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 01/15/2026

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 01/13/2026, Surveyors conducted a verification visit and complaint investigation at Maplewood Villa LLC CBRF. Data collection continued through 01/15/2026. Twenty-two of 24 deficiencies identified in statement of deficiency (SOD) SCFR16 were corrected. The complaint was substantiated. 5 deficiencies were identified. Three of 5 deficiencies were repeat violations, see SOD SCFR16, dated 09/03/2025, and SOD 82FT11, dated 09/21/2022. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 8	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the	N 164		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014330	A. BUILDING: _____ B. WING _____	R-C 01/15/2026

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 164	Continued From page 1	N 164		

provider did not report to the Department within 3 working days after law enforcement responded to the facility involving caregiver to caregiver abuse.

This is a repeat deficiency, see statement of deficiency (SOD) 82FT11, dated 09/21/2022.

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 01/02/2026, the Department received a complaint alleging concerns with resident care.

On 01/13/2026 at approximately 10:30 AM, Surveyors interviewed Licensee A and House Manager (HM) B. Surveyors requested self-reportable's (falls, police interventions, elopements, etc.) since last survey (09/03/2025). HM B reported, "The police were here...Staff reported being assaulted by another staff." HM B indicated that Caregiver D had reported being verbally abused by another staff member, Caregiver E, and the police were called in December 2025. HM B stated that Caregiver D no longer worked at the facility and Caregiver E was still employed. Surveyors asked if HM B reported the incident to the Department. HM B reported that s/he did not report the incident to the Department.

On 01/14/2026 at approximately 10:35 AM, Surveyor interviewed HM B. Surveyor asked about the incident involving Caregiver D and Caregiver E on 12/30/2025. HM B reported that

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 01/15/2026

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 164	Continued From page 2 Caregiver E wrote a statement on 12/31/2025 about the incident and Caregiver D had declined to give a statement and Caregiver D had quit on 12/31/2025. On 01/14/2026, Surveyor reviewed a statement written by Caregiver E. Caregiver E's statement (written on 12/31/2025 per HM B), read in part, "...When I returned from a 4 hour shift awaiting [Caregiver D], when [s/he] did not show up on time, I was overwhelmed with anxiety. [S/He] did not call to indicate [s/he] would be late. Upon arrival of [his/her] shift 20 plus minutes late, [s/he] was disinterested in shift to shift report. I began to explain the situation and what was needed to be done with my residents, and what had been done. [S/He] was more interested in [his/her] own agenda and was ignoring my ever so important shift to shift communication that is required. [S/He] then had [his/her] dog in the kitchen which was clearly a violation of policy and procedures. When I attempted to explain the need for [him/her] to remove [his/her] dog from the kitchen where another resident was involved in making food for [himself/herself]. [S/He] became agitated with my complaint and started verbally abusing me. I attempted to discuss [his/her] tardiness and as well [s/he] became verbally abusive to me. I attempted to discuss what medications I passed as they were due and [s/he] was not clocked in as of yet. [S/He] became verbally abusive with me. I attempted to explain and remain [sic] calm but after working 22 hours total in less than a 24 hr [sic] period, I was becoming overwhelmed with [his/her] attitude. I then left the facility upon discretion of the late House Manager, whom I called to request guidance [S/He] indicated I should leave as to not continue the episode. I then left the facility."	N 164		

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 01/15/2026

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 164	Continued From page 3 On 01/14/2026 at approximately 10:35 AM, HM B verified that Caregiver D called the police after a verbal altercation with Caregiver E on 12/30/2025. HM B reported that HM B was contacted by Caregiver E about the incident and Caregiver D had reported the incident to the police and the police responded to the facility on 12/30/2025. HM B confirmed that HM B did not report the incident to the Department. On 01/14/2026, Surveyor reviewed Department records. Department records did not contain a self-report for police intervention in December 2025. The provider did not report to the Department within 3 working days after law enforcement responded to the facility involving caregiver to caregiver abuse.	N 164		
N 194	83.14(1)(a) Licensee at least 21, fit and qualified A licensee shall be at least 21 years of age and be fit and qualified under s. 50.03(4), Stats., and s. DHS 83.07. This Rule is not met as evidenced by: Based on interview and record review, the licensee did not maintain fit and qualified under s. 50.03(4), Stats., and s. DHS 83.07. Findings include: According to DHS 83.07(2), in determining whether a person is fit and qualified, the department shall consider all of the following: ... (c) Financial history. Financial stability, including: 1. Financial history and financial viability of the	N 194		

