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	0014330	A. BUILDING: _____ B. WING _____	R-C 09/03/2025

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 08/27/2025, Surveyors conducted a verification visit and complaint (x5) investigation at Maplewood Villa LLC CBRF. Data collection continued through 09/03/2025. The deficiency identified in statement of deficiency (SOD) SCFR15 was corrected. Five of 5 complaints were substantiated. 24 deficiencies were identified. Three of 24 deficiencies were repeat violations, see statement of deficiency (SOD) DDBB11, dated 02/19/2020, WKNO11, dated 01/11/2022, WKNO12, dated 06/01/2022. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 9	{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.	N 163		

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

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N 163	Continued From page 1	N 163		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not report to the Department within 3 working days after Resident 1 eloped from the facility.

This is a repeat deficiency, see statement of deficiency (SOD) DDBB11, dated 02/19/2020.

Findings include:

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.

Between 07/11/2025 and 08/14/2025, the Department received five complaints alleging concerns with supervision, medication administration, unsafe living conditions and elopements.

On 08/27/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 04/27/2021. Resident 1's diagnoses included, but not limited to Paranoid Schizophrenia w/elopement tendencies, chronic back pain and alcohol related dementia. According to a progress note, dated 07/03/2025 (2:10 PM), Caregiver F noted, "I received a phone call from [Person H] that a resident which was [Resident 1] was walking down the highway. [Caregiver E] was here and monitored the residents. I took a cigarette with me as a diversia [sic] to get [Resident 1] to get back in my car and give [him/her] a ride back..."

On 08/27/2025 at approximately 11:00 AM,

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N 163	Continued From page 2 Surveyor interviewed House Manager (HM) B. HM B verified that Resident 1's elopement was not reported to the Department. HM B commented that HM B was unfamiliar with the "code and requirements" for reporting elopements. On 08/27/2025 at approximately 8:10 AM, Surveyor interviewed Caregiver F via telephone. Caregiver F verified Resident 1 left the facility on 07/03/2025. Caregiver F reported that Person H (community member) contacted the facility and reported Resident 1 was walking down the highway. Caregiver F reported, "Somedays [Resident 1] is good and sometimes [Resident 1] is bad. [S/He] waffles back and forth. I heard someone say [Resident 1] walked down the road on 08/26/2025. I am not sure of the details." Caregiver F commented that Resident 1 had gotten out of the facility without supervision before. On 09/03/2025 at approximately 10:15 AM, Surveyor interviewed Administrator A via telephone. Surveyor asked about Resident 1's elopements. Administrator A reported, "I was not aware [Resident 1] got off the property." On 09/03/2025, Surveyor reviewed Department records. Department records did not contain a self-report involving Resident 1 eloping on or about 07/03/2025. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 163		
N 214	83.15(3)(a) Administrator shall supervise daily operation	N 214		

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N 214	Continued From page 3 The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider's administrator did not supervise the daily operations and did not ensure the resident's health, safety, care, services and rights were respected and protected. Surveyors conducted a complaint (x5) investigation and verification visit. The complaints were substantiated and 24 deficiencies were identified in the areas of facility safety, resident care, services and staff training. Findings include: 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. Between 07/11/2025 and 08/14/2025, the Department received five complaints alleging concerns with supervision, medication administration, unsafe living conditions, food	N 214		

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N 214	Continued From page 4	N 214		

sanitation (dogs in kitchen and in dining area during meals), staff consuming alcohol and elopements.

On 08/27/2025, Surveyor toured the facility. Surveyor observed an unattended cleaning cart with cleaning chemicals, an unlocked maintenance room containing empty beer cans and locked storage rooms with full boxes containing unorganized resident paperwork.

On 08/27/2025 at approximately 10:00 AM, Surveyor interviewed Resident 2, Resident 8, Caregiver D and Caregiver E about the facility's grievance procedure. The residents were unaware of a grievance procedure. Residents expressed frustration with staff dogs going in the kitchen and begging for food during meal times. The residents and staff expressed concerns with Resident 1's cognitive decline and elopement behavior (Resident 1 eloped on 07/03/2025) and indicated Administrator A was aware of these concerns.

On 08/27/2025 at approximately 10:40 AM, Surveyor interviewed Resident 3. Surveyor asked Resident 3 about the facility's grievance procedure. Resident 3 was unfamiliar with a grievance procedure. Resident 3 stated, "This place is the pits." Resident 3 reported that sometimes there are 5 dogs in the facility and the dogs beg for food during meal times.

On 08/27/2025 at approximately 11:30 a.m., Surveyor interviewed House Manager (HM) B. HM B told Surveyor s/he was unable to locate June medication administration records, previous individual service plans, and other documentations. HM B told Surveyor to ask Caregiver D where these records were as

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N 214	Continued From page 5	N 214		

Caregiver D was the previous house manager.

On 08/27/2025 at approximately 12:13 p.m., Surveyor interviewed Caregiver D. Caregiver D told Surveyor and HM B that previous records were stored in the oxygen room. Caregiver D said s/he took time off work starting 06/29/2025.

On 08/27/2025 at approximately 12:15 p.m., Surveyor and HM B observed the oxygen room. There were multiple boxes of resident records loosely stored in them. Surveyor and HM B also observed the storage room across the hall, which contained boxes of resident's records. HM B had tears in his/her eyes and said, "This has all been dumped on me."

On 08/27/2025 at approximately 12:23 PM, Surveyor interviewed Administrator A. Surveyor asked Administrator A about the facility's grievance policy and procedure. Administrator A indicated that Administrator A had an "open door policy" and residents and staff could bring complaints forward anytime. Administrator A reported that s/he was unaware of complaints about dogs and unaware of Resident 1's elopement. Administrator A reported that s/he was unaware of complaints or concerns involving medication administration, individual service plans (ISPs), training and record storage.

