STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 07/02/2025, with additional information gathered through 07/22/2025, Surveyors conducted 2 complaint investigations and a standard survey at Arbor Village Inc. Two of 2 complaints were substantiated. Fifteen deficiencies were identified. Four of 15 deficiencies were repeat violations. See Statements of Deficiency (SOD) 8CNU11, dated 01/21/2020, and SOD 8CNU12, dated 09/21/2022. Census: 14	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by:	N 158		

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

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N 158	Continued From page 1 Based on record review and interview, the provider did not ensure the safety of all residents and investigate and report an allegation of abuse of Resident 1. On 06/13/2025, the provider was notified of an allegation that Resident 1 was being administered morphine as a means to get him/her to sleep, pillows were being tucked under Resident 1 to restrict him/her from getting out of bed, and a strap was being placed on his/her wheelchair wheels or his/her chair to restrict him/her from moving. The provider did not conduct an investigation into the allegations. Findings include: The provider is licensed to provide services for up to 50 residents who may be developmentally disabled, physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia. On 06/17/2025, the department received complaint information alleging resident abuse, restraint, and neglect. On 07/02/2025, Surveyors conducted a complaint investigation. At approximately 9:55 AM, Surveyors interviewed Manager A who reported being made aware of an allegation of mistreatment of Resident 1 on 06/13/2025 by Adult Protective Services (APS). Manager A stated it's his/her understanding that APS was investigating Caregiver C for giving Resident 1 morphine to sedate him/her and Caregiver D for restraining Resident 1's wheelchair with a strap, as well as lining pillows along his/her bed so Resident 1 could not get out. Manager A stated s/he confirmed that Resident 1 had a physician order for morphine and Caregiver	N 158		

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N 158	Continued From page 2 C followed the order by administering morphine. Manager A said Caregiver D had not worked since they were made aware of the allegation. Surveyor reviewed Caregiver D's employee record and noted s/he was hired on 10/28/2024, worked full time on night shift alone. Surveyor reviewed Resident 1's record and noted no documentation on Resident 1's observation notes, medication administration record, task administration record, and incident reports that were completed by Caregiver D. Manager A said s/he talked to some residents about if they had any concerns about staff and they did not. S/he said s/he was not aware that Caregiver D did not complete any documentation in resident records. Manager A stated s/he did not ask anyone about Resident 1's chair being restrained with a strap. Surveyors inquired whether Manager A conducted an investigation, documented anything on it, or reported the allegations reported to him/her about Resident 1 and s/he said no. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 83.12(3)(a) Investigate Injuries Of Unknown Source N0170 83.12(5)(b) Notification: Abuse And Neglect Allegations N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0351 83.32(3)(g) Rights of Residents: Physical Restraints	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 161	Continued From page 3	N 161		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate an injury to Resident 1 that could not be adequately explained. Findings include: On 06/17/2025, the department received complaint information alleging abuse of residents. On 07/02/2025, Surveyors conducted a complaint investigation. Surveyor reviewed Resident 1's record and noted s/he had diagnoses of atrial fibrillation, hypertension, osteoarthritis, anxiety disorder, and dementia. Surveyor reviewed Resident 1' s January-July 2025 observation notes and noted Resident 1 had multiple falls, restlessness, and combativeness with staff during personal cares. Surveyor noted the following related to an injury of unknown source. 06/23/25 8:00 PM "Elder has a bruise on top of left eyebrow. Unsure when this happened however [s/he] has fallen quite a bit unwitnessed in the past few	N 161		

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N 161	Continued From page 4	N 161		

days."
06/29/2025 12:30 PM "[Resident 1] top of left hand is bruised. Unknown how it happened. Writer discovered this bruise right at 6am."

On 07/10/2025, Surveyor requested any additional notes, incident reports or investigations regarding a bruises of unknown source as multiple incident reports and notes were provided, but nothing related to a discovered bruise on 06/23/2025 and 06/29/2025.

On 07/14/2025, Surveyors received an incident report completed by Manager A for 06/27/2025 with "Multiple Falls" listed as type of incident and "hematoma" as injury. Resident 1's forehead, right knee, left wrist and right hand were identified. "[Resident 1] had multiple falls over the last few days. [Staff] called [Nurse Practitioner I's] office to get x ray of r. [sic]" Surveyor note: "Physician notified ...Resident's family or representative notified ... Was Other notified ..." were all checked as "No."

No other notes, incident reports, or investigations were noted surrounding Resident 1's left hand. Resident 1 was referenced to have multiple falls and exhibited physical aggression towards staff during cares, however nothing connected the bruise to his/her left hand and a source.

On 07/15/2025 at approximately 11:00 AM, Surveyors interviewed Manager A who was unable to confirm whether the bruise on Resident 1's left hand was connected to a fall or not. Manager A acknowledged an investigation for injury of unknown source was not completed.

Cross Reference:
N0158 83.12(2)(a) Caregiver: Investigating Abuse

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N 161	Continued From page 5 & Neglect N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 161		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the safety of all residents and investigate and report an allegation of abuse of Resident 1. On 06/13/2025, the provider was notified of an allegation that Resident 1 was being administered morphine as a means to get him/her to sleep, pillows were being tucked under Resident 1 to restrict him/her from getting out of bed, and a strap was being placed on his/her wheelchair wheels or his/her chair to restrict him/her from moving. The provider did not notify Resident 1's legal representative. Findings include: The provider is licensed to provide services for up to 50 residents who may be developmentally disabled, physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia. On 06/17/2025, the department received complaint information alleging resident abuse,	N 170		

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N 170	Continued From page 6 restraint, and neglect. On 07/02/2025, Surveyors conducted a complaint investigation. At approximately 9:55 AM, Surveyors interviewed Manager A who reported being made aware of an allegation of mistreatment of Resident 1 on 06/13/2025 by Adult Protective Services (APS). Surveyors inquired whether Manager A contacted Resident 1's legal representative, POAHC H and s/he said no. On 07/11/2025 at approximately 4:50 PM, Surveyor interviewed POAHC H who stated s/he was made aware of allegations of abuse, restraint, and neglect towards Resident 1 on 06/12/2025 by Adult Protective Services Manager E. S/he said s/he had not had any communication with the provider regarding the allegations nor had received any follow up. On 07/15/2025 at approximately 11:00 AM, Surveyors interviewed Manager A who acknowledged POAHC A was not notified of the allegations of abuse and neglect affecting Resident 1. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0351 83.32(3)(g) Rights Of Residents: Physical Restraints	N 170		
N 196	83.14(2)(a) Licensee ensures facility complies with laws	N 196		

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N 196	Continued From page 7 The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the Community Based Residential Facility (CBRF), and its operation complied with all laws governing the CBRF. Fifteen deficiencies were identified. Four of 15 deficiencies were repeat violations. See Statements of Deficiency (SOD) 8CNU11, dated 01/21/2020, and SOD 8CNU12, dated 09/21/2022. This is a repeat deficiency. See SOD 8CNU12, dated 09/21/2022. Findings include: The provider is a class CNA (non-ambulatory) community-based residential facility (CBRF) licensed to serve up to 50 residents who may be physically disabled, mentally ill/emotionally disturbed, terminally ill, developmentally disabled, of advanced age, and/or have irreversible dementia/Alzheimer's. On 06/17/2025, the department received 2 complaints regarding allegations of resident abuse and neglect, and allegations of inadequate resident care and supervision. On 07/02/2025, Surveyors reviewed the department's provider records for Arbor Village INC and noted the facility had been licensed by licensee corporation Arbor Village INC with Licensee B listed as the designated agent since	N 196		

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N 196	Continued From page 8 11/22/2017. Surveyors noted the listed Administrator was Former Administrator L. On 07/02/2025, Surveyors conducted complaint investigations and a standard survey. At the time of survey, 14 residents resided at the facility. At approximately 9:55 AM, Surveyors interviewed Manager A who explained that s/he started at the facility in April 2025 and was the Administrator. Manager A stated s/he was trying to organize facility files, assist residents, and complete the Administrator training to be the Administrator as s/he did not meet the DHS 83 Administrator credentials. Manager A acknowledged understanding the need to ensure compliance. On 07/22/2025 at approximately 3:00 PM, Surveyor interviewed Licensee B who stated the residents were most important and s/he was aware of the importance of facility compliance to ensure the residents are being properly cared for. Licensee B acknowledged awareness of Former Administrator L being listed as the Administrator of the facility. Licensee B acknowledged Manager A or Licensee B were not credentialed and qualified to be the Administrator and oversee daily operations. On 07/14/2025, Surveyors reviewed 2025 provider staff meeting minutes: 04/17/2025 Surveyor noted "We need to be treating our residents with compassionate care, dignity and respect ...No excuse for any other treatment will be tolerated. This is their home." 05/15/2025 Surveyor noted "Cares on residents & charting to be completed ..." Manager A provided Surveyors with documentation of additional training topics reportedly provided at each meeting to include:	N 196		

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	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 196	Continued From page 9	N 196		

April 2025 topic "Behavior Management Protocol and Techniques"
May 2025 topic "Abuse Prevention Training"
June 2025 topic "Misconduct Investigation Protocol - Investigation of Allegation of Abuse, neglect, Misappropriation of Property"
Surveyors reviewed sign-in sheets for the April-June 2025 meetings and noted Caregiver D was not listed in attendance for April and June, and noted a handwritten note on May sign-in sheet "[Caregiver D] refused to sign."
Surveyor noted these trainings were provided with Manager A and Licensee B present and/or giving the training, however an investigation of caregiver misconduct was not conducted upon an allegation of abuse and neglect of Resident 1, notification to Resident 1's legal representative was not made following the allegation or at all regarding the situation, Resident 1 was physically restrained, Resident 1's behaviors were not effectively managed and not consistently documented, and Resident 1's medications were not available to him/her as ordered, psychotropic medications were not reviewed and monitored as needed for appropriate use, and were not audited daily to ensure there was no misappropriation of property/medications.