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 01/15/2026

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 194	Continued From page 4 owner or related organization. 2. Outstanding debts or amounts due to the department or other government agencies, including unpaid forfeitures and fines. 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 12/29/2025, Licensee A contacted the department and indicated s/he was experiencing financial hardship. On 01/07/2026, the department received an email from Licensee A stating s/he planned to close his/her facility due to financial difficulties. Licensee A indicated via phone call with the department on 01/07/2026 that s/he would rescind his/her closure notice if s/he was able to admit more residents. On 01/13/2026 at approximately 10:30 AM, Surveyors interviewed Licensee A and House Manager (HM) B. Surveyors conducted a fit and qualified review with Licensee A. Licensee A reported the following: - Licensee A was not current with State and Federal taxes - Licensee A was behind on payroll taxes for over a year (working with accountant on payment plan per Licensee A) - Licensee A had contracts with Lakeland and Inclusa managed care organizations (MCO) - Licensee A had been without facility insurance for over a year (since filing a fire claim in May 2023 - the insurance lapsed 6 months after filing the fire claim per Licensee A)	N 194		

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 01/15/2026

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 194	Continued From page 5 On 01/13/2026 at 12:47 PM, Licensee A verified via e-mail that Licensee A had a business debt with the Department of Revenue totaling $78,389.95. On 01/13/2026, Licensee A provided Surveyor with a Lakeland Care MCO contract. The MCO contract noted that Licensee A must maintain facility insurance coverage. If Licensee A did not follow the contract, s/he risked losing this source of income. On 01/15/2026 at approximately 2:30 PM, Surveyor interviewed Licensee A via telephone. Licensee A verified not having insurance on the property. Licensee A indicated that s/he would continue to look for insurance. Licensee A did not provide verification that Licensee A had a payment plan in place with the Department of Revenue.	N 194		
{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}		

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 01/15/2026

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 381}	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete and prepare a written comprehensive assessment at least annually for 2 of 2 residents reviewed (Resident 1 and Resident 2), who resided at the facility for more than 1 year. This is a repeat deficiency. See Statement of Deficiency (SOD) SCFR16, dated 09/03/2025. Findings include: On 01/13/2026 and 01/14/2026, Surveyor reviewed records for Resident 1 and Resident 2. Resident 1 was admitted to the facility on 04/27/2021. His/her individual service plan (ISP) was signed 10/07/2025. Resident 2 was admitted to the facility on 03/28/2022. His/her ISP was signed 10/01/2025. Surveyor could not locate a recent written comprehensive assessment in the records for Resident 1 and Resident 2. On 01/14/2026 at approximately 12:00 p.m., Surveyor interviewed House Manager (HM) B and asked if there were any written comprehensive assessments for Resident 1 and Resident 2. HM B told Surveyor s/he did not complete any since s/he started working as the house manager and was not aware of the requirement. S/he asked Surveyor if that was completed with their annual doctor's appointments. At 2:00 p.m., HM B told Surveyor s/he located assessment forms that s/he will be utilizing to complete a comprehensive assessment for each resident.	{N 381}		

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 01/15/2026

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 397}	Continued From page 7	{N 397}		
{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 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 ensure at least one qualified resident care staff was present in the facility when one or more residents were present in the facility. Caregiver C was not a qualified resident care staff, and s/he worked alone in the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) SCFR16, dated 09/03/2025.	{N 397}		

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 01/15/2026

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 397}	Continued From page 8 Findings include: Wis. Admin. Code § DHS 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." 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. At the time of the survey the census was 8. On 01/13/2026 and 01/14/2026 Surveyor reviewed the employee schedule and employee records, including Caregiver C's record. Caregiver C's date of hire was 10/15/2025. His/her record did not contain evidence of completing medication administration training. Caregiver C was not a qualified resident care staff as s/he did not successfully complete training in medication administration. The employee schedule for November and December 2025 indicated Caregiver C worked alone in the facility from 7:00 p.m. to 7:00 a.m. on the following dates: 11/01/2025 11/02/2025 11/05/2025 11/06/2025 11/07/2025 11/15/2025 11/16/2025 11/21/2025 11/22/2025	{N 397}		

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 01/15/2026

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 397}	Continued From page 9 11/23/2025 11/25/2025 11/29/2025 11/30/2025 12/01/2025 12/03/2025 12/04/2025 12/06/2025 (9:00 p.m. - 7:00 a.m.) 12/09/2025 12/13/2025 12/14/2025 12/17/2025 12/18/2025 On 01/14/2026 at approximately 10:15 a.m., Surveyor interviewed House Manager (HM) B. HM B told Surveyor Caregiver C did not pass his/her test for medication administration. Surveyor asked who administered medications when Caregiver C was working. HM B told Surveyor s/he passed the scheduled medications. HM B said s/he only lived 2 minutes away and could come in if a resident requested a PRN (as needed) medication. On 01/15/2026 at approximately 2:30 p.m., Surveyor interviewed Licensee A and HM B on the phone. Surveyor explained concerns related to not having a qualified staff present when Caregiver C worked alone. HM B told Surveyor s/he thought since all scheduled medications were administered it was okay for Caregiver C to work alone. Licensee A said, "It won't happen again."	{N 397}		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits	N 637		