On or between 08/27/2025 and 09/03/2025, Surveyor verified the following through record review and interview: The administrator, who is also the Licensee, did not ensure the following:

- Did not report Resident 1's elopement on 07/03/2025
- Did not complete caregiver back ground checks for 2 of 4 staff reviewed prior to their date of

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N 214	Continued From page 6 hire - Did not ensure staff completed training in Fire Safety, orientation and department-approved training courses - Did not maintain a written grievance policy and procedure - Did not ensure the rights of residents to receive medication and health monitoring - Did not ensure qualified staff were in charge and on duty - Did not ensure service plans were developed and updated annually - Did not ensure fire extinguishers were inspected annually - Did not ensure resident records were maintained and safeguarded The administrator did not provide the supervision necessary to ensure residents received proper care and treatment, that their health and safety were protected and promoted, and that their rights were respected. On 09/03/2025, the complaint investigations resulted in five substantiated complaints and the following 24 cites: 83.12(4)(a) Reporting When Residents Whereabouts Unknown 83.15(3)(a) Administrator Shall Supervise Daily Operations 83.17(1) Licensee Conduct Caregiver Background Check 83.19 Orientation 83.20(2)(a)-(d) Department Approved Training Courses 83.25 Continuing Education 83.33(1)(a) Grievance Procedure: Information Required 83.35(1)(a) Pre-Admission and Ongoing Assessments	N 214		

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N 214	Continued From page 7 83.35(3)(b) Service Plan Development: Parties Involved 83.35(3)(d) Service Plans Updated Annually Or On Changes 83.35(5)(a) Initial Evaluation of Evacuation Limitations 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake 83.37(1)(e) Medication Regimen, Administration Review 83.37(1)(g) Disposition of Medications 83.37(1)(i) Prn Psychotropic Medication 83.37(1)(k) Medication Error or Adverse Reaction 83.37(2)(d) Documentation of Medication Administration 83.37(3)(a) Medication Storage: Original Containers 83.38(1)(g) Health Monitoring 83.38(1)(h) Medication Administration 83.42(1) Resident Record Maintained 83.45(2) Storage Areas 83.47(4)(a) Fire Extinguishers: Type And Inspection 83.48(3)(a) Fire Detection Systems Inspected Annually	N 214		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch.	N 219		

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N 219	Continued From page 8 DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct a criminal background check (CBC) for 2 of 4 caregivers reviewed. Findings include: 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 08/28/2025, Surveyor requested a complete CBC for House Manager (HM) B and Assistant House Manager (AHA) C from Administrator A via e-mail. HM B was hired on 07/15/2025. AHA C was hired on 07/31/2025. A complete CBC consists of 3 components: 1. A background information disclosure (BID) filled out by the employee, 2. A criminal history record search from the Department of Justice (DOJ), 3. A government findings report (GFR). On 09/03/2025, Administrator A provided via e-mail HM B's BID, dated 02/23/2017 and AHM C's BID, dated 07/24/2025. On 09/03/2025 at approximately 10:15 AM, Surveyor interviewed Administrator A via	N 219		

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N 219	Continued From page 9 telephone. Surveyor asked Administrator A for HM B's and AMA C's complete CBC. Administrator A reported, "I have not done [HM B's] and [AMA C's] background check." Surveyor reviewed the provider's schedule for July and August 2025. The schedule noted HM B and AMA C worked several shifts unsupervised. The provider did not complete CBC's for 2 of 4 caregivers reviewed. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 219		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Assistant House Manager (AHM) C received orientation prior to performing job duties.	N 230		

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N 230	Continued From page 10 Findings include: The provider is licensed to care for up to 16 residents in the client groups of advanced age, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, terminally ill, and traumatic brain injury. On 07/21/2025, the Department received a complaint with allegations related to adequate staff and training. On 08/27/2025 at approximately 9:45 a.m., Surveyor interviewed AHM C. AHM C told Surveyor s/he was working the floor and was responsible for administering medications that day. At approximately 2:30 p.m., Surveyor interviewed AHM C and asked about his/her training. Surveyor asked if s/he received orientation to include his/her job responsibilities, prevention and reporting of abuse, neglect, and misappropriation, emergency and disaster plans, policies and procedures, and recognizing and responding to a resident's change in condition. AHM C told Surveyor s/he did not receive that training yet. S/he said s/he was a certified nursing assistant and received the medication training. On 09/03/2025, Surveyor reviewed AHM C's training and date of hire. AHM C's date of hire was 07/31/2025. S/he did not have documentation of orientation. AHM C was a certified nurse assistant in Michigan, which expired in 2024. S/he did not have documentation of certification as a certified nurse assistant in Wisconsin. The provider did not ensure AHM C received	N 230		

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N 230	Continued From page 11 orientation training before s/he performed job duties. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 230		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 4 employees	N 239		

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obtained all department approved training as required.

Assistant House Manager (AHM) C, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties.

Findings include:

On 08/27/2025, Surveyor conducted a review of 4 employees to verify compliance with department approved training requirements. Surveyor requested training records from Administrator A for AHM C.

On 08/27/2025 at approximately 9:45 a.m., Surveyor interviewed AHM C. AHM C told Surveyor s/he was working the floor and was responsible for administering medications that day. At approximately 2:30 p.m., Surveyor interviewed AHM C and asked about his/her training. AHM C said s/he was a certified nursing assistant and received the medication training.

The record for AHM C, hired 07/31/2025, did not contain evidence of training or evidence of meeting an exemption for standard precautions. On 09/03/2025, at approximately 10:15 a.m., Surveyor interviewed Administrator A on the phone. Administrator A told Surveyor AHM C was a certified nursing assistant. Surveyor explained to Administrator A that AHM C was not located on the Wisconsin registry as a certified nursing assistant. Administrator A told Surveyor to check the Michigan registry. Surveyor explained the code states the employee must be in good standing on the Wisconsin Nurse Aide Registry. AHM C's record did not contain a transcript of

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N 239	Continued From page 13 CNA courses from Michigan. On 09/03/2025, the provider e-mailed the following document: Nurse Aide Registration Detail (Iron Mountain, Michigan). According to the document, AHM C nurse's aide registration expired on 10/31/2024. On 09/03/2025, Surveyor verified AHM C was not on the Community-Based Care and Treatment training registry for standard precautions. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 239		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers reviewed, that worked a full calendar year, (Caregiver E and Caregiver F) received continuing education in prevention and reporting	N 277		

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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 277	Continued From page 14	N 277		

of abuse, neglect and misappropriation and fire safety and emergency procedures, including first aid in the calendar year 2024.

This is a repeat deficiency. See Statement of Deficiency (SOD) WKNO11, dated 01/11/2022 and SOD WKNO12, dated 06/01/2022.