As a result of Licensee B not upholding his/her responsibilities as the licensee, several complaint investigations and surveys with (5) verification visits conducted from 01/21/2020 through 07/22/2025 resulted in deficiencies. On 07/02/2025, with additional information gathered through 07/22/2025, 15 deficiencies were identified. (4 of 15 deficiencies were repeat violations):
N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect
Based on record review and interview, the

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	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 196	Continued From page 10 provider did not ensure the safety of all residents and investigate and report an allegation of abuse of Resident 1. This requirement is being cited for a third time. See Statement of Deficiencies (SOD) SOD 8CNU12, dated 09/21/2022, and SOD 8CNU11, dated 01/21/2020. N0161 83.12(3)(a) Investigate Injuries Of Unknown Source Based on record review and interview, the provider did not investigate an injury to Resident 1 that could not be adequately explained. N0170 83.12(5)(b) Notification: Abuse And Neglect Allegations Based on record review and interview, the provider did not ensure the safety of all residents and investigate and report an allegation of abuse of Resident 1. N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws Based on observation, record review, and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) SOD 8CNU12, dated 09/21/2022. N0277 83.25 Continuing Education Based on record review and interview, the provider did not ensure Licensee B received 15 hours of continuing education in 2023 and 2024. This requirement is being cited for a third time. See Statement of Deficiencies (SOD) SOD 8CNU12, dated 09/21/2022, and SOD 8CNU11, dated 01/21/2020.	N 196		

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N 196	Continued From page 11 N0351 Rights of Residents: Physical Restraints Based on observation, interview, and record review, the provider did not ensure Resident 1 was free from physical restraint. N0397 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake Based on record review and interview, the provider did not ensure a least one qualified resident care staff was on duty and awake if at least one resident in the CBRF (Resident 1) 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. N0407 83.37(1)(h) Scheduled Psychotropic Medication Based on record review and interview, the provider did not ensure Resident 1 was reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for desired responses and possible side effects of the medication. RN J completed a quarterly psychotropic review on 05/06/2025, but no other quarterly psychotropic reviews were conducted in 2024 and 2025. Resident 1 was on 6-7 scheduled psychotropic medications in 2025. N0408 83.37(1)(i) PRN Psychotropic Medication Based on record review and interview, the provider did not ensure Resident 1's individualized service plan (ISP) did not include the most updated PRN [as needed] psychotropic medication, the rationale for use and a detailed	N 196		

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N 196	Continued From page 12	N 196		

description of the behaviors which indicate the need for administration of PRN psychotropic medication

N0409 83.37(1)(j) Proof-Of-Use-Record
Based on record review and interview, the provider did not maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812(c), and Wisconsin's uniform controlled substances act, ch. 961, Stats.

N0415 83.37(2)(d) Documentation of Medication Administration
Based on record review and interview, the provider did not ensure documentation was completed in the Medication Administration Record (MAR) for Resident 1.

N0426 83.38(1)(b) Supervision
Based on record review and interview, the provider did not provide supervision appropriate to meet the needs of 5 residents. Licensee B took Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6 to the local park for a community event. Resident 2 complained of not feeling well and Licensee B drove Resident 2 back to the facility, leaving Resident 3, Resident 4, Resident 5, and Resident 6 at the park. Four of 4 residents were assessed to require supervision.

N0432 83.38(1)(h) Medication Administration
Based on record review and interview, the provider did not ensure medication administration was appropriate to meet Resident 1's needs.

N0433 83.38(1)(i) Behavior Management
Based on record review and interview, the provider did not provide services to fully manage Resident 1's behaviors that were or had the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 196	Continued From page 13	N 196		

potential to be harmful to themselves or others. This is a repeat deficiency. See Statement of Deficiency (SOD) SOD 8CNU12, dated 09/21/2022.

N0454 83.42(1) Resident Record Maintained
Based on record review and interview, the provider did not maintain Resident 1's record to include: documentation of significant incidents and illnesses; including the dates, times, and circumstances, documentation to accurately describe the resident's condition; significant changes in condition; and changes in treatment and response to treatment.

On 07/22/2025 at approximately 3:00 PM, Surveyor interviewed Licensee B who acknowledged not being aware of certain regulations but confirmed an understanding once discussed with Surveyors.

Cross Reference:
N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect
N0161 83.12(3)(a) Investigate Injuries Of Unknown Source
N0170 83.12(5)(b) Notification: Abuse And Neglect Allegations
N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws
N0277 83.25 Continuing Education
N0351 83.32(3)(g) Rights of Residents: Physical Restraints
N0397 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake
N0407 83.37(1)(h) Scheduled Psychotropic Medication
N0408 83.37(1)(i) PRN Psychotropic Medication
N0409 83.37(1)(j) Proof-Of-Use-Record
N0415 83.37(2)(d) Documentation of Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 196	Continued From page 14 Administration N0426 83.38(1)(b) Supervision N0432 83.38(1)(h) Medication Administration N0433 83.38(1)(i) Behavior Management N0454 83.42(1) Resident Record Maintained	N 196		
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 Licensee B received 15 hours of continuing education in 2023 and 2024. Findings include: On 07/11/2025 at approximately 2:45 PM, Surveyors interviewed Manager A, Surveyors requested Licensee B's continuing education documentation. Manager A stated s/he did not think Licensee B completed continuing education and his/her personal file did not contain continuing education documentation, but s/he would check again. Manager A indicated	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 277	Continued From page 15 Licensee B worked as a caregiver on the floor as backup or if staff need assistance. On 07/22/2025, at approximately 3:00 PM, Surveyor interviewed Licensee B, who stated s/he completed continuing education for 2023 and 2024. Licensee B confirmed being the facility owner since 12/01/2018, working as needed and assists residents daily. Licensee B stated s/he would email the continuing education documentation. On 07/22/2025, Surveyor received an email from the facility including a website link to the University of Wisconsin CBRF Registry. Surveyor confirmed Licensee B completed the Department Approved training, but no continuing education documentation was received. Licensee B's 2023 and 2024 record did not contain evidence of training in the topics of standard precautions; resident rights; fire safety including first aid; prevention and reporting of abuse, neglect and misappropriation; and medications. On 07/15/2025, at approximately 11:00 AM, Surveyors interviewed Manager A. Manager A acknowledged s/he did not find any continuing education for Licensee B but will ensure Licensee B completes continuing education for 2025. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0351 83.32(3)(g) Rights of Residents: Physical Restraints N0397 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0426 83.38(1)(b) Supervision	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 277	Continued From page 16 N0433 83.38(1)(i) Behavior Management	N 277		
N 351	83.32(3)(g) Rights of Residents: Physical restraints In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from physical restraints. Be free from physical restraints except upon prior review and approval by the department upon written authorization from the resident ' s primary physician or advanced practice nurse prescriber as defined in s. N 8.02(2). The department may place conditions on the use of a restraint to protect the health, safety, welfare and rights of the resident. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 1 was free from physical restraint. Findings include: The provider is licensed to care for up to 50 residents in the client groups of advanced aged, developmentally disabled, physically disabled, terminally ill, and irreversible dementia/Alzheimer's disease. On 06/17/2025, the department received complaints, alleging residents were being restrained. On 07/02/2025, Surveyors conducted a complaint	N 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 351	Continued From page 17	N 351		

investigation. At the time of survey, 14 residents resided at the facility.

On 07/02/2025, Surveyor reviewed Resident 1's Individual Service Plan (ISP) which indicated Resident 1 was diagnosed with Vertigo .... right knee arthroplasty ... dementia ... depression ...generalized anxiety disorder ...bilateral hearing loss ... and chronic osteoarthritis.

Resident 1's ISP indicated s/he requires assistance with dressing due to unsteadiness .... has poor safety awareness....increased weakness and unsteadiness s/he should not ambulate independently ....utilizes a sensor alarm on his/her bed due to an increase in falls, sensor alert will alarm when s/he is getting out of the bed....has been identified as a wandering risk and will request to leave the facility and/or will leave the facility without staff .... history of behaviors that require staff intervention including self-harming, agitation, and anxiety .... requires staff to closely monitor him/her during these times and offer a PRN as needed medication when necessary .... additionally requires staff assistance/intervention to maintain positive interactions with others due to increased confusion and difficulty hearing.

On 07/02/2025, at approximately 9:55 AM, Surveyors interviewed Manager A regarding an allegation of Caregiver D utilizing restraints to restrict Resident 1's mobility. Manager A indicated s/he was made aware of the allegation by Adult Protective Services E (APS-E). Manager A explained APS-E came to the facility on 06/12/2025 to investigate the allegation. Manager A stated APS-E questioned if Manager A was aware of Caregiver D, who works night shift restricting Resident 1's movement by strapping a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 351	Continued From page 18	N 351		

rachet type strap around Resident 1's wheels on his/her wheelchair and/or strapping the wheelchair to a table to restrict Resident 1's movement. Manager A indicated APS-E showed him/her a photo of a wheelchair which showed a strap wrapped from one wheel to the other which would restrict the wheels on the wheelchair from moving. Manager A indicated s/he was unaware of any caregivers restricting any residents from movement. Manager A denied Caregiver F or Caregiver G reported any allegations involving Caregiver D and Resident 1. Surveyors inquired whether there were any residents who would be up at night that may have witnessed Resident 1 also being awake on night shift. Manager A indicated Surveyors could interview Resident 7.

