

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020536	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/16/2026
NAME OF PROVIDER OR SUPPLIER PRAIRIE FOX COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 225 PRAIRIE FOX COURT NORTH FOND DU LAC, WI 54937		
(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
M 000	INITIAL COMMENTS On 03/11/2026, with additional information gathered through 03/16/2026, Surveyor reviewed 1 self-report at Prairie Fox Court. As a result of the self-report review, 1 new deficiency was identified. Census 2	M 000		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure prompt and adequate treatment was provided for Resident 1. Resident 1 had a diagnosis of type 1 diabetes. Resident 1 began showing symptoms of high blood sugar on 01/09/2026. Resident 1 began exhibiting stomach pain, vomiting and confusion. Symptoms continued through 01/12/2026 and Resident 1 passed away prior to medical interventions. Findings include: On 03/11/2026 at approximately 8:30AM, Surveyor interviewed Technology Support Manager A (TSM-A). TSM-A explained Resident 1 had a recent insulin medication change. Over the weekend (01/09/2026 - 01/12/2026), Resident 1 began showing cold/flu-like symptoms. TSM-A reported during morning medication administration, Resident 1 wanted to lie back down and was later found unresponsive. TSM-A	M 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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M 580	Continued From page 1 confirmed Resident 1 passed away at home. TSM-A reported there was an investigation and a report was made to the Office of Caregiver Quality for Residential Support Supervisor D (RSS-D) due to the outcome of the investigation. TSM-A explained the provider's policy for DSPs to report concerns is to call the DSP hotline. An on-call person in management responds to the call. Resident 1's condition was reported to the DSP hotline. TSM-advised s/he was not involved in the incident but would obtain the investigation for Surveyor's review. TSM-A reported direct support professionals (DSP) were re-trained about change in condition. On 03/12/2026, Surveyor reviewed Resident 1's face sheet. The face sheet identified Resident 1 was admitted on 05/19/2025 and had a diagnosis of type 1 diabetes mellitus. On 03/12/2026, Surveyor reviewed Resident 1's Individual Service Plan (ISP), dated 10/01/2025 and medication administration record. The ISP identified Resident 1 was diabetic from a young age and the MAR reflected blood sugar checks four times daily. On 03/12/2026, Surveyor reviewed Resident 1's T-log notes - Shift Summary Updates for December 2025 and January 2026. The notes documented the following change in condition: 01/06/2026 "High *no other notes written" 01/09/2026 "AM blood sugar 544" 01/10/2026 "AM blood sugar 425 - got 8 units"	M 580		

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M 580	Continued From page 2 "Note: Please watch [Resident 1], [s/he] began shaking more than usual." 01/11/2026 "6:52am [Resident 1] threw up ... 8:17am [Resident 1] threw up." On 03/12/2026, Surveyor reviewed the provider's investigation dated, 01/12/2026 through 01/16/2026, regarding Resident 1's change of condition. The investigation noted the following timeline: 01/10/2026: RSS-D received text messages from Direct Support Professional E (DSP-E) reporting Resident 1 was having high blood sugar readings. 01/11/2026 at 9:10AM: DSP-E sent a text message to RSS-D to report the following, "[Resident 1] not holding anything down. Sugar high, can't get insulin, I think [his/her] meds came back up too." RSS-D indicated s/he would contact the nurse. 01/11/2026 at 8:45PM: Direct Support Professional C (DSP-C) called the DSP hotline to report Resident 1's condition was getting worse. RSS-D gave no further instruction regarding the blood sugar, increase in symptoms or notifying a nurse or the residential manager. DSP-C continued to monitor. 01/12/2026 at 4:12AM: DSP-C called the DSP hotline again to report Resident 1's condition was getting worse. The report was given to Residential Manager F (RM-F). DSP-C reported Resident 1 was exhibiting cold like symptoms and was running into walls when walking. RM-F advised Resident 1 should be taken to urgent care once RSS-D arrived on his/her shift and to	M 580		