Findings include:

The provider is licensed to care for up to 16 residents in the client groups of advanced age, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, terminally ill, and traumatic brain injury.

On 07/21/2025, the Department received a complaint with allegations related to adequate staff and training.

On 08/28/2025 and 08/29/2025, Surveyor emailed Administrator A and requested training records for Caregiver E and Caregiver F, who have been employed for greater than a calendar year.

Caregiver E's date of hire was 04/20/2018. Caregiver F's date of hire was 07/01/2017.

Surveyor did not receive documentation of 2024 continuing education for Caregiver E and Caregiver F.

On 09/03/2025 at approximately 10:30 a.m., Surveyor interviewed Administrator A on the phone. Administrator A told Surveyor Registered Nurse (RN) G conducted training every month for continuing education. Administrator A said s/he would email the trainings completed in 2024.

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N 277	Continued From page 15 On 09/03/2025, Surveyor reviewed training Caregiver E and Caregiver F received in 2024 from RN G. The documented training did not include continuing education in prevention and reporting of abuse, neglect and misappropriation and fire safety and emergency procedures, including first aid. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 277		
N 359	83.33(1)(a) Grievance procedure: information required A resident or any individual on behalf of the resident may file a grievance with the CBRF, the department, the resident ' s case manager, if any, the board on aging and long term care, Disability Rights Wisconsin, Inc., or any other organization providing advocacy assistance. The resident and the resident ' s legal representative shall have the right to advocate throughout the grievance procedure. The written grievance procedure shall include the name, address and phone number of organizations providing advocacy for the client groups served, and the name, address and phone number of the department ' s regional office that licenses the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a written grievance procedure.	N 359		

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N 359	Continued From page 16 Findings include: 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. Between 07/11/2025 and 08/14/2025, the Department received five complaints alleging concerns with supervision, medication administration, unsafe living conditions, food sanitation (dogs entering the kitchen and dining area during meals) and elopements. On 08/27/2025 at approximately 10:00 AM, Surveyor toured the facility and interviewed Resident 2, Resident 8, Caregiver D and Caregiver E. Surveyor asked about the facility's grievance procedure. The residents were unaware of a grievance procedure. The residents expressed frustration with staff dogs going in the kitchen and begging for food during meal times. The residents and staff expressed concerns with Resident 1's cognitive decline and elopement behavior (Resident 1 eloped on 07/03/2025) and indicated Administrator A was aware of these concerns. Surveyor did not observe a written grievance procedure in the facility. On 08/27/2025 at approximately 10:40 AM, Surveyor interviewed Resident 3. Surveyor asked Resident 3 about the facility's grievance procedure. Resident 3 was unfamiliar with a grievance procedure. Resident 3 stated, "This place is the pits." Resident 3 reported that sometimes there are 5 dogs in the facility and the dogs beg for food during meal times.	N 359		

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N 359	Continued From page 17 On 08/27/2025 at approximately 12:23 PM, Surveyor interviewed Administrator A. Surveyor asked Administrator A about the facility's grievance policy and procedure. Administrator A indicated that Administrator A had an "open door policy" and residents and staff could bring complaints forward anytime. Administrator A reported that s/he was unaware of complaints about dogs and unaware of Resident 1's elopement. On 09/03/2025 at approximately 10:15 AM, Surveyor interviewed Administrator A via telephone. Surveyor asked Administrator A about the facility's grievance procedure. Administrator A reported that s/he had an "open door policy" and residents could talk to Administrator A if there were problems or complaints. Administrator A confirmed that s/he did not have a grievance policy and procedure in writing. The provider did not maintain a written grievance procedure.	N 359		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.	N 381		

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N 381	Continued From page 18	N 381		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a comprehensive assessment was completed at least annually and with changes in condition for Resident 1 and Resident 2.

Findings include:

The provider is licensed to care for up to 16 residents in the client groups of advanced age, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's disease, emotionally disturbed/mental illness, terminally ill, and traumatic brain injury.

On 07/11/2025, the Department received a complaint that alleged adequate services were not provided for a resident with mental illness.

RESIDENT 1

On 08/27/2025, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 04/27/2021. Resident 1 was under guardianship and protective placement. Surveyor located documentation of an assessment dated 04/27/2021, which included the following diagnoses: anxiety, depression, chronic back pain, chronic hepatitis, and a back surgery from a herniated disc. This assessment did not include medications, behavior patterns, elopement risks, or capacity for self-care, and self-direction. Surveyor could not locate a more recent assessment in Resident 1's record.

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N 381	Continued From page 19 On 08/27/2025 at approximately 1:00 p.m., Surveyor interviewed House Manager (HM) B and Assistant House Manager (AHM) C. AHM C said Resident 1 did not take any medications. HM B told Surveyor Resident 1 "fired" his/her doctors, but s/he had an appointment coming up. Surveyor reviewed a discharge note, dated 10/14/2024. There was a handwritten note that read: "Pt. (patient) has a dressing on umbilical area drainage from surgery. May remove dressing if no further drainage." Surveyor asked what kind of surgery Resident 1 had. HM B said s/he did not know. Surveyor reviewed other after visit summaries for Resident 1 which indicated Resident 1 also had diagnoses of paranoid schizophrenia, status post lumbar spinal fusion, spinal stenosis of lumbar region with radiculopathy (pinching of nerves at the root). The AVS summary, dated 03/27/2025, indicated Resident 1 was prescribed: gabapentin, lorazepam (as needed), meloxicam, quetiapine, rosuvastatin, sertraline, and zolpidem. Resident 1's record contained a fax, dated 03/07/2025, from Resident 1's guardian that read: "It is increasingly concerning that the facility is not returning calls in regards to the health and safety of [Resident 1]. [Guardianship] is requesting documentation from Urgent Care Visit / UTI (urinary tract infection) screening that was requested middle of February ..." There was another fax from Resident 1's guardian that read, in part: "Also looking for wandering, and non-med (medication) compliance." This date was cut off and only the day and year appeared as "/5/2025." Notes in Resident 1's chart indicated Resident 1 was verbally aggressive towards staff and exit-seeking with elopements. Staff documented	N 381		