On 07/02/2025 at approximately 11:30 AM, Surveyor interviewed Resident 7 who was seated at a table in the dining room with Resident 2. Resident 7 described being active with community activities such as church picnics, fire department activities, local park concerts and ice cream socials. Resident 7 stated, "[Resident 1] had some problems and would be awake all night, but it wasn't [his/her] fault. Staff spend a lot of time with [Resident 1] but one morning [Caregiver D] tied up [Resident 1's] wheelchair to the rail by the nurse's station." Resident 7 stated, "There was straps on [Resident 1's] wheelchair that were used to tie up the wheelchair ... but I only seen that one time."

On 07/02/2025, at approximately 12:00 PM, Surveyors interviewed Managed Care Organization K (MCO-K), s/he stated they were made aware of the allegation of restraint from APS on 06/12/2025, which prompted them to start seeking alternative placement for Resident 1. Resident 1 was relocated to an alternative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 351	Continued From page 19 facility on 07/01/2025 by the MCO-K. On 07/09/2025 at approximately 2:50 PM, Surveyor interviewed Adult Protective Services Manager E (APS-E). APS-E stated on 07/12/2025, a referral was made to them alleging Caregiver D, who worked 3rd or night shift alone was restraining Resident 1 from self-propelling in his/her wheelchair by putting a strap around the wheels of his/her wheelchair. APS-E referenced being provided a picture of a strap on the back tires of a wheelchair. APS-E stated s/he notified Resident 1's Managed Care Organization (MCO) care team and Power of Attorney for Healthcare H of the allegation. APS-E reported interviewing provider staff who described Resident 1 as having dementia, was exit seeking, and was up during the night frequently. APS-E indicated it was reported that Resident 1's wheelchair was both restrained from moving, but also was tied to a hospital table at one point as well. Staff reported having reported the allegation to Manager A on 07/09/2025 without any follow up. Caregiver G reported witnessing the strap on Resident 1's wheelchair on more than one occasion. Caregiver G said s/he felt Caregiver D's patience had just run out; s/he witnessed Caregiver D say things like "I wish I could just knock you out" to Resident 1. APS-E stated Resident 1's allegation was substantiated for abuse. On 07/10/2025 at approximately 9:56 AM, Surveyor interviewed Licensee B regarding an allegation of Caregiver D utilizing restraints to restrict Resident 1's mobility. Licensee B indicated s/he was made aware of the allegation by APS-E. Licensee B explained APS-E came to the facility on 06/13/2025 to investigate the allegation. Licensee B stated APS-E questioned if	N 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 351	Continued From page 20	N 351		

Licensee B was aware of Caregiver D restricting Resident 1's movement by strapping a rachet type strap around Resident 1's wheels on his/her wheelchair and/or strapping the wheelchair to a table to restrict Resident 1's movement. Licensee B indicated APS-E showed him/her a photo of a wheelchair which showed a strap wrapped from one wheel to the other which would restrict the wheels on the wheelchair from moving. Licensee B indicated he was unaware of any caregivers restricting any residents from movement.

On 07/10/2025 at approximately 1:27 PM, Surveyor interviewed Caregiver G who stated s/he arrived at the facility at approximately 5:30 AM on 06/09/2025 along with Caregiver F. Caregiver F pointed out to Caregiver G directing his/her attention to Resident 1's wheelchair and the blue gait belt strapped around the wheels. Caregiver G described a blue gait belt strapped around the large back main wheels of Resident 1's wheelchair and 2 additional gait belts strapped around the smaller front wheel securing the strap around a hospital type table. Caregiver G indicated s/he immediately took a photograph of the wheelchair, avoiding photographing Resident 1 for privacy. Caregiver G stated Caregiver D had removed the straps immediately after seeing Caregiver G was near Resident 1. Caregiver G described waiting for Manager A to arrive for his/her shift to report the incident immediately at 8:00 AM. Caregiver G stated that s/he along with Caregiver F met with Manager A and Licensee B in the office and reported their observations and shared the photograph Caregiver G took of the blue gait belt attached to the wheelchair. Caregiver G stated Manager A advised not adding the observation to the communication notes for Resident 1 or detailing his/her observation in an incident report, Manager A explained this should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 351	Continued From page 21	N 351		

not be shared, it is an internal situation. Caregiver G detailed being frustrated with the lack of attention to the incident by Manager A and Licensee B and after many follow up conversations with them, s/he self- terminated employment with the facility on 06/14/2025.

On 07/10/2025 at approximately 2:55 PM, Surveyor interviewed Caregiver F who stated s/he arrived at the facility at approximately 5:30 AM on 06/09/2025 along with Caregiver G. Caregiver F stated s/he pointed out to Caregiver G directing his/her attention to Resident 1's wheelchair and the blue gait belt strapped around the wheels. Caregiver F described a blue gait belt strapped around the large back main wheels of Resident 1's wheelchair and 2 additional gait belts strapped around the smaller front wheel securing the strap around a hospital table. Caregiver F indicated this was the second occurrence of observing Resident 1's wheelchair being strapped to a hospital table. Caregiver F explained a week prior at the start of his/her shift at approximately 5:45 am s/he observed Resident 1 seated in his/her wheelchair and the blue strap being strapped around the large wheels of Resident 1's wheelchair. Caregiver F explained that s/he asked Caregiver D in a non-accusatory tone, "what's this all about?" Caregiver D responded, "I can't get nothing done at night, so I have to strap [Resident 1] down." Caregiver F stated s/he reported both incidents to Manager A and Licensee B. Caregiver F detailed being frustrated with the lack of attention to the incident by Manager A and Licensee B and after many follow up conversations with them, s/he together with Caregiver G self-terminated employment with the facility on 06/14/2025.

On 07/16/2025 at approximately 1:00 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 351	Continued From page 22 Surveyors interviewed Manager A who stated again s/he was not made aware of Resident 1 being physically restrained until APS notified him/her. Manager A acknowledged physical restraint should not have been used on Resident 1. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 83.12(3)(a) Investigate Injuries Of Unknown Source N0170 83.12(5)(b) Notification: Abuse And Neglect Allegations N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0397 83.36(3)(b) Qualified Staff In Charge, On Duty And Awake N0433 83.38(1)(i) Behavior Management N0454 83.42(1) Resident Record Maintained	N 351		
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	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 23 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 a least one qualified resident care staff was 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. Licensee B, Caregiver D, and Caregiver M did not have all required trainings and were not qualified resident care staff that could provide the supervision, intervention and services for Resident 1 on a 24/7 basis. Licensee B, Caregiver D, and Caregiver M were scheduled and worked multiple days a week alone on night shift. Caregiver D and Caregiver M who were not qualified, relied on Licensee B to pass medications and assist when working alone, however Licensee B was also not qualified. Findings include: The CBRF is licensed to serve up to 50 residents who may be developmentally disabled, physically disabled, terminally ill, of advanced age, and/or	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 397	Continued From page 24 have irreversible dementia/Alzheimer's disease. On 06/17/2025, the department received complaint information alleging resident supervision and medication concerns. On 07/02/2025, Surveyors conducted a complaint investigation and standard survey. At approximately 10:00 AM, Surveyors interviewed Manager A who indicated staffing was 2 caregivers on AM's from 6:00 AM-2:00 PM, 2 caregivers on PM's from 2:00 PM-10:00 PM, and 1 caregiver on NOC's (night shift) from 10:00 PM-6:00 AM. Surveyors and Manager A reviewed the staff list to identify caregivers and medication passers. Manager A indicated Caregiver D and Caregiver M were not medication administration and management certified, so did not pass medications. Surveyor inquired what shifts Caregiver D and Caregiver M worked and Manager A stated night shift. Surveyor inquired whether any residents required scheduled or PRN (as needed) medications, or needed 1:1 services or support on night shift and Manager A stated yes and gave resident examples to include Resident 1. Manager A indicated Resident 1 was up most of the nights, was a fall risk, and required PRN's at night. Surveyors inquired who would pass medications or assist on night shift if Caregiver D or Caregiver M needed assistance or to pass medications and Manager A stated "[Licensee B] is always here." Manager A verified Caregiver D and Caregiver M were not qualified resident care staff. Manager A indicated Licensee B lived at the other end of the facility onsite. Surveyor inquired who assisted when Licensee B was not available, present, or asleep, and Manager A said s/he would then come in and/or assist how s/he could.	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 397	Continued From page 25 At approximately 11:23 AM, Surveyors toured the facility and noted a handwritten sign in the nurse's station that said if medications or assistance is needed, contact me [Licensee B] and I will come down and help. Surveyor reviewed Resident 1's record as referenced by Manager A for requiring 24/7 supervision, overnight assistance and support, as well as PRN medication administration. Surveyor noted Resident 1 moved into the facility on 05/11/2022 with diagnoses of thyroid disorder, vertigo, dementia, depression, generalized anxiety disorder, other specified bilateral hearing loss, chronic atrial fibrillation, right knee arthroplasty, and primary osteoarthritis. Resident 1 required 24/7 supervision, had a history of self-injurious behaviors, history of wandering, history of exit seeking and elopement, increased anxiety and restlessness, frequent falls, chronic pain, difficulty seeing and hearing, increased confusion, difficulty making his/her needs known, and increased agitation with redirection. Surveyor reviewed Resident 1's May-July 2025 Medication Administration Record (MAR) and noted 3 PRN pain medications and 2 PRN anxiety medications. Surveyor noted documentation on Resident 1's MAR of being administered both pain and anxiety medications. Surveyor reviewed sample staff schedules and noted the following shifts that did not have a qualified resident care staff. On the week of 06/01/2025-06/07/2025, Caregiver D worked 06/02/2025, 06/03/2025, 06/06/2025, and 06/07/2025. Caregiver M worked 06/01/2025, 06/04/2025, and 06/05/2025. On the week of 06/15/2025-06/21/2025,	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 397	Continued From page 26 Caregiver M was scheduled from 10:00 PM-6:00 AM on 06/15/2025, 06/18/2025, and 06/19/2025. Licensee B worked 06/16/2025, 06/17/2025, 06/20/2025, and 06/21/2025. Surveyors reviewed Caregiver D's record and noted s/he was hired on 10/28/2025 as a night shift caregiver. Surveyor reviewed Caregiver M's record and noted s/he was hired on 05/24/2025 as a night shift caregiver. Surveyor reviewed the UWGB CBRF registry and verified Caregiver D and Caregiver M were not certified in medication administration and management. Surveyors noted Licensee B was on the CBRF registry for medication administration certification. 07/02/2025, at approximately 11:00 AM, Surveyors interviewed Manager A who stated Licensee B's file was empty. Manager A explained the employee records were a mess when s/he started at the facility, and s/he was unable to locate Licensee B's training records. Manager A indicated Licensee B's continuing education for 2024 was before him/her, so s/he was unsure whether s/he got it. Manager A acknowledged Licensee B was not a qualified resident care staff. On 07/22/2025, at approximately 3:00 PM, Surveyor interviewed Licensee B who indicated employee records were disorganized. No employee record was provided for Licensee B. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 397	Continued From page 27 N0277 83.25 Continuing Education N0351 83.32(3)(g) Rights of Residents: Physical Restraints N0407 83.37(1)(h) Scheduled Psychotropic Medication N0408 83.37(1)(i) PRN Psychotropic Medication N0409 83.37(1)(j) Proof-Of-Use-Record N0426 83.38(1)(b) Supervision N0432 83.38(1)(h) Medication Administration N0433 83.38(1)(i) Behavior Management	N 397		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for desired responses and possible side effects of the medication. RN J completed a quarterly psychotropic review on 05/06/2025, but no other quarterly psychotropic reviews were conducted in 2024 and 2025. Resident 1 was on 6 scheduled psychotropic medications in May and 7 scheduled	N 407		