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M 580	Continued From page 3 report worsening symptoms. 01/12/2026 at 6:16AM: DSP-C began medication pass. DSP-C described Resident 1 continued to sleep and did not take medications. At 6:45AM, DSP-C checked on Resident 1 and s/he was still sleeping. 01/12/2026 at 6:50AM: DSP-E arrived to relieve DSP-C. DSP-C and DSP-E discussed Resident 1's condition. DSP-C told DSP-E the plan was for Resident 1 to go to urgent care later, but DSP-C said s/he felt Resident 1 should be sent to the hospital. 01/12/2026 at 7:15AM: DSP-E checked on Resident 1 and noted Resident 1 was in bed facing the window. DSP-E returned to his/her duties. 01/12/2026 at 7:54AM - DSP-E went to check on Resident 1 and noted, "[Resident 1] is on [his/her] back in [his/her] bed, with [his/her] hand resting on [his/her] stomach ..." The investigation further noted, "[DSP-E] notices that [s/he] cannot hear breathing and [s/he] does not see [Resident 1's] chest rising and falling. [DSP-E] touches [Resident 1] and [Resident 1] is warm to the touch, but remains unresponsive. [DSP-E] realizes [Resident 1] has passed away ..." 01/12/2026 at 8:20AM - RSS-D instructed DSP-E to call 911. 01/12/2026 approximately between 8:20AM and 9:07AM - Residential Manager G (RM-G), RSS-D, the police, emergency medical services (EMS) and the coroner's office arrived to the home. On 03/13/2026, at 6:54AM, Surveyor interviewed	M 580		

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M 580	Continued From page 4 Direct Support Professional B (DSP-B). DSP-B identified s/he works the overnight shift and worked on Friday, 01/09/2026, into the next morning. DSP-B reported the day shift caregiver arrived and assisted Resident 1 with obtaining his/her morning blood sugar reading. As DSP-B was getting ready to leave s/he overheard Resident 1's blood sugar reading was 544. DSP-B identified this was too high and advised the day shift caregiver to "call someone." DSP-B reported this was the last shift s/he worked with Resident 1. On 03/16/2026 at 7:44AM, Surveyor interviewed DSP-C. DSP-C identified s/he works the overnight shift and worked on Sunday, 01/11/2026 into the following morning, 01/12/2026. DSP-C reported s/he was not informed that Resident 1 was not feeling well over the weekend. DSP-C described Resident 1's condition during the 01/11/2026 overnight shift. DSP-C reported Resident 1's blood sugar was running high and at approximately 7:30PM, s/he vomited. Resident 1 reported his/her stomach was hurting and DSP-C observed Resident 1 holding his/her abdominal area. DSP-C stated s/he called and reported to the DSP hotline between 8:30PM and 8:45PM. At approximately 10:00PM, DSP-C reported Resident 1 said his/her stomach hurt. DSP-C reported sometime between midnight and 1:00AM (01/12/2026), Resident 1 got up to use the bathroom. DSP-C reported Resident 1 was independent with ambulating and toileting, but this time, Resident 1 requested help because s/he was weak and could not reach for things. DSP-C explained Resident 1 needed assistance getting back into bed as s/he was groggy and running into his/her nightstand. DSP-C recalled Resident 1 said s/he "felt like puking." DSP-C stated at approximately	M 580		

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M 580	Continued From page 5 4:00AM to 4:10AM, s/he called the DSP hotline again. The on-call person informed DSP-C Resident 1 would be taken into urgent care later that morning when the supervisor was on shift. DSP-C stated s/he felt Resident 1 needed to go to the emergency room. DSP-C stated s/he was informed later that day that Resident 1 passed away. On 03/11/2026, at 4:45PM, Surveyor reviewed information regarding high blood sugar (hyperglycemia) from the Mayo clinic found at https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631. The Mayo Clinic noted the following: "High blood sugar, also called hyperglycemia, affects people who have diabetes ...It's important to treat hyperglycemia. If it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care ...Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL) ... If hyperglycemia isn't treated, it can cause toxic acids, called ketones, to build up in the blood and urine. This condition is called ketoacidosis. Symptoms include: Fruity-smelling breath Dry mouth Abdominal pain Nausea and vomiting Shortness of breath Confusion Loss of consciousness" Resident 1 began showing signs of a change in condition on 01/09/2026. According to Resident 1's T-log notes, beginning on 01/09/2026, s/he	M 580		

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M 580	Continued From page 6 began showing high blood sugar readings. On 01/10/2026, the T-log notes described Resident 1 was shaking. On 01/11/2026, the T-log notes indicated s/he was vomiting. Interviews identified Resident 1 experiencing weakness, confusion, stomach pain and vomiting. The provider's investigation noted Resident 1's symptoms were worsening and were reported by DSPs working the home on 01/11/2026 at 9:10AM, 01/11/2026 at 8:45PM and 01/12/2026 at 4:12AM. The DSPs were not provided guidance on medical interventions until 01/12/2026 at 4:12AM, which included waiting until RSS-D was on shift. Resident 1 passed away at home in his/her bed.	M 580		