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N 381	Continued From page 20 on 9 dates related to Resident 1's verbal aggression towards staff from February to July 2025. Staff documented on 4 dates related to Resident 1 exit seeking from May to July 2025. On 07/03/2025, staff documented they received a phone call from a neighbor notifying staff Resident 1 was walking down the highway. RESIDENT 2 On 08/27/2025 at approximately 10:30 a.m., Surveyor interviewed Resident 2. Resident 2's face was swollen, and s/he told Surveyor s/he had an abscess tooth. Resident 2 told Surveyor s/he had concerns but was leaving for an appointment. Resident 2 did not elaborate on what his/her concerns were about. On 08/27/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 03/28/2022. Surveyor could not locate a comprehensive assessment in Resident 2's record. Resident 2 did have an updated individual service plan (ISP) dated 08/24/2025. On 08/27/2025 at approximately 12:00 p.m., Surveyor interviewed HM B. HM B said s/he started recently and has been going through each resident's record. S/he said s/he updated Resident 2's ISP but has not been able to locate previous assessments and ISPs. On 08/28/2025 and 08/29/2025, Surveyor emailed Administrator A and requested the most recent assessment for Resident 1 and Resident 2.	N 381		

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N 381	Continued From page 21 As of 09/03/2025, Surveyor did not receive a recent assessment for Resident 1 and Resident 2. On 09/03/2025 at approximately 10:30 a.m., Surveyor interviewed Administrator A on the phone. Administrator A told Surveyor Caregiver D, who was the previous house manager, was responsible for completing assessments. Administrator A said HM B will now be completing assessments. The provider did not ensure a comprehensive assessment was completed at least annually and with changes in condition for Resident 1 and Resident 2. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 381		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in	N 387		

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N 387	Continued From page 22 the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 and Resident 2 and their legal representatives were involved in developing their individual service plans (ISP), when their ISPs were not signed by the resident or their legal representative, acknowledging their involvement in, understanding of, and agreement with the plan. Findings include: On 07/11/2025, the Department received a complaint related to resident care and services. On 08/27/2025, Surveyor reviewed Resident 1's record. Resident 1 had a legal guardian and was under protective placement. Resident 1's ISP was last dated 12/13/2024 and it was initialed by Caregiver D, who was the previous house manager. There were no other signatures on the ISP. On 08/27/2025, Surveyor reviewed Resident 2's record. Resident 2 had a legal guardian and was under protective placement. Resident 2's ISP was dated 08/24/2025. There were no signatures on the ISP.	N 387		

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N 387	Continued From page 23 On 08/27/2025 at approximately 11:30 a.m., Surveyor interviewed House Manager (HM) B. HM B said s/he recently started working at the facility. S/he said s/he came back to help get things in order. S/he explained s/he went through the charts and was unable to locate documentation. HM B told Surveyor s/he started updating residents' ISPs including Resident 2's ISP. Surveyor explained the regulation to ensure the residents, and their legal representatives have input into their ISPs and sign that they agree with their ISP. HM B told Surveyor s/he was unaware of this regulation. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 387		
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 review and revise Resident 1's	N 389		

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N 389	Continued From page 24 individual service plan (ISP) when Resident 1 had a change in his/her needs and mental health. Findings include: On 07/11/2025, the Department received a complaint related to resident care and services, including medication administration and behavior management. On 08/27/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/27/2021. S/he had a guardian and was under protective placement. Resident 1 had multiple diagnoses including: paranoid schizophrenia, anxiety and depression. Staff documented the following notes: 02/04/2025 - " ... [S/he] threw the meds (medications) across the table and told writer to get the [explicative] away from [him/her] ..." 04/13/2025 - " ... "Kicking the front door, saying [s/he's] overstayed [his/her] welcome here ..." 04/14/2025 - "[Resident 1] yelling at staff about [his/her] tractor that is in the garage and [s/he] wants the [explicative] thing back ... Resident upset about [his/her] truck being stolen ..." 05/12/2025 - " ... went on a tangeat [sic] about being in the National Guards. I had to go outside and get [him/her] back in. [S/he] was walking towards the neighbors. Checking out '[his/her]' truck." 06/20/2025 - "[Resident 1] tried leaving, walking	N 389		

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N 389	Continued From page 25 away several times today. I went outside and asked [him/her] to come back twice [s/he] did. The 3rd time [s/he] wouldn't return and walked all the way down to the highway ... [s/he] imagines that [s/he] has [his/her] truck outside and [his/her] motorcycle in the garage. Which [s/he] clearly doesn't. [S/he] also accuses me of taking [his/her] tools and all of [his/her] money. Which I obviously haven't. When[s/he] is doing something that we feel is incorrect and we, the staff, ask [him/her] not to [s/he] can and often does become very vocally abusive, vulgar, and angry at the staff for trying to correct 'bad' behavior." 06/23/2025 - "[Resident 1] has been very combative and imagining things the 'kids' are stealing all of [his/her] money and tools ... very foul mouthed and abusive verbally to me and the other residents ... [s/he] was trying to leave numerous times. Went outside and was walking away until I went out and offered [him/her] a cigarette to get [him/her] back in. [S/he] wouldn't listen at all." 07/03/2025 - "I received a phone call from [Person H] that a resident which was [Resident 1] was walking down the highway ..." 07/12/2025 - "Numerous times today [Resident 1] accused me of taking [his/her] keys and license (drivers). At 11:20 [s/he] walked up to me demanded [his/her] keys and put [his/her] finger near my face and called me a [explicative]. [S/he] then said [s/he] was going to [explicative] get me before its done." Resident 1's ISP, last dated 12/13/2024, read, in part: "Alteration in thought process R/T (related to) short term memory problems	N 389		

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Goal: Make it to meals on time
Interventions, all staff
Reminders given
Meal times [sic] posted
Need to be told @ times that it is time to eat.
Very forgetful
Most times staff has to go & get [him/her] when it is meal times.
Goal: Not met
Still needs reminders for meal times has no regards for time."

"Problems/Strengths Thought Process
Alteration in knowing what's true or fiction
R/T degenerative brain disorder
Goal: Calm environment
Interventions, all staff
When [s/he] is yelling @ someone in [his/her] room, just gently knock and ask if everything is alright.
Reassurance that everything is fine."

On 08/27/2025 at approximately 1:00 p.m., Surveyor interviewed House Manager (HM) B. HM B told Surveyor Resident 1 did not take any medications as s/he refused everything.

