STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012460	A. BUILDING: _____ B. WING _____	C 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE GARDENS I	606 VAN ALTENA CEDAR GROVE, WI 53013

(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 01/22/2026, Surveyor conducted one (1) complaint investigation at Cedar Grove Gardens I. As a result of the survey, 1 complaint was substantiated resulting in 2 deficiencies. Census: 20	N 000		
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 1 of 1 individual service plan (ISP) reviewed was updated when there was a change in resident's needs. Resident 1's ISP was not updated to reflect Resident 1 was a fall risk and/or to include interventions put in place. Findings include: On 01/22/2026 at 9:30 AM, Surveyor interviewed Manager A. Manager A confirmed Resident 1 had a history of falls. Manager A stated Resident	N 389		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012460	A. BUILDING: _____ B. WING _____	C 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE GARDENS I	606 VAN ALTENA CEDAR GROVE, WI 53013

(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 389	Continued From page 1 1 had a chair alarm and bed alarm in his/her room to alert staff when s/he was getting up. Manager A acknowledged Resident 1 was independent with transferring and ambulation. On 01/22/2026 at approximately 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 12/29/2023. Resident 1's ISP, dated 01/03/2025, documented that Resident 1 was independent with transfers/mobility and toileting. Under safety it identified "No safety concerns-no recent falls." Review of incident reports for Resident 1 reflected Resident 1 had a fall on 10/17/2025, 10/18/2025, 11/24/2025, 12/21/2025 and 12/27/2025. On 01/22/2026 at 12:00 PM, Surveyor interviewed Manager A. Manager A confirmed the ISP had not been updated to reflect Resident 1's falls or that the chair alarm and bed alarm had been implemented. The provider did not ensure ISP reviewed was updated when there was a change in resident's needs.	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	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012460	A. BUILDING: _____ B. WING _____	C 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE GARDENS I	606 VAN ALTENA CEDAR GROVE, WI 53013

(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 415	Continued From page 2	N 415		

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 ensure medications were accurately documented when medications were administered in each residents' medication administration record (MAR) for 1 of 1 resident reviewed (Resident 1).

Findings include:

On 01/02/2026, the Department received a complaint alleging concerns with medication management.

On 01/22/2026 at 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 12/29/2023. Resident 1's MAR indicated Resident 1 had multiple orders including:
* Triamcinolone Acetonide 0.1% cream, apply externally every 12 hours to dry, itchy skin, 8:00 AM and 8:00 PM.
* Vitamin B1 100 mg, One tab PO daily 8:00 AM
* Solifenacin 10 mg, One tab PO daily 8:00 PM
* Memantine 110 mg, PO BID, 8:00 AM and 8:00 PM
* Pataday 0.1% Ophthalmic solution, one drop in each eye daily, 8:00 AM
* Wixela Inhub 500-500 mcg, inhalation aerosol powder breath activated, one puff into lungs BID, 8:00 AM and
HS.
* Eliquis 5 mg, PO BID, 8:00 AM and HS
* Citracal Plus, one PO BID, 8:00 AM and HS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012460	A. BUILDING: _____ B. WING _____	C 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE GARDENS I	606 VAN ALTENA CEDAR GROVE, WI 53013

(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 415	Continued From page 3	N 415		

* Melatonin 10 mg, one tab PO q HS
* Lorazepam 0.5 mg, one tab PO BID, 8:00 AM and HS
* Vitamin D3 5000 units, one PO daily, 8:00 AM
* Vitamin B12 1000 mg, one tab PO daily, 8:00 AM
* Polyethylene Glycol 3350 powder, 17 gm mixed in 8 oz liquid PO BID, 8:00 AM and 8:00 PM
* Atorvastatin Calcium 10 mg, one tab PO q HS
* Fluticasone Propionate 50 mg nasal suspension, one spray in each nostril BID, 8:00 AM and HS
* Midodrine 2.5 mg, PO every 6 hours while awake, 8:00 AM, 2:00 PM and 8:00 PM
* Sertraline 100 mg, one tab PO daily, 8:00 AM
* Acetaminophen 500 mg, 2 tabs=1000 mg PO TID, 8:00 AM, 2:00 PM, 8:00 PM

Resident 1's December MAR starting from 12/01/2025 at 8:00 AM through 12/26/2025 at 8:00 PM reflected several medications and several doses not signed out.

