STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020930	A. BUILDING: _____ B. WING _____	C 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARROW VILLA	210 SOUTH PARKWAY DRIVE BRILLION, WI 54110

(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 01/07/2026, Surveyor conducted 1 complaint investigation at Garrow Villa in Brillion. One (1) of 1 complaint was substantiated. As a result of the survey, 2 deficiencies were issued. Census: 17	N 000		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after a resident's whereabouts were unknown for 1 of 1 (Resident 2) resident reviewed. On 11/12/2025, Resident 2 was found by staff outside about a block from the facility. The facility did not send a written report within 3 days to the department regarding this incident.	N 163		

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

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N 163	Continued From page 1 Findings Include: On 11/19/2025, the department received a complaint regarding resident elopements. On 01/07/2026, Surveyor conducted an onsite visit at the facility. A sample of residents was selected, including the resident record of Resident 2. Resident 2 was admitted to the facility on 11/08/2025 with diagnoses to include unspecificed dementia, moderate, with mood disturbance, major depressive disorder and repeated falls. Resident 2's most recent annual ISP (individualized service plan) printed 01/07/2026 indicated Resident 2 can walk and ambulate independently. The ISP also states Resident 2 is to receive "full supervision and redirection from staff to avoid and prevent wandering episodes." On 01/07/2026, Surveyor reviewed Resident 2's observation notes. The following was noted: -11/12/2025 at 1:15 PM..."Resident was seen by hospice walking outside. Both caregiver[sic] were in room [numbered resident room] when hospice told writer if that was one of our residents. Writer then went outside to bring resident inside, who at least walked a block out of the building." On 01/07/2026 at approximately 11:00 AM, Surveyor interviewed Administrator A. Administrator A indicated s/he did not have an incident report nor did s/he file a self report with the department regarding the elopement on 11/12/2025. Administrator A stated s/he didn't treat it as an elopement because Resident 2 had just admitted to the facility a few days earlier and was just looking to go home which is only 5 blocks from the facility. Administrator A stated	N 163		

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N 163	Continued From page 2 Resident 2 is very confused on a regular basis but has not had any further incidents since the one in November. Administrator A indicated s/he understood why this is an elopement incident and now understands when these incidents need to be reported to the department. On 01/07/2026, Surveyor reviewed the department's facility folder and no self report was located.	N 163		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not document in the resident's record any error in the administration of prescription medication for 1 of 1 (Resident 1) resident reviewed. Resident 1 has an order for Fentanyl 12 mcg	N 410		

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N 410	Continued From page 3	N 410		

(mircrograms)/hour patch to apply 1 patch to upper torso every 72 hours for chronic pain, *remove existing patch.* On 10/20/2025, a Resident 1 observation note stated a staff member had to use the last fentanyl patch due to "still having the one that writer put on Thursday 10/16. Writer also found an old patch on resident." Resident 1's record did not contain documentation of the medication error.

Findings Include:

On 11/19/2025, the department received a complaint regarding medications.

On 01/07/2026, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the record of Resident 1.

Surveyor reviewed Resident 1's Observation Notes. The following was noted:
-10/20/2025 at 8:00 PM "Writer had to put resident's last fentanyl patch on due to still having the one that writer put on Thursday 10/16. Writer also found an old patch on resident."

Surveyor reviewed Resident 1's October 2025 MAR (Medication Administration Record). Resident 1 has an order for Fentanyl 12 mcg (mircrograms)/hour patch to apply 1 patch to upper torso every 72 hours for chronic pain, *remove existing patch.* The MAR indicated Resident 1 received the Fentanyl patch on 10/16/2025 and 10/19/2025. The MAR did not indicate a patch was applied on 10/20/2025.

On 01/07/2026 at approximately 11:00 AM, Surveyor interviewed Administrator A. Administrator A stated s/he talked with the caregiver involved with the situation and the

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N 410	Continued From page 4 caregiver verified s/he changed the patch on 10/19/2025 but did not put his/her initials or the date on it. Administrator A stated the caregiver would never do anything to harm the resident and that the caregiver and another caregiver did not get along. Administrator A stated s/he did not have documentation of any interviews with the caregiver about the situation or documentation about the allegation of the medication error. Administrator A stated s/he did talk with the caregiver about "doing better" next time. Administrator A indicated the caregiver involved is no longer employed at the facility. Administrator A stated Resident 1 did not have any negative effects from the medication error.	N 410		