

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0010589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/22/2024
NAME OF PROVIDER OR SUPPLIER PRAIRIE GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 900 O'KEEFFE AVE SUN PRAIRIE, WI 53590		
(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 05/22/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit for Statement of Deficiency (SOD) XR2712, dated 12/29/2023, and SOD ILNU11, dated 01/26/2024, at Prairie Gardens, a community-based residential facility (CBRF) located in Sun Prairie, WI. As a result of the survey, 0 deficiencies were identified. All 5 deficiencies from SOD XR2712 and both deficiencies from SOD ILNU11 were corrected. Under statutory provisions of Wis. Stat. Chapter 50, a \$200 revisit fee is being assessed. Census: 38	{N 000}		

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

TITLE

(X6) DATE