On 08/27/2025 at approximately 2:00 p.m., HM B told Surveyor Resident 1 walked off on 08/26/2025. S/he said s/he yelled for him/her and the neighbors yelled back that Resident 1 was here. Surveyor asked how often Resident 1's safety checks were. HM B said Resident 1 did not have any safety checks set up. S/he said staff were aware of where Resident 1 was at.

On 09/03/2025 at approximately 10:30 a.m., Surveyor interviewed Administrator A on the phone. Surveyor explained concerns that Resident 1's ISP did not include interventions

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N 389	Continued From page 27 related to his/her elopement risk, refusing medications, and verbal aggression towards staff. Administrator A said HM B is trying to get everything in place. Resident 1's ISP did not include Resident 1's refusal of medications, elopement risk with interventions, and behavior management for verbal aggression towards staff.	N 389		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not evaluate Resident 3's evacuation status within 3 days of admission. Findings include: 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	N 393		

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MAPLEWOOD VILLA LLC CBRF	9343 STATE HWY 101 ARMSTRONG CREEK, WI 54103

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N 393	Continued From page 28 disabled, traumatic brain injury and emotionally disturbed/mental illness. On 08/27/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 05/01/2025. Resident 3's file did not contain a resident evacuation assessment. On 08/28/2025, Surveyor requested Resident 3's evacuation assessment from Administrator A via e-mail. On 09/02/2025, Administrator A provided Resident 3's evacuation assessment, dated 09/01/2025, via e-mail. On 09/03/2025 at approximately 10:15 AM, Surveyor interviewed Administrator A via telephone. Administrator A confirmed that Resident 3's evacuation assessment was completed on 09/01/2025. Administrator A commented that Resident 3's evacuation assessment "should have been done upon entrance to the facility." The provider did not ensure Resident 3's evacuation assessment was completed within 3 days of admission.	N 393		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents	N 397		

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N 397	Continued From page 29 are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a qualified resident care staff present in July 2025 and August 2025 when one or more residents were present. Wis. Admin. Code D"S 83.02(42) states: "Qualified resident care staff means an employee who has successfully completed all of the applicable training and orientation under Subch. IV." Findings include: 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. Between 07/11/2025 and 08/14/2025, the Department received five complaints alleging	N 397		

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concerns with supervision, medication administration, unsafe living conditions, food safety and elopements.

On 08/27/2025 at approximately 11:15 AM, Surveyor interviewed Assistant House Manager (AHM) C. Surveyor asked about caregiver schedules. AHM C reported that caregivers worked 12 hour shifts (7AM-7PM; 7PM-7AM). Apart from kitchen staff and the housekeeper, AHM C indicated the facility is staffed with one caregiver per shift.

On 08/28/2025, Surveyor requested training records for House Manager (HM) B and Assistant House Manager (AHM) C from Administrator A via e-mail.

On 09/03/2025, Surveyor reviewed HM B's date of hire and training record. HM B's hire date was 07/15/2025. HM B's training record did not contain Fire Safety training. Surveyor reviewed AHM C's date of hire and training record. AHM C's hire date was 07/31/2025. AHM C's training record did not contain orientation training, Fire Safety training or standard precautions' training.

According to the provider's July and August 2025 schedule, HM B worked approximately 17 shifts alone in July and approximately 18 shifts alone in August. AHM C worked approximately 8 shifts alone in August.

On 09/03/2025 at approximately 10:15 AM, Surveyor interviewed Administrator A via telephone. Administrator A verified documents provided by the facility (July & August 2025 work schedules and one caregiver worked per shift). Surveyor instructed Administrator A to provide any additional survey relevant records by 3:00 PM on

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N 397	Continued From page 31 09/03/2025. On 09/03/2025 at approximately 1:43 PM, Administrator A e-mailed Surveyor. In regard to records requested by Surveyor, Administrator A noted, "This should be all you've requested." The provider did not have record of HM B completing Fire Safety training and did not have record of AHM C completing orientation and standard precautions' training. The provider did not have a qualified care staff present when residents were present during 17 shifts in July 2025 and 26 shifts in August 2025. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 397		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing	N 404		

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practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not arrange for a pharmacist or physician to review Resident 1 and Resident 2's medication regimen at least annually. The provider did not ensure a physician, pharmacist, or registered nurse conducted an onsite review of their medication administration and medication storage system annually with a written report.

This is a repeat deficiency. See Statement of Deficiency (SOD) DDBB11, dated 02/19/2020.

Findings include:

On 07/11/2025, 07/21/2025, 08/11/2025, and 08/14/2025, the Department received complaints related to medication administration.

On 08/27/2025, Surveyor reviewed Resident 1's record. Resident 1 had multiple diagnoses including paranoid schizophrenia. There were multiple notes stating Resident 1 refused his/her medications. An after visit summary, dated 03/27/2025, indicated Resident 1 had the following medication orders: gabapentin, lorazepam (as needed), meloxicam, quetiapine, rosuvastatin, sertraline, and zolpidem.

On 08/27/2025 at approximately 1:00 p.m., Surveyor interviewed Assistant House Manager (AHM) C. AHM C told Surveyor Resident 1 has not taken any medications since s/he started

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working. AHM C's date of hire was 07/31/2025.

On 08/27/2025, Surveyor reviewed Resident 2's record. Resident 2 had an after visit summary, dated 01/15/2025, which indicated Resident 2 was to stop taking lorazepam and start taking alprazolam. Another after visit summary, dated 07/11/2025, by the same doctor, indicated for Resident 2 to stop taking lorazepam and start taking alprazolam.

On 08/28/2025 and 08/29/2025, Surveyor emailed Administrator A and requested the most recent medication regimen review for Resident 1 and Resident 2. Surveyor also requested the most recent onsite review of the facility's medication administration and medication storage systems.

As of 09/03/2025, Surveyor did not receive the requested reports.

On 09/03/2025 at approximately 11:00 a.m., Surveyor interviewed Administrator A and Registered Nurse (RN) G on the phone. RN G told Surveyor s/he did not complete annual medication regimen reviews for the residents and their pharmacy did not conduct reviews either.

The provider did not have documentation of each resident's medication regimen review and did not have documentation of an onsite review of the provider's medication administration and storage systems.

