STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010279	A. BUILDING: _____ B. WING _____	C 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD VILLAGE	**1425 HEMLOCK STREET SAUK CITY, WI 53583**

(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
U 000	INITIAL COMMENTS From 08/18/2025 to 08/22/2025, Surveyor conducted a complaint investigation at Maplewood Village, a RCAC in Sauk City. One deficiency was identified. This was a repeat deficiency - See Statement of Deficiency (SOD) TUO411, dated 01/22/2025. The complaint was substantiated. Census: 26	U 000		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medication management services were provided for 1 of 5 tenants reviewed. Tenant 1 did not receive his/her	U 118		

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

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U 118	Continued From page 1	U 118		

medications as prescribed and the provider did not accurately document Tenant 1's medication administration.

Findings include:

From 08/18/2025 to 08/26/2025, Surveyor conducted a complaint investigation alleging the provider did not manage medication administration tasks appropriately.

On 08/18/2025 at approximately 10:30 a.m., Surveyor interviewed Hospice RN C. Hospice RN C stated s/he followed Tenant 1 at the provider's complex and had concerns about medication management. Hospice RN C stated medications were allegedly refused; however, the provider's documentation did not consistently document refusals.

On 08/18/2025 at approximately 12:00 p.m., Surveyor reviewed Tenant 1's record. Tenant 1 admitted to the provider's complex on 03/05/2025 and discharged on 08/05/2025. Tenant 1's care plan, dated 06/05/2025, documented that the provider's staff assisted with medications. Tenant 1's Medication Administration Record (MAR), dated 06/01/2025 through 08/05/2025, documented several medication changes and included several blank entries leaving Surveyor unclear what Tenant 1 had received. The following concerns were identified:

- Acetaminophen 1000 mg 3 times daily (Start Date: 06/09/2025) had 138 blank entries in the MAR, leaving it unknown whether this medication was administered, refused or missed for some other reason.
- Oxybutynin Chloride ER 5 mg 1 time daily (Start date: 06/18/2025 / Stop Date: 07/08/2025) was

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U 118	Continued From page 2	U 118		

only documented as administered from 07/01/2025 through 07/09/2025, leaving it unclear if Tenant 1 received this medication, refused this medication or missed this medication for some other reason from 06/18/2025 through 06/30/2025.
- Olanzapine Dose 2.5 mg daily (Start date: 06/19/2025) had 16 blank entries in the MAR, leaving it unknown whether this medication was administered, refused or missed this medication for some other reason.
- Sertraline 25 mg 1 time daily (Start Date: 07/11/2025) was only documented as administered from 07/29/2025 through 08/05/2025, leaving it unclear if Tenant 1 received this medication, refused this medication or missed this medication for some other reason from 07/11/2025 through 07/28/2025.
- Prochlorperazine Dose 10 mg daily (Start Date: 06/17/2025) was listed on the MAR as PRN only and not documented as administered.

On 08/21/2025 at approximately 11:30 a.m., Surveyor reviewed medication management concerns with Administrator A. Administrator A stated Tenant 1 had a history of medication refusals. Administrator A stated the provider's documentation of refusals could have been better. Administrator A stated Tenant 1's medications were constantly changing while s/he was on hospice. Administrator A stated Tenant 1 used the provider's pharmacy for medication fills and it was the pharmacy's responsibility to update MARs as medication changes occurred.

On 08/22/2025 at 8:15 a.m., Surveyor requested clarification from Pharmacist B, the pharmacy affiliated with the provider, to determine whether medications were dispensed and available for administration during the above durations when

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U 118	Continued From page 3 there were blank entries. On 08/25/2025 at approximately 5:20 p.m., Pharmacist B informed Surveyor that orders were received and processed, except Prochlorperazine 10 mg daily. Pharmacist B stated the scheduled order for Prochlorperazine was missed; however, since there was a PRN order, a 30 tablet supply was sent to the provider's complex on 06/02/2025, so some tablets would have been available for administration. On 08/25/2025 at approximately 6:00 p.m., Surveyor reviewed hospice notes, obtained by Surveyor. A note, dated 07/30/2025, stated hospice staff reviewed Tenant 1's handwritten MAR and monthly blister pack of medications and noted the paper MAR did not match medications that were missing from blister packs for several medications. The provider did not administer medications as prescribed or document medication administration accurately.	U 118		