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 01/15/2026

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 637	Continued From page 10 providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure exits, sidewalks and driveways used for exiting were kept free of ice and snow and the provider did not maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. 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.	N 637		

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 01/15/2026

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 637	Continued From page 11 On 01/02/2026, the Department received a complaint alleging concerns with resident falls due to icy entrances/exits and icy parking lot. On 01/13/2026 at approximately 10:30 AM, Surveyor entered the facility. Surveyor observed that the parking lot was covered in ice and the sidewalks leading to the two main facility entrances/exits were covered with packed snow and icy spots. On 01/13/2026 at approximately 11:30 AM, Surveyor observed the two main facility entrances/exits were sanded (sand was applied to the icy spots on the sidewalks in front of the entrances/exits). On 01/13/2026 at approximately 11:45 AM, Resident 3 informed Surveyor that sometime in December 2025, an ambulance driver fell on the ice outside the facility when trying to enter the building to respond to a resident concern. On 01/14/2026 at approximately 10:30 AM, Surveyor entered the facility for the second day of survey. Surveyor observed the parking lot was covered in ice and the two main facility entrances were covered with packed snow and icy spots. The sand that was applied to the entrances/exits the day prior was worn off. On 01/14/2026 at approximately 10:35 AM, Surveyor interviewed House Manager (HM) B. Surveyor asked about resident falls and the provider's entrances, exits and parking lot. HM B reported, "[Resident 4] likes to go out and shovel snow and we'll tell [him/her] not to." HM B indicated that Resident 4 had gone to the emergency room on 12/09/2025 after Resident 4	N 637		

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 01/15/2026

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 637	Continued From page 12	N 637		

complained of falling on the ice outside the facility. HM B stated that Resident 5 fell outside while smoking in December 2025. HM B commented, "[Resident 5] fell outside on the snow covered sidewalk because [Resident 5's] shoes were worn out and did not have traction." HM B indicated that Resident 5 got new boots with better traction. HM B reported, "[Maintenance Person (MP) F] does a good job cleaning the entry ways and puts sand down when needed."

On 01/14/2026 at approximately 11:45 AM, Surveyor observed that sand had been applied to the icy spots on the sidewalks in front of the entrances/exits.

On 01/14/2026, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 03/04/2020. A progress note, dated 12/02/2025, read in part, "Resident sitting on buttocks outdoors attempting to get up. Wears slippery shoes on snow covered surface to go out and smoke. Care team notified. Resident assisted to stand and able to walk into building. Discussed safety with resident. Agreeable to use w/c (wheel chair) [sic] to exit facility and return safely."

On 01/14/2026, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 11/10/2022. A progress note, dated 12/09/2025, read in part, "Resident sleeping this AM [sic]. When [s/he] awoke c/o (complained of) [sic] headache. Gait unsteady. Stated [s/he] fell yesterday and hit the back of [his/her] head on the ground outdoors...Sending resident to the ER [sic] for eval [sic] and TX (treatment)/assessment [sic]." Am emergency department note, dated 12/09/2025 at 8:32 PM, indicated, "Chief Complaint: Fall: (Pt. arrives ambulatory for

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 01/15/2026

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 637	Continued From page 13	N 637		

complaint of fall due to slip on ice while shoveling snow. [S/He] hit her head and reports no loss of consciousness or amnesia to event. [S/He] is not anticoagulated. [S/He] was able to get self up. [S/He] reports right shoulder pain and states 'it popped out of place and I had to put it back.'"

On 01/14/2026 at approximately 11:47 AM, Surveyor interviewed Resident 4. Surveyor asked about facility entrances and exits. Resident 4 reported that s/he fell outside the facility while walking to the designated smoking area in December 2025. Resident 4 indicated that s/he went to the emergency room on 12/09/2025 after falling on the ice outside the facility. Resident 4 commented, "The entrances and exits can be icy at times (and) the parking lot is always icy."

On 01/14/2026 at approximately 12:14 PM, Surveyor interviewed Resident 6. Surveyor asked about facility entrances and exits. Resident 6 stated that s/he goes out to smoke during the day. Resident 6 indicated that the facility entrances and exits were icy at times. Resident 6 reported that residents let MP F know when the sidewalks get icy, and MP F puts sand down "when [MP F] gets here."

The provider did not ensure exits, sidewalks and driveways used for exiting were kept free of ice and snow and the provider did not maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building.