STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014330	A. BUILDING: _____ B. WING _____	R-C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD VILLA LLC CBRF	9343 STATE HWY 101 ARMSTRONG CREEK, WI 54103

(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 06/03/2025, Surveyor conducted a verification visit and complaint investigation (x2) at Maplewood Villa LLC CBRF. Data collection continued through 06/11/2025. One of 2 complaints was substantiated. One deficiency was identified. The deficiency identified in statement of deficiency (SOD) SCFR14 was corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 10	{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 Resident 1 received all medications as prescribed. Resident 1 did not receive his/her scheduled Alprazolam ER 0.5mg BID (twice daily) as prescribed. Findings include:	N 352		

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

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N 352	Continued From page 1 The provider is licensed to care for 16 residents in the following client groups: advanced aged, irreversible dementia/Alzheimer's disease, physically disabled, terminally ill, developmentally disabled, traumatic brain injury and emotionally disturbed/mental illness. On 02/28/2025, the Department received a complaint alleging medication administration errors. On 06/03/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 03/08/2022. According to Resident 1's medication administration record (MAR), Resident 1 was prescribed Alprazolam ER 0.5mg BID and may take 1 tablet as needed daily. Resident 1's MAR indicated Resident 1 did not receive Alprazolam ER 0.5mg BID and 1 tablet as needed daily on the following dates: 02/01/2025, 02/02/2025, 02/03/2025 and 02/04/2025. On 06/03/2025 at approximately 11:25 AM, Surveyor interviewed Care Manager A. Surveyor asked Care Manager A about medication administration. Care Manager A stated, "We wait for the doctor to write the prescription." Surveyor asked Care Manager A if Resident 1 ever ran out of his/her Alprazolam. Care Manager A stated, "Yes, absolutely." Care Manager A commented that Care Manager B would have more information about Resident 1's Alprazolam medication. On 06/03/2025 at approximately 11:40 AM, Surveyor interviewed Care Manager B via telephone. Surveyor asked Care Manager B about medication administration and Resident1's medications. Care Manager B reported that in January 2025; the doctor switched Resident 1's	N 352		

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N 352	Continued From page 2	N 352		

Lorazepam to Alprazolam extended release. Care Manager B stated that Resident 1 went without Alprazolam for "maybe a week" in February 2025. Care Manager B stated, "I might have a note written down." Care Manager B reported that Care Manager B would send a follow-up e-mail regarding Resident 1's medication administration to Surveyor.

On 06/03/2025 at approximately 1:13 PM, Surveyor interviewed Resident 1. Surveyor asked Resident 1 about his/her medications. Resident 1 reported that s/he had gone for about a week without his/her Lorazepam in February 2025. Surveyor asked Resident 1 about not getting his/her medication in February 2025. Resident 1 stated, "It seems like there is a problem with my pain meds (medications) and Lorazepam. If I don't get the pain meds, I get sick. When I don't get my Lorazepam, I feel down (and) I stay in my room; I don't want to take it out on anyone else."

On 06/10/2025, Care Manager B noted via email the following:

* Resident 1 had an appointment on January 15, 2025, and a new medication order was put in place
* Resident 1's new medication order was Alprazolam ER 0.5mg BID and may have a PRN (as needed) daily
* The new medication order was replacing Resident 1's Lorazepam 1mg PRN TID
* Resident 1's last dose of Lorazepam was on 01/30/2025
* "PT (Resident 1) then had no medication from last dose of Lorazepam on 01/30/2025 [sic] Thursday evening/nighttime [sic] 01/31/2025 Friday [sic] the weekend [sic] Monday 02/03/2025 [sic] on Tuesday [sic] 02/4/2025 [sic]

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N 352	Continued From page 3 Alprazolam was picked up and given as scheduled BID and PRN Daily only." On 06/11/2025 at approximately 10:10 AM, Surveyor interviewed Care Manager A via telephone. Care Manager A verified the information provided by Care Manager B's e-mail and Care Manager A indicated that Care Manager A was present when Care Manager B emailed Surveyor on 06/10/2025. Care Manager A confirmed Resident 1 went without his/her Alprazolam in early February 2025. The provider did not ensure Resident 2 received all of his/her prescribed medications.	N 352		