Cross References:
N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations
N0406 DHS 83.37(1)(g) Disposition Of Medications

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N 404	Continued From page 34 N0408 DHS 83.37(1)(i) PRN Psychotropic Medications N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0417 DHS 83.37(3)(a) Medication Storage: Original Containers	N 404		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 406		

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N 406	Continued From page 35 did not develop and implement a policy for disposing medications in compliance with federal, state and local standards or laws. The provider did not ensure the administrator or designee, and one other employee witnessed, signed, and dated a record of destruction. Findings include: On 07/11/2025, 07/21/2025, 08/11/2025, and 08/14/2025, the Department received complaints related to medication administration. On 08/27/2025 at approximately 10:00 a.m., Surveyor observed the medication storage system with Assistant House Manager (AHM) C. While observing the medications, a pill belonging to Resident 3 fell out of the pack and onto the floor. Surveyor asked AHM C what s/he will do with that medication. AHM C said s/he took the whole day out and will destroy it. Surveyor asked AHM C to explain the process of destroying a medication. AHM C said House Manager (HM) B will take care of it. On 08/27/2025 at approximately 11:45 a.m., Surveyor interviewed HM B. Surveyor asked if there was a destruction log for medications destroyed. HM B said there was not, and s/he was unaware of the requirements related to destruction of medications. Surveyor reviewed DHS 83 with HM B.	N 406		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s	N 408		

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N 408	Continued From page 36 individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor at least monthly for the inappropriate use of PRN (as needed) psychotropic medication for Resident 2. Findings include: On 07/11/2025, 07/21/2025, 08/11/2025, and 08/14/2025, the Department received complaints related to medication administration. On 08/27/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 03/28/2022. S/he had a legal guardian and was under protective placement. S/he had diagnoses that included: post-traumatic stress disorder (PTSD), anxiety, depression, chronic prescription opiate use, mood disorder as late effect of	N 408		

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N 408	Continued From page 37 traumatic brain injury, and on long term drug therapy. An after visit summary, dated 01/15/2025, indicated Resident 2 was to stop taking lorazepam PRN and start taking alprazolam 0.5 milligrams (mg) twice daily and may take an additional tablet daily if needed. An after visit summary, dated 07/11/2025, by the same doctor, indicated again for Resident 2 to stop taking lorazepam and to start taking alprazolam 0.5 mg three times a day. Resident 2's medication administration record indicated staff continued to administer PRN lorazepam to Resident 2 until 07/24/2025 when the provider initiated the scheduled alprazolam order. On 08/28/2025 and 08/29/2025, Surveyor requested the monthly reviews of PRN psychotropic medications for Resident 2, completed in 2025. As of 09/03/2025, Surveyor did not receive the monthly reviews of Resident 2's PRN medication administration of lorazepam. On 09/03/2025 at approximately 11:00 a.m., Surveyor interviewed Administrator A on the phone. Surveyor asked if they conducted monthly reviews of PRN psychotropic medications. Administrator A said they did not.	N 408		
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	N 410		

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N 410	Continued From page 38 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 report to Resident 1's prescribing practitioner, supervising nurse, or pharmacist after Resident 1 refused his/her medications for more than 2 consecutive days. Findings include: On 07/11/2025, the Department received a complaint related to medication administration. On 08/27/2025 at approximately 1:00 p.m., Surveyor interviewed House Manager (HM) B. HM B told Surveyor Resident 1 did not take any medications as s/he refused everything. A progress note, dated 03/27/2025, read: "Resident has been refusing meds (medications) for months now also has increased agitation but able to redirect most times. May have increased pain but not able to verbalize wondering if that's causing behaviors. Any questions call Maplewood Villa ..."	N 410		

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N 410	Continued From page 39 It was not clear who this note was intended for. There was no other documentation to indicate Resident 1's prescribing physician was notified of Resident 1's refusal of medications. On 09/03/2025 at approximately 11:00 a.m., Surveyor interviewed Administrator A and Registered Nurse (RN) G on the phone. RN G told Surveyor s/he did not complete annual medication regimen reviews for the residents and their pharmacy did not conduct reviews either. Surveyor asked about Resident 1's refusal of medications. Administrator A told Surveyor Resident 1 refused his/her medications for "well over a year." Surveyor asked if Resident 1's prescribing physicians were notified of Resident 1's refusals. Administrator A said they were notified. Surveyor requested documentation of when Resident 1's physicians were notified. Administrator A said it would have been by phone. Surveyor asked if they documented communication with the physicians. Administrator A said, "It is now, probably wasn't at the time." The provider did not report to Resident 1's prescribing practitioner, supervising nurse, or pharmacist after Resident 1 refused his/her medications for more than 2 consecutive days. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 410		
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	N 415		

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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 interview, the provider did not ensure medication administration was documented appropriately for 5 of 8 residents that received medication administration from the provider (Resident 4, Resident 5, Resident 6, Resident 7, and Resident 8).

Findings include:

On 07/11/2025, 07/21/2025, 08/11/2025, and 08/14/2025, the Department received complaints related to medication administration.

On 08/27/2025 at approximately 10:00 a.m., Surveyor observed the medication cart and August 2025 medication administration record (MAR) with Assistant House Manager (AHM) C, which included the following:

Resident 4 - The August 2025 MAR did not have documentation to indicate of Resident 4's medications were administered on 08/15/2025, 08/17/2025, and 08/18/2025. AHM C said Caregiver E needs to sign the MAR.