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	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 407	Continued From page 28 psychotropic medications in June 2025. Findings include: On 06/17/2025, the department received complaint information alleging residents were given psychotropic medication contrary to the intended use. On 07/02/2025, Surveyors conducted a complaint investigation and standard survey. Surveyor reviewed Resident 1's record and noted s/he had diagnoses of dementia, right knee arthroplasty, depression, generalized anxiety disorder, and osteoarthritis. Resident 1 had an activated Power of Attorney for Healthcare. Surveyor reviewed Resident 1's May-June 2025 Medication Administration Record (MAR) and noted the following scheduled psychotropic medications: Sertraline tab 100 mg - 1 tablet by mouth once daily dose change 05/08/2025 Busprione tab 10 mg - 1 tablet by mouth three times daily dose change 05/19/2025 Pregabalin cap 25 mg - 1 capsule by mouth twice daily "for pain" start date 01/23/2025 Rivastagmine cap 6 mg - 1 capsule by mouth twice daily dose change 05/19/2025 Rexulti tab 2 mg - 1 tablet by mouth once daily dose change 05/19/2025 Levetiracetam 112 mcg - 1 tablet by mouth once daily start date 04/03/2025 06/11/2025 started Oxycodone/ APAP (Percocet) - Take oxycodone/apap 5/325 mg three times daily by mouth Surveyor note: documentation of medication changes and start dates were not consistent in Resident 1's record maintained.	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 407	Continued From page 29 Surveyor noted Resident 1's psychotropic medications were not identified with reason for use. Surveyor noted Resident 1's diagnosis list did not include a seizure condition in correlation with levetiracetam. Surveyor reviewed Resident 1's individualized service plan (ISP) with print date 07/03/2025 and noted the following related to psychotropic medications. "MEDICATION MANAGEMENT - STAFF ADMINISTER ...Resident requires staff to manage/administer medications ..." "PAIN HISTORY AND MANAGEMENT - STAFF ASSISTANCE ...Resident does have chronic pain and receives scheduled oral analgesics for maintenance and prevention. Resident also has PRN oral and topical analgesics that may be utilized for increased or uncontrolled pain." "MENTAL ILLNESS ...Resident has a history of anxiety and depression for which [s/he] receives scheduled and PRN medication for." On 07/11/2025 at approximately 2:56 PM, Surveyor requested from Manager A all of Resident 1's 2025 psychotropic reviews by email. On 07/14/2025 at approximately 9:45 AM, Manager A responded with written information through email stating "I started in April. [RN J] started around the same time. [Licensee B] didn't have [sic] RN before that, this is the one that was done in 2025." Manager A indicated Resident 1 has had numerous medication changes, mainly psychotropics related to behaviors and pain, but s/he had always been on some sort of psychotropic from his/her understanding and review. Surveyor reviewed Resident 1's "CBRF Scheduled Psychotropic Review," which included	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 407	Continued From page 30	N 407		

a listing of PRN psychotropic medications. "Date of review: 05/06/2025 by RN J ... Name(s) of scheduled psychotropic medication(s) reviewed ...lorazepam, sertraline, buspirone, rexulti ...Did resident have desired responses to the medication(s)? [box 'No' checked] ...If no, explain. Continue with drowsiness during the day and sleeplessness at night. Patient becomes combative at night at times. Possible side effects of the medication(s)? Nausea, dizziness, headache, depression, hostility, confusion, fatigue, insomnia. Additional comments.. Continue to receive PRN [as needed] lorazepam routinely."

No other psychotropic reviews of Resident 1's scheduled psychotropics in 2024 and 2025 were provided. Resident 1's scheduled pregabalin was not reviewed. No follow up was completed or documented regarding RN J's review of psychotropic medications of sertraline, buspirone, and rexulti upon identifying Resident 1 was not having desired responses to his/her psychotropic medications.

On 07/15/2025 at approximately 11:00 AM, Surveyors interviewed Manager A who acknowledged Resident 1 was not assessed for all prescribed psychotropic medications at least quarterly and as needed.

On 07/22/2025 at approximately 3:00 PM, Surveyor interviewed Licensee B who acknowledged concerns with assessing, reviewing, and documentation of psychotropic medications. Licensee B stated s/he was not aware this was required.

Cross Reference:
N0158 83.12(2)(a) Caregiver: Investigating Abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 407	Continued From page 31 & Neglect N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0408 83.37(1)(i) PRN Psychotropic Medication N0409 83.37(1)(j) Proof-Of-Use-Record N0415 83.37(2)(d) Documentation of Medication Administration N0432 83.38(1)(h) Medication Administration N0433 83.38(1)(i) Behavior Management N0454 83.42(1) Resident Record Maintained	N 407		
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 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 ensure Resident 1's	N 408		

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	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 408	Continued From page 32	N 408		

individualized service plan (ISP) included the most updated PRN [as needed] psychotropic medication, the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. The administrator or qualified designee did not monitor at least monthly for inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the ISP, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. Documentation did not consistently include the description of behaviors requiring the PRN psychotropic medication, the effectiveness, and any side effects.

Findings include:

On 06/17/2025, the department received complaint information alleging residents were given psychotropic medication contrary to the intended use.

On 07/02/2025, Surveyors conducted a complaint investigation and standard survey.

Surveyor reviewed Resident 1's record and noted s/he had diagnoses of dementia, right knee arthroplasty, depression, generalized anxiety disorder, and osteoarthritis. Resident 1 had an activated Power of Attorney for Healthcare.

Surveyor reviewed Resident 1's May-June 2025 Medication Administration Record (MAR) and noted the following PRN psychotropic medications and usage:
Hydroxyzine HCl tab 25 mg - Give 1 tablet by mouth three times daily as needed for anxiety started on 05/27/2025 - 20 doses in May and 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 408	Continued From page 33	N 408		

doses in June administered
Alprazolam 0.25 mg - Take 1 tablet by mouth 1 time daily as needed for anxiety and restlessness "(ATTEMPT TO GIVE THE HYDROXAZINE FIRST DUE TO THIS CAN [sic] ONLY BE GIVEN 1 TIME DAILY. IF HYDROXAZINE IS NOT EFFECTIVE THAN [sic] TRY ALPRAZOLAM)" started on 05/26/2024 and discontinued on 05/29/2025 - 4 doses in May administered
Oxycodone/APAP tab 5-325 mg - Give 1 tablet by mouth three times daily as needed for pain started on 10/31/2024 - 47 doses in May and 25 doses in June administered
Morphine Sulfate 100 mg/5mL (Roxanol) 0.5 mL (10 mg total) - Take 0.5 mL (10 mg total) by mouth every house as needed for difficulty breathing or pain started on 05/29/2025 and discontinued on 06/13/2025 - 6 doses in May (5/30-5/31) and 9 doses in June (06/01-06/09) administered
Lorazepam 0.5 mg tab - Take 1 tablet (0.5 mg) by mouth every two hours as needed for anxiety started 05/29/2025 and discontinued on 06/23/2025 - 5 doses in June (06/27-06/28)

Surveyor reviewed Resident 1's individualized service plan (ISP) with print date 07/03/2025 and noted the following related to psychotropic medications.
"MEDICATION MANAGEMENT - STAFF ADMINISTER ...Resident requires staff to manage/administer medications ..."
"PRN PSYCHOTROPIC MEDICATION (Medication Administration/Medication Management) Resident's Needs: Resident has an order for PRN hydroxyzine and alprazolam for anxiety. Resident does get restless and will ignore staff when they are trying to redirect. Resident's Desired Outcomes: To received desired outcomes of psychotropic medications."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 408	Continued From page 34	N 408		

"BEHAVIOR ...[Resident 1] does have a PRN medication for anxiety/agitation ...Staff need to utilize PRN medication for anxiety."
"RISK - ELOPEMENT ...Redirection, activities, snack, PRN analgesics [pain medication] and/or anxiety medication can all be effective tools."
"PAIN HISTORY AND MANAGEMENT - STAFF ASSISTANCE ...Resident does have chronic pain and receives scheduled oral analgesics for maintenance and prevention. Resident also has PRN oral and topical analgesics that may be utilized for increased or uncontrolled pain."
"MENTAL ILLNESS ...Resident has a history of anxiety and depression for which [s/he] receives scheduled and PRN medication for."