* Triamcinolone Acetonide 8:00 AM - 12/10/2025, 12/12/2025, 12/13/2025, 12/14/2025, 12/24/2025
* Triamcinolone Acetonide 8:00 PM - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/11/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025
* Vitamin B1, 8:00AM - 12/12/2025, 12/13/2025, 12/14/2025, 12/15/2025, 12/22/2025, 12/24/2025, 12/25/2025
* Solifenacin, 8:00 PM - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/11/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012460	A. BUILDING: _____ B. WING _____	C 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE GARDENS I	606 VAN ALTENA CEDAR GROVE, WI 53013

(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 415	Continued From page 4 * Memantine, 8:00 AM - 12/12/2025, 12/13/2025, 12/14/2025, 12/15/2025, 12/24/2025 * Memantine, 8:00 PM - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/11/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025 * Pataday,8:00 AM - 12/13/2025, 12/14/2025, 12/24/2025 * Wixela Inhub, 8:00 AM - 12/13/2025, 12/14/2025,12/24/2025 * Wixela Inhub HS - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/12/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025 * Eliquis, 8:00 AM - 12/13/2025, 12/14/2025, 12/24/2025 * Eliquis, HS - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/12/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025 * Citracal Plus, 8:00 AM - 12/13/2025, 12/14/2025, 12/24/2025 * Citracal Plus HS - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/12/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025 * Melatonin, HS - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/12/2025, 12/13/2025,	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012460	A. BUILDING: _____ B. WING _____	C 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE GARDENS I	606 VAN ALTENA CEDAR GROVE, WI 53013

(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 415	Continued From page 5 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025 * Lorazepam, 8:00 AM - 12/13/2025, 12/14/2025, 12/24/2025 * Lorazepam, HS - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/12/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025 * Vitamin D3, 8:00 AM - 12/13/2025, 12/14/2025, 12/24/2025 * Vitamin B12, 8:00 AM - 12/12/2025, 12/13/2025, 12/14/2025, 12/24/2025 * Polyethylene Glycol, 8:00 AM - 12/13/2025, 12/14/2025, 12/24/2025 * Polyethylene Glycol, 8:00 PM - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/12/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025 * Atorvastatin Calcium, HS - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/12/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025 * Fluticasone Propionate, 8:00 AM - 12/10/2025, 12/13/2025, 12/14/2025, 12/24/2025 * Fluticasone Propionate HS - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/12/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025,	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012460	A. BUILDING: _____ B. WING _____	C 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE GARDENS I	606 VAN ALTENA CEDAR GROVE, WI 53013

(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 415	Continued From page 6 12/22/2025, 12/23/2025, 12/24/2025 * Midodrine, 8:00 AM - 12/13/2025, 12/14/2025, 12/24/2025 * Midodrine 2:00 PM - 12/13/2025, 12/14/2025, 12/22/2025, 12/24/2025 * Midodrine 8:00 PM - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/11/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025 * Sertraline, 8:00 AM - 12/13/2025, 12/14/2025, 12/24/2025 * Acetaminophen, 8:00 AM - 12/13/2025, 12/14/2025, 12/24/2025 * Acetaminophen, 2:00 PM - 12/13/2025, 12/14/2025, 12/22/2025, 12/24/2025 * Acetaminophen, 8:00 PM - 12/02/2025, 12/04/2025, 12/05/2025, 12/09/2025, 12/10/2025, 12/11/2025, 12/13/2025, 12/14/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025, 12/25/2025, 12/26/2025 On 01/22/2026 at 12:30 PM, Surveyor interviewed Manager A. Manager A stated the medications were given, s/he believed the staff just forgot to sign the medications out after given. Surveyor explained concerns that there were blanks on Resident 1's MAR for some of his/her scheduled medications. Manager A said the medication card would identify if the staff administered the medication or not, but the cycle change had happened, and the medication cards were no longer there. Manager A stated s/he will talk with staff to ensure the MAR's reflect the	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012460	A. BUILDING: _____ B. WING _____	C 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE GARDENS I	606 VAN ALTENA CEDAR GROVE, WI 53013

(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 415	Continued From page 7 medications given. The provider did not ensure medications were accurately documented in each residents' medication administration record when administered.	N 415		