Resident 5 - There was a sticky note on 08/17/2025 for Caregiver E to sign the MAR. AHM C said, "[Caregiver E] needs to sign meds

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N 415	Continued From page 41 (medications)." Resident 6 - Resident 6 received his/her medications from the Veterans Affairs (VA) and the medications remained in the pill bottles. Resident 6's MAR had multiple blanks without documentation if the medication was given or not. There was a sticky note for AHM C to sign medications administered on 08/18/2025 and 08/23/2025. AHM C said s/he gave the medications but forgot to initial. AHM C documented his/her initials on the MAR. There was also a note for Caregiver E to document medications administered on 08/15/2025 - 08/17/2025. Resident 7 -Resident 7's medications remained in the pill bottles. On 08/15/2025, staff did not document if Resident 7's gabapentin was administered at 3:00 p.m. and 11:00 p.m. On 08/17/2025, staff did not document if any of Resident 7's medications were administered. Resident 8 - On 08/17/2025, staff did not document if Resident 8's medications were administered. Resident 8's PRN (as needed) medication administration documentation indicated staff administered Flexeril (cyclobenzaprine) on the following dates without reason and effectiveness of cyclobenzaprine: 08/01/2025, 08/02/2025, 08/05/2025, 08/06/2025, 08/10/2025, 08/12/2025, 08/13/2025, 08/14/2025, 08/16/2025, 08/18/2025, 08/22/2025 - 08/27/2025. Resident 8 also had PRN albuterol inhaler and PRN Symbicort inhaler that staff documented they administered without documentation of reason and effectiveness. On 08/27/2025 at approximately 12:45 p.m., Surveyor interviewed House Manager (HM) B.	N 415		

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N 415	Continued From page 42 HM B told Surveyor Caregiver E resigned his/her position. S/he was residing at the facility as s/he was in the process of moving. HM B said Caregiver E worked when absolutely needed but preferred not to work. HM B told Surveyor s/he told Caregiver E multiple times to look at the MAR as s/he was not documenting like s/he should. HM B said Caregiver, E, Caregiver D, and Caregiver F have all missed documentation. The provider did not ensure staff documented all medication administration as required.	N 415		
N 417	83.37(3)(a) Medication storage: original containers. Original containers. The CBRF shall keep medications in the original containers and not transfer medications to another container, unless the CBRF complies with all of the following: 1. Transfer of medications from the original container to another container shall be done by a practitioner, registered nurse, or pharmacist. Transfer of medication to another container may be delegated to other personnel by a practitioner, registered nurse or pharmacist. 2. If a medication is administered by CBRF employees and the medication is transferred from the original container by a registered nurse, or practitioner or other personnel who were delegated the task, the CBRF shall have a legible label on the new container that includes, at a minimum, the resident ' s name, medication name, dose and instructions for use. The CBRF shall maintain the original pharmacy container until the transferred medication is gone. This Rule is not met as evidenced by:	N 417		

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N 417	Continued From page 43 Based on observation and interview, the provider transferred medications from their original container into individual dose packages for 5 of the 9 residents. The provider did not maintain the original pharmacy container until the transferred medication was gone. Findings include: On 07/11/2025, 07/21/2025, 08/11/2025, and 08/14/2025, the Department received complaints related to medication administration. On 08/27/2025 at approximately 10:00 a.m., Surveyor observed the medication storage system with Assistant House Manager (AHM) C. The medications were in a medication card with bubbles for each day. There were multiple medications in each bubble. AHM C said House Manager (HM) B packaged the medications from the bottle into the medication cards. Surveyor did not observe the empty medication bottles from the pharmacy. On 08/27/2025 at approximately 2:00 p.m., Surveyor interviewed HM B. HM B told Surveyor Registered Nurse (RN) G delegated him/her to re-package the medications. HM B said s/he was a licensed practical nurse in the past and also worked in a pharmacy packaging medications. On 08/29/2025, Surveyor emailed Administrator A and asked what happened to the medication bottles from the pharmacy after the medications were transferred into the medication cards. On 09/02/2025, Administrator A responded via email, which read: "Regarding the pill bottles. All labels are removed and they are recycled." On 09/03/2025 at approximately 11:00 a.m.,	N 417		

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N 417	Continued From page 44 Surveyor interviewed Administrator A on the phone. Surveyor explained the regulation to Administrator A that the original medication package from the pharmacy must be maintained until the transferred medication is gone. Administrator A said, "okay." Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 417		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

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N 431	Continued From page 45	N 431		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not document changes in Resident 1's health and communication with Resident 1's physician.

Findings include:

On 07/11/2025, the Department received a complaint related to resident care and services.

On 08/27/2025, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 04/27/2021.

Progress notes in Resident 1's chart went from 11/22/2022 to 06/19/2024 without documentation between these dates. On 06/19/2024, Caregiver E documented, in part: "[Resident 1's] behaviors have been changing rather quickly ... [S/he] is having a really hard time saying what [s/he] wants to say. It's difficult to complete a sentence ... We will remain closely monitoring for more changes in behaviors." The next note was documented 11/04/2024, by Caregiver D. The note on 11/04/2024 read, in part: [Resident 1] is becoming more & more agitated almost daily. Refusing meds (medications). [Resident 1] is very suspicious of almost everyone. Thinks we have stole [his/her] cars, trucks, money etc. Very difficult @ times to redirect. Will continue to monitor." There was no documentation to indicate if Resident 1's physician was notified of these changes in Resident 1's mental health and refusal to take medications. Staff documented Resident 1's refusal of medications in November

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N 431	Continued From page 46	N 431		

and December of 2024. Staff documented in January 2025, exact date was illegible, that Resident 1 required assistance with putting his/her coat and belt on and lighting his/her cigarette. The next staff note was not until 03/27/2025. This note read: "Resident has been refusing meds (medications) for months now also has increased agitation but able to redirect most times. May have increased pain but not able to verbalize wondering if that's causing behaviors. Any questions call Maplewood Villa ..." It was not clear who this note was intended for.

A discharge summary, dated 10/14/2024, indicated Resident 1 had surgery. The discharge summary did not indicate what type of surgery Resident 1 had. There was a handwritten note that read: "Pt (patient) has a dressing on umbilical area drainage from surgery. May remove dressing if no further drainage."

On 08/27/2025 at approximately 1:00 p.m., Surveyor interviewed House Manager (HM) B. Surveyor asked HM B what Resident 1 had surgery on in October 2024. HM B replied, "I do not know." HM B told Surveyor Caregiver E, Caregiver D, and Caregiver F all missed documentation and s/he would be training all staff on documentation.

