STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011364	A. BUILDING: _____ B. WING _____	R-C 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARGONNE	9835 W ARGONNE DR WAUWATOSA, WI 53222

(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 11/21/2025, Surveyor completed a verification visit, and 1 complaint investigation at Argonne. As a result, 3 of 4 previous deficiencies were corrected. One deficiency was recited with 2 new deficiencies; therefore, 3 total deficiencies were identified. One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 4	{N 000}		
N 400	83.37(1)(a) Written order for medications, supplements. Practitioner ' s order. There shall be a written practitioner ' s order in the resident ' s record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident. This Rule is not met as evidenced by: Based on observation and record review the provider did not ensure there was a written practitioner's order for prescription medications for 1 of 1 resident record (Resident 7) reviewed. Findings include: On 10/21/2025 at approximately 1:14 PM, Surveyor observed Resident 7's medications. The medications were stored in a locked wall cabinet. Each resident had their own plastic container. Resident 7's plastic container contained the following:	N 400		

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

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N 400	Continued From page 1	N 400		

-Paroxetine Tab 40 mg
-Losartan 50 mg
-Amlodipine10 mg
-Vitamin D3
-Reguloid 0.4 mg

On 10/21/2025 at approximately 1:14 PM, Surveyors reviewed Resident 7's medication administration record (MAR) and identified the following:

Resident 7 was admitted on 03/24/2025. Resident 7's record did not contain evidence of a written practitioner's order for Resident 7's medications. Resident 7's October 2025 MAR indicated Resident 7 was on the following medications:

-Amlodipine 10 Milligrams (mg) daily
-Ipratropium 0.06% nasal spray three times day
-Loratadine 10 mg daily
-Losartan 50 mg daily
-Paroxetine 40 mg twice a day
-Pravastatin 10 mg daily
-Vaseline petroleum jelly application daily
-Vitamin D3 5000 units daily
-Ketoconazole 2% shampoo every other day
-Polymyxin B-Trimethoprim 1 drop in the right eye every four hours

On 10/21/2025 at approximately 1:30 PM, Surveyor interviewed Program Director H. Program Director H confirmed there were no physician's orders in Resident 7's record.

On 10/21/2025 at approximately 4:00 PM, Surveyors called the provider's contracted pharmacy to request written orders for Resident 7 to determine if Resident 7 had any medication

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N 400	Continued From page 2 changes. The pharmacy reported they were having difficulty providing the records requested due to an acquisition that occurred with the pharmacy and another medical company on 09/22/2025. As of 12/02/2025, at 5:00PM, Surveyors did not receive the requested records. Cross Reference: N0415 83.37(2)(d) Documentation of Medication Administration	N 400		
{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 staff interview, the provider did not have documentation of the time of medication administration, the person administering the medication or treatment and the name, dosage, date, and time of medication taken or treatments performed and initialed in the medication administration record (MAR) for 1 of 1 resident (Resident 7). This is a repeat deficiency. See Statement of	{N 415}		

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{N 415}	Continued From page 3 Deficiency (SOD) 2TX612, dated 03/26/2025. Findings include: On 10/21/2025 at approximately 1:14 PM, Surveyor reviewed Resident 7's October 2025 MAR. Resident 7's MAR had a total of 98 blank entries for administering his/her medications. Resident 7's MAR stated Resident 7 is on the following medications: -Amlodipine 10 milligrams (mg) daily -Ipratropium 0.06% nasal spray three times day -Loratadine 10 mg daily -Losartan 50 mg daily -Paroxetine 40 mg twice a day -Pravastatin 10 mg daily -Vaseline petroleum jelly application daily -Vitamin D3 5000 units daily -Ketoconazole 2% shampoo every other day -Polymyxin B-Trimethoprim 1 drop in the right eye every four hours Resident 7's October 2025 MAR had missing entries on the following dates: -10/1 at 7:00 PM (2 entries), 10/1 at 9:00 pm (1 entry) -10/2 at 4:00 PM (2 entries), 10/2 at 7:00 pm (2 entries) -10/4 at 7:00 AM (4 entries), 10/4 at 8:00am (4 entries), 10/4 at 12:00pm (2 entries), 10/4 at 9:00pm (1 entry). -10/5 at 7:00 AM (4 entries), 10/5 at 8:00am (4 entries), 10/5 at 12:00pm (2 entries). -10/6 at 9:00 PM (1 entry). -10/7 at 7:00 AM (4 entries), 10/7 at 8:00am (4	{N 415}		

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{N 415}	Continued From page 4	{N 415}		

entries), 10/7 at 12:00pm (2 entries), 10/7 at 9:00pm -(1 entry).
-10/8 at 9:00 PM (1 entry).
-10/9 at 7:00 AM (4 entries), 10/9 at 8:00am (4 entries), 10/9 at 12:00pm (2 entries), 10/9 at 9:00pm (1 entry).
-10/10 at 9:00 PM (1 entry)
-10/11 at 9:00 PM (1 entry)
-10/13 at 7:00 AM (5 entries), 10/13 at 8:00 AM (4 entries), 10/13 at 12:00 PM (3 entries), 10/13 at 7:00 PM (1 entry), 10/13 at 5:00 PM (1 entry), 10/13 at 9:00 PM (1 entry).
-10/14 at 9:00 PM (1 entry)
-10/15 at 7:00 AM (4 entries), 10/15 at 8:00 AM (4 entries), 10/15 at 12:00 PM (2 entries), 10/15 at 9:00 PM (1 entry).
-10/16 at 5:00 PM (1 entry), 10/16 at 9:00 PM (1 entry).
-10/17 at 9:00 PM (1 entry)
-10/18 at 5:00 PM (1 entry)
-10/19 at 7:00 AM (4 entries), 10/19 at 8:00 AM (4 entries), 10/19 at 12:00 PM (2 entries), 10/19 at 5:00 PM (1 entry).