Surveyor reviewed Resident 1's May-July 2025 observation notes and noted the following related to PRN medications.
05/10/2025 "[Resident 1] has not slept in 2 days despite the PRN medications given to [him/her] ..."
05/16/2025 " ...Writer attempted to give [him/her] [PRN] medications multiple times with no success. Administration aware ..."
06/09/2025 "Pain medication given due to [him/her] complaining of knee and back pain."
06/20/2025 "[Resident 1] has been up and down in [his/her] wheelchair, walking through facility, yelling, kicking, scratching punching staff ...Redirection of any kind is not effective ...PRN medication was given by Administration around 4pm with no effectives nor positive results."

On 07/11/2025 at approximately 2:56 PM, Surveyor requested from Manager A all of Resident 1's 2025 psychotropic reviews by email.
On 07/14/2025 at approximately 9:45 AM, Manager A responded with written information through email indicating s/he did not have any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 408	Continued From page 35	N 408		

record of psychotropic reviews completed other than Resident 1's "CBRF Scheduled Psychotropic Review" completed by RN J on 05/06/2025. Surveyor reviewed the completed scheduled psychotropic review and noted lorazepam was listed and "Continue to receive PRN [as needed] lorazepam routinely."
Surveyor note: Resident 1 did not have an order for PRN lorazepam until 05/29/2025.

Surveyor noted there were no notes from Licensee B, Manager A, RN J, or designee of Resident 1's PRN's being monitored for appropriate use and efficacy, and Resident 1's ISP did not identify all PRN psychotropic medications Resident 1 was prescribed.

On 07/15/2025 at approximately 11:00 AM, Surveyors interviewed Manager A who acknowledged Resident 1's PRN psychotropic medications were not appropriately reviewed, monitored, and documented.

On 07/22/2025 at approximately 3:00 PM, Surveyor interviewed Licensee B who acknowledged concerns with monitoring and documentation of PRN psychotropic medications. Licensee B stated s/he was not aware this was required.

Cross Reference:
N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect
N0170 83.12(5)(b) Notification: Abuse And Neglect Allegations
N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws
N0397 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake
N0407 83.37(1)(h) Scheduled Psychotropic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 408	Continued From page 36 Medication N0409 83.37(1)(j) Proof-Of-Use-Record N0415 83.37(2)(d) Documentation of Medication Administration N0432 83.38(1)(h) Medication Administration N0433 83.38(1)(i) Behavior Management N0454 83.42(1) Resident Record Maintained	N 408		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812(c), and Wisconsin's uniform controlled substances act, ch. 961, Stats. The administrator or designee did not audit, sign, and date the proof-of-use records on a daily basis. Findings include: On 06/17/2025, the department received complaint information alleging residents were given psychotropic medication contrary to the intended use.	N 409		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 409	Continued From page 37 On 07/02/2025, Surveyors conducted a complaint investigation.. On 07/02/2025, Surveyors reviewed proof-of-use records titled "Controlled Drug Receipt Record/Disposition Form," provided by Manager A. Surveyor noted record headers of "Given" as in administered to resident and "Left" as count completed by staff. Surveyor noted the following proof-of-use record entries for Resident 1: Morphine Sul Sol 100/5ML - 20 doses - Dispense Date - 05/29/2025 05/30/2025 2:45 PM Given 1, Total 19 05/30/2025 5:00 PM Given 1, Total 18 05/30/2025 6:15 PM Given 1, Total 17 05/30/2025 9:50 PM Given 1, Total 16 05/31/2025 11:20 PM Given 1, Total 15 05/31/2025 2:20 PM Given 1, Total 14 05/31/2025 6:30 PM Given 1, Total 13 06/01/2025 4:20 PM - Given 1, Total 12 06/01/2025 9:00 PM - Given 1, Total 11 06/02/2025 4:00 PM - Given 1, Total 10 06/03/2025 8:30 PM - Given 1, Total 9 06/04/2025 7:30 AM - Given 1, Total 8 06/06/2025 9:01 (AM or PM not indicated) - Given 1, Total 7 06/06/2025 4:00 PM - Given 1, Total 6 06/06/2025 8:00 PM - Given 1, Total 5 06/06/2025 9:45 PM - Given 1, Total 4	N 409		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 409	Continued From page 38 06/09/2025 9:45 PM - Given 1, Total 3 Surveyor noted proof-of-use record audit was not completed daily. Morphine Sul Sol 100/5ML prescription was discontinued on 06/13/2025, no counted medication entries on proof-of-use record from 06-10-2025 to 06/13/2025. Oxycodone/APNP Tablet 5-325MG - 30 doses - Dispense Date - 06/30/2025 06/30/2025 11:45 (AM or PM not indicated) - Given 1, Total 29 06/30/2025 1:22 (AM or PM not indicated) - Given 1, Total 27 - Late Entry 07/01/2025 6:42 (AM or PM not indicated) - Given 1, Total 28 Surveyor noted proof-of-use record audit was not completed daily. Surveyor requested proof-of-use records for Oxycodone/APNP Tablet 5-325MG from 05-01-2025 to 07/01/2025, no records for this period were received. On 07/14/2025, Surveyors reviewed provider staff training minutes and noted on 05/15/2025, a topic covered was "Med count is to be completed at the end of every shift NO EXCEPTIONS to this." On 07/11/2025 at approximately 11:35 AM, Surveyor interviewed Manager A who indicated s/he was unaware of the required daily audit of the proof-of-use records, confirming the correct count and totals. Manager A stated s/he acknowledges understanding the requirement to review the proof-of-use record daily to confirm an accurate record and avoid future discrepancies. On 07/23/2025, Surveyor interviewed Licensee B, who stated staff are paid to stay an extra 15	N 409		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 409	Continued From page 39 minutes after each shift to audit, sign and date proof-of-use records. Licensee B acknowledged not reviewing the proof-of-use records daily but acknowledges the importance of the proof-of-use record review and completing it on a daily basis. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0397 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0407 83.37(1)(h) Scheduled Psychotropic Medication N0408 83.37(1)(i) PRN Psychotropic Medication N0409 83.37(1)(j) Proof-Of-Use-Record N0415 83.37(2)(d) Documentation of Medication Administration N0432 83.38(1)(h) Medication Administration N0433 83.38(1)(i) Behavior Management N0454 83.42(1) Resident Record Maintained	N 409		
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 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.	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 415	Continued From page 40	N 415		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1's medication administration was documented.

Findings include:

On 06/17/2025, the department received complaints regarding medication administration.

On 07/02/2025, at approximately 10:55 AM, Surveyor reviewed Resident 1's record and identified the following:

Resident 1:

Resident 1 was admitted on 05/24/2022. Resident 1's individual service plan, dated 04/11/2025, indicated Resident 1 requires staff to manage and administer medications. Resident 1's April 2025, May 2025 and June 2025 MAR contained boxes where staff would initial to indicate the medication was given.

The boxes were not documented on acknowledging Resident 1's medications were administered or a reason for not administering for the following medications, dates and doses:

-Acetaminophen tablet 500 mg - one tablet by mouth three times daily - 04/19/2025, 04/21/2025, 05/13/2025, 05/25/2025, 05/26/2025, 05/28/2025, 05/29/2025, 05/30/2025, 05/31/2025, 06/01/2025, 06/02/2025, 06/03/2025, 06/08/2025, and 06/09/2025.

-Buspirone tablet 10 mg - one tablet by mouth three times daily - 04/19/2025, 04/21/2025,