On 09/03/2025 at approximately 11:00 a.m., Surveyor interviewed Administrator A on the phone. Administrator A said communication with the physicians was done by phone. Administrator A said they would start documenting communication in the resident's record. Administrator A said Assistant House Manager (AHM) C called to get information on Resident 1's surgery in October 2024. Administrator A said Resident 1 had an appendectomy. There was no

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N 431	Continued From page 47 documentation in Resident 1's related to the appendectomy other than the discharge summary. The provider did not document changes in Resident 1's health. There was no documentation related to Resident 1's appendectomy. There was no documentation to indicate Resident 1's physicians were notified of changes in his/her mental health and refusal of medications. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 431		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide medication administration services appropriate to meet Resident 2's needs. Findings include: On 07/11/2025, 07/21/2025, 08/11/2025, and 08/14/2025, the Department received complaints	N 432		

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N 432	Continued From page 48 related to medication administration. On 08/27/2025, Surveyor reviewed Resident 2's record. Resident 2 had an after visit summary, dated 01/15/2025, which indicated Resident 2 was to stop taking lorazepam and start taking alprazolam. Another after visit summary, dated 07/11/2025, by the same doctor, indicated for Resident 2 to stop taking lorazepam and start taking alprazolam. Resident 2's medication administration record indicated staff continued to administer lorazepam to Resident 2 through 07/23/2025. On 07/24/2025, Resident 2's order for alprazolam was started. On 09/03/2025 at approximately 11:00 a.m., Surveyor interviewed Administrator A on the phone. Surveyor asked about Resident 2's medication orders for lorazepam and alprazolam. Administrator A told Surveyor that was an error on management's part. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 432		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g);	N 454		

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N 454	Continued From page 49 (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of	N 454		

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N 454	Continued From page 50 pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident record was maintained. Findings include: On 08/27/2025, Surveyor reviewed resident records for Resident 1, Resident 2, Resident 3, and Resident 4. Surveyor did not locate the June 2025 medications administration records (MARs) for Resident 1, Resident 2, Resident 3, and Resident 4. Resident 2 was admitted on 03/28/2022. His/her individual service plan (ISP) was dated 08/24/2025. Surveyor could not locate a previous ISP for Resident 2. On 08/27/2025 at approximately 11:30 a.m., Surveyor interviewed House Manager (HM) B. HM B told Surveyor s/he was unable to locate June MARs, ISPs, and other documentation. HM B told Surveyor to ask Caregiver D where these records were as Caregiver D was the previous house manager.	N 454		

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N 454	Continued From page 51 On 08/27/2025 at approximately 12:13 p.m., Surveyor interviewed Caregiver D. Caregiver D told Surveyor and HM B that previous records were stored in the oxygen room. Caregiver D said s/he took time off work starting 06/29/2025. On 08/27/2025 at approximately 12:15 p.m., Surveyor and HM B observed the oxygen room. There were multiple boxes of resident records loosely stored in them. Surveyor and HM B also observed the storage room across the hall, which contained boxes of resident's records. HM B had tears in his/her eyes and said, "This has all been dumped on me." On 09/03/2025 at approximately 10:30 a.m., Surveyor interviewed Administrator A on the phone. Administrator A told Surveyor s/he audits resident records at least monthly. Surveyor asked if s/he was aware there were loose records stored in the oxygen and storage rooms. Administrator A said s/he was just made aware of that. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 454		
N 498	83.45(2) Storage areas. Storage. The CBRF shall maintain storage areas in a safe, dry and orderly condition. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain storage areas in an orderly fashion. Findings include:	N 498		

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N 498	Continued From page 52 On 07/21/2025 and 08/11/2025, the Department received complaints related to the physical environment of the facility. On 08/27/2025 at approximately 12:15 p.m., Surveyor observed the oxygen storage room with House Manager (HM) B. This storage area contained oxygen tanks, walkers, commodes, and other medical equipment. There were boxes on the floor and stacked on medical equipment that had loose resident records in them. There was no organization to the storage area. There was a maintenance storage room across the hall from the oxygen storage room. This room had a box of records stored on a desk along with paint and other maintenance supplies. On 09/03/2025 at approximately 11:00 a.m., Surveyor interviewed Administrator A on the phone. Surveyor explained observations of the storage rooms and the regulation for storage rooms to be maintained orderly. Administrator A said, "Got it." Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 498		
N 531	83.47(4)(a) Fire extinguishers: type and inspection. At least one portable dry chemical fire extinguisher with a minimum 2A, 10-B-C rating shall be provided on each floor of the CBRF. All fire extinguishers shall be maintained in readily usable condition. Inspections of the fire extinguisher shall be done by a qualified professional one year after initial purchase and annually thereafter. Each fire extinguisher shall be provided with a tag documenting the date of	N 531		

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N 531	Continued From page 53 inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider's fire extinguishers were not inspected annually by a qualified professional. Findings include: 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 08/27/2025, Surveyor toured the facility. Surveyor observed the provider's fire extinguishers were last inspected by Complete Fire Solutions, Inc (CFS) in June 2024. On 08/28/2025, Surveyor requested the provider's annual fire extinguisher inspection report via e-mail from Administrator A. On 09/03/2025 at approximately 10:15 AM, Surveyor interviewed Administrator A via telephone. Surveyor asked Administrator A for the facility's annual fire extinguisher inspection report. Administrator A indicated that Administrator A thought the fire extinguishers were recently inspected and would follow up with CFS. Administrator A stated that if the fire extinguishers were not inspected in 2025, Administrator A would get the inspection scheduled. On 09/05/2025 at approximately 5:53 PM, Administrator A verified via email that the fire extinguishers were last inspected by CFS on 07/10/2024.	N 531		

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N 531	Continued From page 54 Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 531		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the fire detection system (smoke and heat detectors) was tested annually by certified and qualified personnel in accordance with the specifications in NFPA 72 and the manufacture's specifications and procedures. Findings include: 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 08/28/2025, Surveyor requested the provider's annual smoke and heat detection inspection report from Administrator A via e-mail. On 09/03/2025 at approximately 10:15 AM, Surveyor interviewed Administrator A via telephone. Surveyor asked Administrator A for the facility's annual smoke and heat detection	N 538		

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 09/03/2025

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 538	Continued From page 55 inspection report. To date, Administrator A did not provide the facility's annual smoke and heat detection inspection report. Administrator A indicated that the facility's smoke and heat detection system was being tested on today's date, 09/03/2025. Administrator A reported that the smoke and heat detection system was last inspected on 07/23/2024. The provider did not ensure the fire detection system (smoke and heat detectors) was tested annually by certified and qualified personnel in accordance with the specifications in NFPA 72 and the manufacture's specifications and procedures. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 538		