Surveyors observed Resident 7's medication bubble packs labeled for the month of July 2025. All medications were present for 07/21/2025-07/29/2025, 07/31/2025, and 07/30/2025 (PM medications only). Surveyors observed Resident 7's MAR for October 2025 documented medications were administered on 10/21/2025 in the morning. All medications were present in the bubble packs for the October 2025 cycle.

On 10/21/2025 at approximately 1:30 PM, Surveyors interviewed Caregiver I about the medication administration. Caregiver I reported they administered medications to Resident 7 in the morning and pulled from the July 2025

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{N 415}	Continued From page 5	{N 415}		

medication bubble packs. Caregiver I reported s/he thought the date was the 20th; therefore s/he pulled the medications from the end of the bubble pack, since there were none in the bubble pack for 07/20/2025 for the July cycle they were using. Surveyors asked Caregiver I why Resident 7 had undocumented missed medication doses. Caregiver I reported s/he did not know why. Surveyors asked Caregiver I if s/he was trained to administer medication. Caregiver I indicated s/he was trained to administer medications and proceeded to demonstrate how s/he administered medications.

On 10/21/2025 at approximately 1:30 PM, Surveyor interviewed Program Director H about missing entries on Resident 7's MAR. Program Director H reported s/he was unsure as to why Resident 7 had missed doses that were not documented. Surveyors asked Program Director H why medications for Resident 7 were being administered from the month of July 2025 instead of the current month of October 2025. Program Director H reported the facility recently changed pharmacies and indicated there may have been some confusion as to why medications were being administered from bubble packs dated July 2025, instead of the current month of October 2025.

On 10/21/2025 at approximately 4:00 PM, Surveyors called the provider's contracted pharmacy to request written orders for Resident 7 to determine if Resident 7 had any medication changes. The pharmacy reported they were having difficulty providing the records requested due to an acquisition that occurred with the pharmacy and another medical company on 09/22/2025. As of 12/02/2025, at 5:00PM, Surveyors did not receive the requested records.

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N 663	83.59(6)(c) Mounting height of handrails on ramps Handrails. 1. Ramps in CBRFs initially licensed on or after January 1, 1997 shall have a handrail on each side which shall be mounted between 34 inches and 38 inches above the ramp surface. CBRFs licensed before January 1, 1997 shall have handrails mounted at least 30 inches above the ramp surface. 2. Handrails on unenclosed ramps shall include an intermediate parallel rail at mid-height. This Rule is not met as evidenced by: Based on observation, review, and interview, the provider did not ensure all exit ramps were equipped with handrails. Resident 1 fell and obtained an injury below his/her eyebrow. Findings include: The provider is licensed to care for 5 adults in the client group of developmentally disabled. The provider is licensed for Class CNA(Non Ambulatory). The Department received a complaint dated 07/22/2025. The complaint alleged a resident fell and obtained a gash below the eyebrow due to a broken railing located where residents smoke. On 10/21/2025, at approximately 11:28 AM, Surveyors observed the facility front door exit to not contain a handrail. Surveyors observed Resident 1 sitting outside on the landing in a chair. Surveyors observed Resident 1 to walk without any assistive devices. Surveyors measured the landing drop off with a tape measure. The drop off measured approximately 5 ½ inches from the top of the landing to the	N 663		

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N 663	Continued From page 7 ground. On 10/21/2025, at approximately 11:35 AM, Surveyors interviewed Resident 1. Resident 1 indicated the railing had been missing for a few months. Resident 1 denied falling outside. Surveyors observed Resident 1 to have small scar below his/her left eyebrow. Resident 1 could not recall how s/he obtained the scar below his/her left eyebrow. On 10/21/2025, at approximately 11:45 AM, Surveyors reviewed Resident 1's Individual Service Plan (ISP) dated 12/05/2024. Resident 1 was admitted to the facility on 05/31/2024. Resident 1 had a diagnosis of cerebral palsy, anoxic brain damage, cannabis use and suicidal ideation. Resident 1 had a guardian. The ISP identified Resident 1 used a walker while walking and needed to use the walker daily. The ISP did not identify Resident 1 to refuse the use of his/her walker. Surveyors reviewed incident reports dated 7/08/2025, 07/20/2025, and 07/21/2025. Resident 1 fell outside 3 times in the month of July. Incident report dated 07/08/2025 indicated Resident 1 had an unwitnessed fall while outside smoking on the porch. Incident Report dated 07/21/2025 indicated Resident 1 fell outside on the side of the house while taking a smoke break and in the living room area. Surveyor reviewed an email dated 07/20/2025 with a time stamp of 10:08 PM. The email indicated Resident 1 had an unobserved fall outside of the house. Resident 1 was described to grab a railing at the side door and the railing broke. Per the email, "Resident 1 fell on his/her face and obtained a cut above his/her eyebrow." Program Director H was notified of the fall and instructed facility staff to	N 663		

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N 663	Continued From page 8 call emergency medical services. Resident 1 was not transported to the hospital but received onsite treatment for the cut below his/her eyebrow. None of the incident reports indicated if Resident 1 used his/her walker at the time of the falls. On 10/21/2025, at approximately 1:30 PM, Surveyors interviewed Program Director H. Program Director H indicated s/he had requested their maintenance team to replace the missing hand railing months ago. Program Director H acknowledged Resident 1 should use his/her walker, however Resident 1 often refused to walk with his/her walker making him/her prone to falling. The provider did not ensure all ramps were equipped with handrails.	N 663		