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	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 415	Continued From page 41 05/05/2025, 06/20/2025, and 06/23/2025. -Levothyroxin tablet 112 mcg - one tablet by mouth once daily - 04/12/2025, 04/26/2025, 04/30/2025, 05/06/2025, 05/11/2025, 05/14/2025, 05/25/2025, 05/26/2025 -Levetiracetam tablet 750 mg - tablet by mouth in the morning and one tablet in the evening - 04/03/2025, 04/04/2025, 04/19/2025, 04/21/2025, 05/05/2025, 06/02/2025 and 06/22/2025. -Meloxicam tablet 7.5 mg - one tablet by mouth daily - 06/20/2025, 06/22/2025 and 06/23/2025. -Amlodipine tablet 2.5 mg - one tablet by mouth daily - 06/22/2025 -Pregabalin capsule 25 mg - one capsule by mouth twice daily - 06/20/2025, 06/22/2025 and 06/23/2025. -Rivastigmine capsule 6 mg - one capsule by mouth twice daily - 06/20/2025, 06/22/2025 and 06/23/2025. -Oxycodone / APAP (Percocet) 5-325 mg - tablet by mouth three times daily - 06/15/2025, 06/18/2025, 06/20/2025, 06/22/2025, 06/23/2025 and 06/27/2025. On 07/11/2025, at approximately 1:47 pm, Surveyors interviewed Manager A regarding the missing documentation on the MAR. Manager A stated s/he was unaware that the documentation was not always being initialed. Manager A confirmed this is required and s/he would ensure staff are initialing the MAR consistently after administering the medications.	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 415	Continued From page 42 Cross Reference: N0407 83.37(1)(h) Scheduled Psychotropic Medication N0408 83.37(1)(i) PRN Psychotropic Medication N0409 83.37(1)(j) Proof-Of-Use-Record N0432 83.38(1)(h) Medication Administration N0454 83.42(1) Resident Record Maintained	N 415		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision 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 supervision appropriate to meet the needs of 5 residents. Licensee B took Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6 to the local park for a community event. Resident 2 complained of not feeling well and Licensee B drove Resident 2 back to the facility, leaving Resident 3, Resident 4, Resident 5, and Resident 6 at the park. Four of 4 residents were assessed to require supervision. Findings include:	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 426	Continued From page 43 The provider is licensed to provide services for up to 50 residents who may be developmentally disabled, physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia. On 06/17/2025, the department received complaint information alleging residents were left unsupervised at the park. On 07/02/2025, Surveyors conducted a complaint investigation. At approximately 10:47 AM, Surveyors interviewed Manager A who identified 4 residents were left at Badger Park on 06/11/2025 at approximately 7:30 PM. S/he identified Resident 3, Resident 4, Resident 5, and Resident 6 as having been left without staff supervision at the park. Manager A stated Resident 2 had reported being sick, which is not uncommon for Resident 2. S/he said that Licensee B should not have done that/left the residents alone, and going forward they will always have 2 staff for any trip to the community. Surveyor note: Surveyors observed Badger Park to be approximately 1 mile up the road from the facility. Manager A stated it was a concert that was known to be attended by many people. On 07/10/2025, at approximately 9:56 AM, Surveyor interviewed Licensee B. Licensee B discussed taking Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6 to the local park for a community event. Licensee B stated Resident 2 was seated next to him/her and after a few minutes Resident 2 complained of not feeling well. Licensee B reported s/he transported Resident 2 to the facility, leaving Resident 3, Resident 4, Resident 5, and Resident 6 at the park for approximately 10 minutes unsupervised.	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 426	Continued From page 44 Licensee B returned to the park and observed residents did not appear to be enjoying the music, so s/he returned to the facility with Resident 3, Resident 4, Resident 5, and Resident 6. Licensee B expressed .... "We usually have 2 caregivers for outings, but one caregiver was out ... I made the decision to take them anyways, I like the residents to get out and enjoy the community ... I spend so much time with them they are like family and that did not help me to make the best decision for their safety." On 07/07/2025, Surveyor reviewed Resident 3, Resident 4, Resident 5, and Resident 6's records. Surveyor reviewed Resident 3's individual service plan (ISP) with print date 07/03/2025 and noted s/he had diagnoses of intellectual disability and congestive heart failure. Resident 3 was under corporate guardianship and was able to make his/her needs known. Resident 3 had a history of wandering, was identified as "not fully aware of staff, condition and limitations," and was unable to read. Surveyor noted Resident 3's ISP listed "PUBLIC OUTINGS (Social Participation/ Leisure Time Activities) Directions: Individual requires constant supervision when in public to ensure [his/her] safety in a public setting. Staff will provide guidance and assistance." Surveyor reviewed Resident 4's ISP with print date 07/03/2025 and noted s/he had diagnoses of a brain tumor, spastic hemiplegia, seizures and chronic pain syndrome. S/he had an activated Power of Attorney for Healthcare. Resident 4 was identified as a choking risk, a fall risk, and seizure risk. Surveyor noted Resident 4's ISP listed "END OF SHIFT CHARTING ...Summarize details throughout shift. (Outings, bathing, mood, level of care needed, etc.)"	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 426	Continued From page 45 Surveyor reviewed Resident 5's ISP dated 07/03/2025 and noted diagnoses of dementia, seizure disorder, dizziness, chronic pain, tinnitus, depression, and anxiety. Resident 5 utilized a walker for ambulation and was encouraged to request assistance "if feeling weak or unsteady." Surveyor noted Resident 5 had a history of suicidal ideation and making suicidal comments. Surveyor reviewed Resident 6's ISP dated 07/03/2025 and noted diagnoses of anxiety disorder, seizures, cerebral palsy, developmental delays, tremors, and repeated falls. Resident 6 was identified as a choking risk, required assistance with transferring, utilized a wheelchair for mobility frequently, was a fall risk, seizure risk, vision impairment, and required the use of a helmet. Resident 6's ISP listed "[Resident 6] is developmentally delayed and does need reminders with what is socially acceptable at times. [Resident 6] does have a tendency to invade other's personal space and tries to tickle people without their permission. [S/he] needs reminders that [s/he] cannot do this." On 07/08/2025, Surveyor reviewed Resident 3 and Resident 6's incident reports from the incident on 06/11/2025. Resident 3's incident report stated "[Licensee B] had left [Resident 3] alone at Badger Park for 5 mins [minutes] to bring another resident back to Arbor Village who had became sick. No injuries." Resident 6's incident report stated "[Resident 6] stated [Licensee B] asked if [s/he] was ok to stay here for 5 mins. [Resident 6] said [s/he] was ok." "[Licensee B] left [Resident 6] & another resident unattended at Badger Park. Another resident was sick & needed to be brought back to Arbor Village." No additional incident reports regarding the	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 426	Continued From page 46 incident were provided. On 07/09/2025 at approximately 2:50 PM, Surveyor interviewed Aging and Disability Resource Center (ADRC) Manager E who stated Adult Protective Services (APS) received a referral reporting that residents were left at the park unsupervised. S/he stated "Bands at Badger" event brings in hundreds of people from both in town and out of the area as there is a campground next to the park. ADRC Manager E indicated APS substantiated their investigation of neglect. On 07/15/2025 at approximately 11:00 AM, Surveyors interviewed Manager A who acknowledged residents were not provided adequate supervision when left unattended at the park. Cross Reference: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0277 83.25 Continuing Education N0397 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake	N 426		
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.	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 432	Continued From page 47	N 432		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure medication administration was appropriate to meet resident's needs for Resident 1.

Findings Include:

On 06/17/2025, the department received complaints regarding medication administration.

On 07/02/2025, at approximately 10:55 AM, Surveyors reviewed Resident 1's record and identified the following:

Resident 1 was admitted on 05/24/2022. Resident 1's individual service plan, dated 04/11/2025, indicated Resident 1 requires staff to manage and administer medications. Resident 1's April 2025, May 2025 and June 2025 Medication Administration Record (MAR) noted the following medications were not administered as ordered:

April 2025 MAR

-Levetiracetam 750 mg - tablet by mouth in the morning and one tablet in the evening - A total of 7 doses were documented as not administered on the following dates: 04/12/2025, 04/13/2025, 04/15/2025, 04/16/2025, 04/17/2025,04/22/2025, and 04/23/2025. For each date the reason was noted "not the right dosage or wrong dosage" with no further explanation.

May 2025 MAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 432	Continued From page 48 -Levetiracetam 750 mg - tablet by mouth in the morning and one tablet in the evening - A total of 12 doses were documented as not administered on the following dates: 05/04/2025, 05/06/2025, 05/07/2025, 05/08/2025, 05/09/2025, 05/09/2025, 05/11/2025, 05/10/2025, 05/11/2025, 05/11/2025, 05/12/2025, and 05/13/2025 For each date the reason was noted "not here" "waiting on script" "pharmacy contacted' or "not in house" June 2025 MAR -Oxycodone/APAP (Percocet) 5-325 mg - tablet by mouth three times daily. On 06/30/2025 the medication was not administered and noted to be "not in cart" -Sertraline tablet 100 mg - one tablet by mouth once daily - A total of 7 doses were documented as not administered on 06/19/2025, 06/21/2025, 06/22/2025, 06/26/2025, 06/27/2025, 06/28/2025 and 06/30/2025. For each date the reason for not administering the medication was noted "not in cart" or "not here". On 07/11/2025, at approximately 1:47 pm, Surveyors interviewed Manager A regarding the medications not at the facility to be administered to Resident 1. Manager A stated s/he does not recall why the medications were not at the facility but stated we are trying to work better with the pharmacy to fulfill the prescriptions on time and remind med passers to notify Manger A if medications need to be refilled. Manager A acknowledged Resident 1 did not receive his/her medications as ordered. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 432	Continued From page 49 N0170 83.12(5)(b) Notification: Abuse And Neglect Allegations N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0397 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0407 83.37(1)(h) Scheduled Psychotropic Medication N0408 83.37(1)(i) PRN Psychotropic Medication N0409 83.37(1)(j) Proof-Of-Use-Record N0415 83.37(2)(d) Documentation of Medication Administration N0433 83.38(1)(i) Behavior Management N0454 83.42(1) Resident Record Maintained	N 432		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services to fully manage Resident 1's behaviors that were or had the potential to be harmful to themselves or others. Resident 1 exhibited wandering, exit seeking, verbal and physical aggression towards others, elopement, picking at his/her skin/ self-injurious behaviors, medication refusals, disrupted	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 433	Continued From page 50	N 433		

circadian rhythm, increased impulsivity, restlessness, property destruction, and frequent falls related to these behaviors. The provider staff did not follow redirection techniques known to benefit Resident 1 and did not mitigate his/her behaviors leading to escalated behaviors and incident. Resident 1's Managed Care Organization (MCO) relocated him/her to an alternative community-based residential facility (CBRF) on 07/01/2025.

This is a repeat deficiency, see SOD 8CNU12, dated 09/21/2022.

Findings include:

The CBRF is licensed to serve up to 50 residents who may be developmentally disabled, physically disabled, terminally ill, of advanced age, and/or have irreversible dementia/Alzheimer's disease.

On 06/17/2025, the department received complaint information alleging residents were being neglected.

On 07/02/2025, Surveyors conducted a complaint investigation.

