11/10/2025 12:30 PM, Surveyor interviewed Employee Relations H regarding the above observations. Employee Relations H verified the above insulin pens had been opened previously and did not document a date as to when each were opened. Employee Relations H further verified the above insulin pens stored within the blue plastic boxes in the medication cart did not contain a resident name or pharmacy label. Employee Relations H stated, "Staff are supposed to be using a white sticky label and writing the resident name, date opened and attaching it to the pens."

On 11/10/2025 at 1:25 PM, Surveyors shared the

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N 432	Continued From page 3 above observations with Administrator A. Surveyors asked if the facility had a policy and procedure for Medication Storage and Labeling. Administrator A indicated the facility did not have a policy and stated, "We want staff to use address labels and write the resident's name, with the date the pen was opened with a marker and stick it to the pen."	N 432		
{N 617}	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and staff interviews the provider did not ensure water temperatures at fixtures used by residents were 115 degrees F (Fahrenheit) or less. This is a repeat deficiency and is being cited for the third time. See SOD (Statement of Deficiency) SOD D5V212 dated 02/25/2020 and SOD V31R11 04/29/2025 Findings include: This facility is licensed as a Class CNA (non-ambulatory) and serves residents who are advanced aged, terminally ill, and who have	{N 617}		

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{N 617}	Continued From page 4 irreversible dementia or Alzheimer's disease. The facility's Water Temp Policy, dated 07/06/2025 indicated, "Water temps will be taken weekly by administrative staff or maintenance staff. They are to be logged in the maintenance binder in each building. The water temperature policy for community-based residential facilities (CBRFs) is as follows: To avoid injury, check the temperature of hot water at sinks, tubs, and showers before resident use...The temperature of water at fixtures used by residents should be automatically regulated by valves and may not exceed 115°F... Management should be notified of any discrepancies within one business day of the findings. Management is to contact and schedule a plumber to come out and have the situation addressed and resolved within 1 week of findings." On 11/10/2025 at approximately 10:45 AM, Surveyor tested water temperatures at the sink in the east wing resident bath/shower room with Supervisor G. The water temperature at the sink in the east wing bath/shower room across from Room 8 was 126 degrees F. Supervisor G confirmed the temperature was 126 degrees F and verified the east wing bath/shower room was used by the residents. Supervisor G stated, "The water does get hot at times." Surveyor and Supervisor G then tested the water at the sink in Resident 4's bedroom on the east wing which tested at 126 degrees F. Supervisor G confirmed the temperature was 126 degrees F. On 11/10/2025 at 12 PM, Surveyor tested the water temperature at the sink in the east wing bath/shower room for a second time. The temperature was 126 degrees F. Surveyor then	{N 617}		

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{N 617}	Continued From page 5 went into Resident 4's bedroom to test the water at the sink for a second time. The temperature was 127 degrees F. At 12:10 PM, Surveyor tested the water temperature at the sink in Resident 5's bedroom. The temperature was 127 F. On 11/10/2025, Surveyor reviewed the facility's "Water Temperatures log" and noted the following: *08/26/2025- Common bath on the west wing was 150 degrees F *09/04/2025- Common bath on the west wing was 140 degrees F with a note "hot" *09/09/2025- Common bath on the east wing was 125 degrees F *09/16/2025- Common bath on the west wing was 124 degrees F *09/23/2025- Common bath on the west wing was 135 degrees F *09/30/2025- Common bath on the west wing was 120 degrees F *10/07/2025- Common bath on the west wing was 145 degrees F and 120 degrees F on the east wing *10/14/2025- Common bath on the west wing was 140 degrees F with a note "hot" and 125 degrees F on the east wing *10/23/2025- Common bath on the west wing was 140 degrees F and 125 degrees F on the east wing *10/28/2025- Common bath on the west wing was 145 degrees F and 120 degrees F on the east wing *11/06/2025- Common bath on the west wing was 145 degrees F with a note "hot" and 125 degrees F on the east wing During the exit with Surveyors on 11/10/2025 at	{N 617}		

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{N 617}	Continued From page 6 approximately 1:10 PM, Surveyors shared the above findings with Administrator A and Employee Relations H. Surveyors asked what steps were taking when the above recorded water temperatures exceeded safe levels. Administrator A stated, "Our maintenance staff takes and records the water temperatures on the log. Maintenance should be telling me or [Employee Relations H] the water temperatures are exceeding the requirement so I can call a plumber...Maintenance staff hasn't been notifying us of the discrepancies." Administrator A then stated, "On 11/03/2025, we installed two new water softeners and replaced the mixing valve units on the east and west wing water heaters to help control the water temperatures."	{N 617}		