STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018008	A. BUILDING: _____ B. WING _____	C 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCHWOOD SENIOR LIVING	25025 75TH STREET SALEM, WI 53168

(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 05/28/2026, Surveyors completed a complaint and standard survey at Archwood Senior Living. As a result, 3 deficiencies were identified. One of 1 complaint was substantiated. Census: 28	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner for 1 (Resident 1) of 3 residents reviewed. Resident 1 did not receive his/her rivastigmine as prescribed. Resident 1 did not receive 1 dose of his/her medication in January 2026 and 9 doses of medication in March 2026. Findings include: On 04/20/2026, the department received a complaint alleging a resident was not being offered their prescribed medication(s). On 05/28/2026 at approximately 9:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/28/2025. Resident 1 was	N 352		

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

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N 352	Continued From page 1	N 352		

diagnosed with mixed hyperlipidemia and age-related cognitive decline. Resident 1's individual service plan (ISP), dated 04/21/2025, indicated staff assisted Resident 1 with medication management and administration. Resident 1 had a physician order for the following medications:

Melatonin 3 milligram tablet, take one tablet by mouth at bedtime.
Sertraline 100 milligram tablet, take one tablet by mouth every day at noon.
Midodrine hydrochloride 2.5 milligram tablet, take one tablet by mouth every day at noon.
Rivastigmine 4.6 milligram/24-hour patch, Apply 1 patch every day by transdermal route. "Remove old patch, before putting new patch on. MUST wear gloves."

Resident 1's January 2026 medication administration record (MAR) indicated on January 22, 2026, Resident Assistant A, placed a new rivastigmine patch before removing the old rivastigmine patch. In addition, Resident 1 was not administered melatonin on 01/03/2026.

Resident 1's March 2026 MAR indicated Resident 1 was not administered sertraline on 2 occasions, melatonin on 1 occasion, midodrine on 2 occasions, and rivastigmine on 4 occasions.

On 05/28/2026 at approximately 12:15 PM, Surveyor interviewed Executive Director B, Director of Nursing C, Activity Director D, and Community Relations E. Executive Director B acknowledged Resident 1 was provided with a new rivastigmine patch prior to the old rivastigmine patch being removed. Executive Director B reported once this medication error was identified, education was provided to all the

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N 352	Continued From page 2 caregivers about the residents' six medication rights: "right patient, right medication, right dose, right time, right to refuse, and right route." Executive Director B was unsure as to why Resident 1 may have not been administered the above medications but stated he/she "would look into it."	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 (Resident 1 and Resident 2) of 3 residents reviewed had an updated individual service plan (ISP) when there was a change in her/his needs. Resident 1's ISP did not address Resident 1's behaviors and enrollment onto hospice services. Resident 2's ISP did not address Resident 2's enrollment onto hospice services.	N 389		

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N 389	Continued From page 3 Findings include: On 05/28/2026 at approximately 9:30 AM, Surveyor reviewed resident's records. The following was identified: Resident 1 was admitted on 01/28/2025. Resident 1's observation notes between January 2026 and March 2026 indicated Resident 1 refused multiple showers, refused medications multiple times, removed his/her rivastigmine patch multiple times, displayed agitation and combativeness towards facility staff. On 03/31/2026, and observation note indicated "hospice nurse" contacted the facility to inform them of Resident 1's return to the facility and to notify the hospice agency of any change in condition. Resident 1's ISP, dated 04/21/2025, did not address Resident 1's continued refusal for showers, continued refusal for medications, Resident 1 removing his/her rivastigmine patch, or Resident 1 enrolling onto hospice service. Resident 2 was admitted on 09/10/2025. Resident 2's record contained a "Hospice Alliance Admission Information" document, dated 04/02/2026. The form stated, "Please inform your staff that the patient is now: Admitted to Hospice Alliance." In addition, Resident 2's record contained a document that stated, "Hospice Alliance: Partners in Care - Memorandum Of Understanding," dated 04/02/2026. The document indicated skilled nursing would see Resident 2 once a week and the hospice aide would assist with personal care and feeding 4 times a week. The document was signed by the hospice nurse and Executive Director B. Resident 2's ISP, dated 10/27/2025, did not address Resident 2's enrollment onto	N 389		

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N 389	Continued From page 4 hospice services. On 05/28/2026 at approximately 12:15 PM, Surveyor interviewed Executive Director B, Director of Nursing C, Activity Director D, and Community Relations E. Executive Director B disclosed the director of nursing is responsible for completing and updating ISPs when a resident is enrolled onto hospice services or if there is a change of condition. Executive Director B reported the previous director of nursing recently left the company and Director of Nursing C started on 05/28/2026. Executive Director B reported he/she would look at residents' ISP and update them accordingly.	N 389		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have documentation of the time of medication administration, the person administering the medication or treatment and the	N 415		

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N 415	Continued From page 5	N 415		

name, dosage, date and time of medication taken or treatments performed and initialed in the medication administration record (MAR) for 1 (Resident 1) of 3 residents reviewed.

The provider did not accurately document when Resident 1 was administered medications.

Findings include:

On 04/20/2026, the department received a complaint alleging a resident was not being offered their prescribed medication(s).

On 05/28/2026 at approximately 9:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/28/2025. Resident 1 was diagnosed with mixed hyperlipidemia and age-related cognitive decline. Resident 1's observation note, dated 03/21/2026, stated, "writer assisted med passer with resident's patch and early noon care ..." Resident 1's individual service plan (ISP), dated 04/21/2025, indicated staff assisted Resident 1 with medication management and administration. Resident 1 had a physician order for the following medications:

Sertraline 100 milligram tablet, take one tablet by mouth every day at noon.
Midodrine hydrochloride 2.5 milligram tablet, take one tablet by mouth every day at noon.
Rivastigmine 4.6 milligram/24-hour patch, Apply 1 patch every day by transdermal route. "Remove old patch, before putting new patch on. MUST wear gloves."

Resident 1's March 2026 MAR did not indicate that Resident 1's sertraline, midodrine and rivastigmine was administered as no initials were observed on the MAR.

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N 415	Continued From page 6 On 05/28/2026 at approximately 12:15 PM, Surveyor interviewed Executive Director B, Director of Nursing C, Activity Director D, and Community Relations E. Executive Director B acknowledged the missing signatures. Executive Director B acknowledged the observation note that indicated Resident 1 was administered medication. Executive Director B could not state why the medications were not signed out as administered, but "would look into it."	N 415		