At approximately 9:55 AM, Surveyors interviewed Manager A who stated Resident 1 moved to another facility "yesterday," 07/01/2025. Manager A described Resident 1 as needing a 1:1 from staff due to his/her dementia. S/he said Resident 1's anxiety medications were discontinued last week and his/her family could not sit with him/her. Manager A said Resident 1 moved quickly and despite primarily being in a wheelchair, s/he could still walk at times, especially when s/he was expressing behaviors. Resident 1 was a wanderer and exit seeker, and did not like to be

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N 433	Continued From page 51	N 433		

alone. S/he was known to be up "all the time" at night exit seeking and refusing to go to bed. Resident 1 had a history of successful elopements overnight and frequent falls. Surveyor inquired whether Resident 1 had a behavior support plan and Manager A stated s/he did not believe so. Manager A stated staffing ran with 2 staff on AM's and PM's and one staff on Night shift.

On 07/14/2025 at approximately 9:36 AM, Surveyor interviewed Caregiver M who stated s/he worked night shift from 10:00 PM to 6:00 AM full time. S/he described Resident 1 as being awake and out of his/her room most of the night and exhibiting behaviors. S/he said Resident 1 rarely would sleep. Caregiver M stated if Resident 1 was having a bad night, you (staff) could not take your eyes off of him/her. S/he said s/he would keep Resident 1 in his/her wheelchair by the nurse's station and give him/her lots of snacks, give him/her books to read, and word searches to complete, so s/he could get his/her tasks completed. Caregiver M stated when Resident 1 was "too much," which was often, s/he would call Manager A or Licensee B to help watch Resident 1. Caregiver M stated Resident 1 got out of the facility one time on his/her shift during the night, but s/he was able to redirect him/her back in. Surveyor asked whether Resident 1 had a behavior support plan or mention of behaviors in his/her care plan, and Caregiver M stated s/he was not sure.

On 7/11/2025 at approximately 4:50 PM, Surveyor interviewed Resident 1's Power of Attorney for Healthcare (POAHC) H who described Resident 1 as always being a very independent and determined individual. S/he said s/he received many complaints from provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

(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 433	Continued From page 52	N 433		

staff about how Resident 1 would be up all night, all the time. S/he said Resident 1 worked night shift for most of his/her life, so POAHC H was not surprised that s/he was up at night often. POAHC H stated s/he had told staff this a number of times, so s/he does not know why staff were so surprised when s/he was up at night. S/he indicated that s/he felt that Resident 1's care had seem to have "gotten worse" the last few months as Resident 1 was sleeping and lethargic upon his/her visits, which concerned him/her. S/he would get frequent calls at night, saying that Resident 1 was awake, anxious, and restless. S/he also said that Resident 1 fell the most overnight. S/he stated "they [provider] didn't seem to be making any efforts."

On 07/14/2025 at approximately 8:00 AM, Surveyor interviewed Resident 1's Nurse Practitioner (APNP) I and Case Manager (CM) N. APNP I described Resident 1 as exhibiting anxiety, restlessness, exit seeking, and self-abuse in the form of skin picking at his/her face, arms, and abdomen. S/he said Resident 1 had been a 7a to 7b on the Functional Assessment Screening Tool (FAST) for severe dementia for quite some time, indicating s/he was high on the scale for functional deterioration. APNP I stated s/he witnessed and felt the provider staff did not know how to redirect Resident 1 appropriately which caused Resident 1 more anxiety. S/he also spoke to Resident 1 having "horrific pain," indicating s/he could barely move and grimaced and moaned when APNP I would evaluate and palpate Resident 1's muscles, as well as other non-verbal signs of pain. S/he stated Resident 1 did not have any safety awareness, scooted all over the building in a wandering fashion, self-transferred unsafely, was up and down out of his/her wheelchair, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 433	Continued From page 53	N 433		

had his/her nights and days mixed up. APNP I said Resident 1 was known to sleep often during the day due to him/her being up at night often, however now that Resident 1 was at the new facility, s/he had gotten better with a routine.
Surveyor note: According to Medical News Today, "The FAST scale enables clinicians and caregivers to accurately assess a person's decline in cognitive function throughout the disease. It can also help them monitor how effective the treatment is. If the scale indicates that a treatment is no longer effective, a healthcare professional may refer them to palliative or hospice care ....This stage [7] indicates severe AD [advanced dementia], in which the individual shows evidence of the following declines in cognitive functioning: Their ability to speak is limited to six or fewer intelligible words over an average day or during an intensive interview. Their vocabulary is limited to a single intelligible word that they may repeat continually over an average day or during an intensive interview."
https://www.medicalnewstoday.com/articles/fast-scale-dementia. Retrieved 07/17/2025.

Surveyor reviewed Resident 1's record and noted s/he moved into the facility from the hospital on 05/11/2022 with diagnoses of thyroid disorder, vertigo, dementia, depression, generalized anxiety disorder, other specified bilateral hearing loss, chronic atrial fibrillation, right knee arthroplasty, and primary osteoarthritis.

Surveyor reviewed Resident 1's most recent assessment dated 05/07/2025:
"Chronic Illness ...Resident has chronic illness(es) that require proper treatment and management including but not limited to dementia, hypertension, anxiety, and depression.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 433	Continued From page 54 Resident has chronic knee pain which requires injections as needed ... Ambulation - Partial Assistance ...Resident requires partial assistance from staff when ambulating d/t [due to] increased weakness and unsteadiness. Resident has poor safety awareness and should no longer ambulate independently as [s/he] did previously ...[Surveyor note: contradicting assessment] Hearing ...Resident requires staff assistance to manage hearing needs. Resident is extremely hard of hearing, did utilize hearing aid to left ear however hearing aid was misplaced and net that one has not yet been obtained ... PRN Psychotropic Medication ...Resident has an order for PRN hydroxyzine and alprazolam for anxiety. Resident does get restless and will ignore staff when they are trying to redirect ... Interaction - Staff Assistance ...Resident requires staff assistance/intervention to maintain positive interactions with others d/t increased confusion and difficulty hearing ... Motivation and Attitude ...Resident requires staff assistance to maintain motivation and positive attitude. Resident can become easily agitated and frustrated d/t disease progression and chronic pain. Staff required for intervention with agitation and assistance with pain management ... Resident is unaware of personal limitations, diseases or their progression ... Aggressive/Combative ...[Resident 1] can be verbally aggressive at times and request to go home or call [his/her] parents. Resident frequently packs belongings in anticipation of leaving. Redirection and close monitoring required during these episodes. PRN medication may be utilized as needed. Resident is not physically aggressive ... Destructive ...Resident displays destructive	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 433	Continued From page 55	N 433		

behaviors. Resident's Desired Outcomes: To have interventions in place that help alleviate behaviors ...
Suicidal Tendencies Does resident have suicidal tendencies? [No is checked] [Surveyor note contradicting of other record items] ...
Risk - Wandering ...Resident has been identified as a wandering risk. Staff need to monitor closely when resident has increased anxiety and is wanting to leave the facility. Resident at times will start packing belongings and stating [s/he] has to go home to take care of [his/her] parents. Door alarms need to be activated when resident is agitated and ensure they are aware of [his/her] whereabouts during those times. Resident's Desired Outcomes: To have proper redirection techniques in place to prevent wandering episodes ...
Risk - Elopement ...Resident's Desired Outcomes: To have proper precautions and redirection techniques in place to prevent elopement ...
Communication ... Resident is not always able to communicate own wants and needs effectively. Resident can be difficult to understand at times ..."

Surveyor reviewed Resident 1's individual service plan (ISP) with print date 07/03/2025 and noted: "Behaviors - [Resident 1] does have history of behaviors that require staff intervention. [Resident 1] will request to leave. If [s/he] is not able to leave [s/he] may state [s/he] will find a way to leave, state [s/he] would rather be dead than living here. [Resident 1] has scratched [his/her] wrist and shown staff [s/he] will find a way to get out of here. [Resident 1] does have a PRN medication for anxiety/agitation. [Resident 1] does have some physical signs that [s/he] may become upset and begin to state [s/he] wants to

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N 433	Continued From page 56	N 433		

leave to go home. [Resident 1] at times will come to the desk and have furrowed brows, shaking mouth and hands. Staff need to be aware that [s/he] may move to the next steps of wanting to leave the building. [S/he] may pack [his/her] belongings, get [his/her] purse. [s/he] has begun to go outside again now that the weather is warmer. Staff need to utilize PRN medication for anxiety. Staff need to try distraction, redirection. Staff should remain calm. Staff should use a soothing voice. Staff should be empathetic to [his/her] feelings of wanting to go home. [Resident 1] does attempt to call [his/her] [family members]. [Resident 1] knows where the phone is and knows [s/he] does have the right to make phone calls. [Resident 1] likes to talk about family, books, plants...There are forms in the file folder to utilize to complete 15 minute checks for [Resident 1] for 24 hours after [s/he] makes comments about harming [him/herself]... Staff should also compete an incident report and verbal report to supervisor ...
RISK - WANDERING ...Resident becomes more confused in late afternoon/evening; this is when [s/he] typically wants to go home or to [his/her] parents. Staff need to redirect and offer activities such as crocheting, reading, visiting, helping fold laundry, etc. Snacks and soda are effective options at times as well."
Surveyor note: All other items listed on assessment were automatically pulled into Resident 1's ISP.
Resident 1's record referenced having interventions in place to alleviate and prevent behaviors, but does not identify interventions and redirection techniques that are successful with Resident 1.
Resident 1's ISP was silent to his/her history of being awake at night and asleep during the day or disruption in his/her circadian rhythm, incidents of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 433	Continued From page 57	N 433		

physical aggression, property destruction, impulsivity, and medication refusals.
Surveyor reviewed Resident 1's closed paper record and noted a "Behavior Support Plan" (BSP) dated 06/16/2023. There was no evidence of Resident 1's BSP being reviewed and/or updated since 2023. "[Resident 1] has a history of elopement and making suicidal comments ...No reported history of elopement or suicidal statement prior to [residency] ..."
"[Resident 1] may pack [his/her] possessions before stating [s/he] wants to leave the facility or [s/he] may say [s/he] is leaving without [his/her] possessions. [Resident 1] makes statements such as threatening to leave the facility if [s/he] is not able to have soda, snacks, call [his/her] parents, etc ...[Resident 1] could attempt to leave the facility. [Resident 1] could become argumentative. Examples include telling staff they better not tell [him/her] that [his/her] parents are dead.
What should response be to behavior? Staff should be aware of where [Resident 1] is. Staff should try to comfort [Resident 1], be understanding of [his/her] desire to go home. Staff should attempt to redirect [Resident 1]. Staff should not get into a power struggle with [Resident 1]. Staff need to remain calm, talk calmly. [Resident 1] likes snacks, soda, talking about [his/her] family, [his/her] pets, gardening, reading. Staff should ask [Resident 1] to call [his/her] parents for a ride. Staff should let [Resident 1] know they understand [his/her] desire to go home. Staff should offer [Resident 1] PRN [as needed] medication for anxiety to help reduce the risk of [Resident 1] eloping. Staff should remain with [Resident 1] if [s/he] is attempting to leave the facility, as [s/he] is leaving the facility. [sic] Staff should call the police department if unable to redirect [Resident 1] back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 433	Continued From page 58	N 433		

to the facility if [s/he] has left the building. Staff need to let the police department know that [Resident 1] is a vulnerable adult with dementia when calling for assistance."
"[Resident 1] may inflict self-injurious behaviors such as scratching [his/her] wrist ..."

Surveyor reviewed Resident 1's provider observation notes and the following were related to Resident 1's behaviors or falls.
01/10/2025 1:30 AM "So far [s/he] has been very busy. [S/he] tired to go out the front door twice."
01/21/2025 9:15 PM "[Resident 1] believes [s/he] is here to kill us. [Resident 1] would not say who [s/he] is. No other issues."
01/23/2025 1:15 AM "[Resident 1] has been taking short naps but is mostly up. A couple times [s/he] mentioned going home."
01/24/2025 2:30 AM "[Resident 1] got up at 200 AM [sic]."
02/28/2025 9:15 PM "Writer asked resident for [his/her] hearing aid and [s/he] said NO. Resident then took [his/her] hearing aid out of [his/her] ear and broke into 3 pieces."
03/01/2025 9:15 AM "Resident was up all Noc [night] shift. Resident was very agitated when writer arrived for Day shift. PRN [as needed] Alprazolam given at 7am due to PRN Hydroxazine [sic] attempted on noc shift however resident spit it out.:
03/02/2025 10:30 AM "Resident was up entire NOC shift wandering all over facility."
03/02/2025 1:45 PM "Resident awake, roaming about the facility. Looking for [his/her] parents. Re-direction will be attempted. Will continue to monitor due to being on 15 minute checks."
03/07/2025 9:45 PM "Resident started to get agitated after supper. Redirection by multiple staff, multiple times given, multiple snacks, writer set [him/her] up with a coloring sheet and

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N 433	Continued From page 59	N 433		

crayons, many books, 1:1. Hydroxazine [sic], APAP [Tylenol] and biofreeze to Right knee at 9:30pm [sic]. Resident still agitated. If resident still anxious at 10:30 staff will have to contact [Licensee B] to administer PRN Alprazolam."
03/09/2025 9:15 PM "[POAHC H] came to visit today but [s/he] was not in a very good mood so [s/he] left. [S/he] was agitated at the beginning of the shift so PRN Alprazolam 0.25 mg was given."
03/15/2025 11:45 AM "Resident refused to get out of bed all shift. Ignoring staff,refused cares, refused breakfast and refused all morning medications. Writer updated [Licensee B]. Will continue to monitor. 15 minute checks will be done appropriately. Bed alarm on and in working order."
03/16/2025 12:30 PM "Resident was very restless and combative on Noc shift. Slept for about 3 hours and got up and was going into residents room, yelling, etc.Redirection [sic] was attempted many times with no good outcomes. It just made [his/her] behaviors worse. [S/he] thinks the staff is trying to kill [him/her]. PRN Oxycodone and Hydroxazine given at 7am along with [his/her] 8am scheduled medications. Writer fed [him/her] a breakfast sandwich, banana, orange and cookies. Resident then requested to go lay down. Writer offered the bathroom and to get washed up and [s/he] refused. 'No, lay me down now!' Writer granted [his/her] wish and layed [sic] [him/her] down."
03/26/2025 8:15 PM "resident slept through supper tonight and wouldn't get up so later at 8:30 had a yogurt and three slices of French toast. Is refusing hs [bedtime] cares but will attempt again before end of shift."
03/26/2025 9:30 PM "states [s/he] feels drunk. 'I think somebody put something in my food within the last 24 hours."
04/06/2025 5:17 AM "Resident had mean and

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	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 433	Continued From page 60	N 433		

aggressive behaviors towards staff. When [s/he] woke up about 4am or so [s/he] came out of [his/her] room and staff asked [him/her] what [s/he] needed and [s/he] responded with an attitude "I don't have to tell you" then started kicking at staff. Staff left [him/her] be and [s/he] then went into the bathroom. When [s/he] was out of bathroom staff noticed [s/he] had 1 of the floor squeegees in [his/her] hand like [s/he[was going to hit something or someone with it. Staff was able to get it from resident without confrontation and [s/he] proceeded to leave the [shared] bathroom. As staff was walking out of the bathroom resident started swinging and kicking at staff. Staff backed up as much as possible so resident couldn't make contact with swinging or kicking at staff and staff walk to nurses station and let [him/her] be right in hallway by [his/her] room. [s/he] did return to [his/her] room and has been in room since."
04/29/2025 3:00 AM "[Resident 1] slept 40 minutes ....The rest of the night [s/he] has been walking around ... ."
05/10/2025 10:45 AM "[Resident 1] has not slept in 2 days despite the PRN medications given to [him/her]. [S/he] has been combative, disruptive at night where other residents have been complaining that [his/her] behaviors at night are keeping them up and they are not getting proper sleep. Elder [Resident 1] is mean towards staff and peers, tries standing up every few seconds and staff is having to rush to [him/her] so [s/he] does not fall on the floor. [His/her] behaviors are becoming more and more of a problem."
05/16/2025 6:15 PM "Elder behaviors [sic] have been out of control since writer arrived at 2pm. [S/he] was trying to elope, hit staff, yell out stating 'help me everyone is trying to kill me.' Staff tried to redirect multiple times with no success as usual. [S/he] doesn't sleep more than 15 minutes

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	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 433	Continued From page 61	N 433		

at noc and disrupts other residents whom are not sleeping at night for the past 2 weeks. [His/her] disruptive behaviors are keeping staff from taking care of other residents. [S/he] is trying to throw [him/herself] on the floor, yelling that staff are hitting [him/her], etc. Writer attempted to give [him/her] [sic] prn [as needed] medications multiple times with no success. Administration aware. Will continue to monitor because [s/he] is on 15 minutes checks and [s/he] does not sit still."
06/04/2025 9:15 PM "staff tried to get resident out of another residents [sic] room when this [resident] started slapping at staff and trying to scratch staff. Resident started breathing heavy and mumbling. MS [morphine syringe] was given."
06/09/2025 6:15 PM "Elder received a shower and hair washed. Toe nails were clipped however, resident was quite non compliant with the shower so [s/he] kept kicking writer during cares and nail clipping. Pain medication given due to [him/her] complaining of knee and back pain. Will continue to monitor behaviors and pain through the shift."
06/10/2025 10:15 AM "I spoke with [APNP I's] office asking about a sleeping pill [as] [Resident 1] is up & get [sic] agitated. [S/he] will give me a call today."
06/17/2025 3:31 AM Lorazepam follow up - "still restless"
06/20/2025 11:00 AM "[Resident 1] laid out a blanket & used [his/her] sweater for a pillow. [S/he] was up & down all morning. [Resident 1] seems very tired & just won't stay in bed."
06/20/2025 9:30 PM "Elder has been up and down in [his/her] wheelchair, walking throughout facility, yelling, kicking, scratching, punching staff. Resident has been going into residents room all shift. Redirection of any kind is not effective. Any

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	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 433	Continued From page 62	N 433		

redirection attempted makes [him/her] more agitated and mean. Staff tried giving [him/her] spac however [s/he] gets up from [his/her] wheelchair and tries to ambulate. Elder is very unstable and has fallen multiple times the last couple of days. PRN medication was given by Administration around 4pm with no effectiveness nor positive results. Will continue to monitor as elder is on 15 minute checks."
06/21/2025 5:45 AM "Event Notes:Agitation, restlessness, combativeness, anxiousness, pain, anger, confusion."
06/22/2025 9:30 PM "resident is getting out of control=punching, striking out at residents, taking flatware and trying to throw it at staff. PRN for anxiety given, tried to redirect resident but no success. Resident even trying to take pictures off wall."
06/23/2025 8:00 PM "Elder did not receive a shower this evening due to being combative and trying to hit staff. Redirection of any sorts did not work as usual."
06/25/2025 1:00 AM "Toileted resident then brought [him/her] back to bed. Resident removed brief, laid back down, and had an accident. I assisted fully changing, including new brief, and [s/he] laid down again." 1:15 AM "Up to remove brief a second time, then laid down again." 1:30 AM "Up again, requesting to be toileted and asked for a new brief. Once to bed [s/he] removed pants then laid back down." 2:00 AM "Toileted again." 2:30 AM "Toileted again." 3:45 AM "Toileted at 3:30"
6/26/2025 1:15 AM "Asked me to show [him/her] around; gave [him/her] a tour of facility, then [s/he] said [s/he] would like to take a nap. Laid down without issues."
06/26/2025 11:15 AM "[Othe provider] came for assessment & saw [Resident 1] is on 1 on 1, was taking off [his/her] clothes & wanting to stand/sit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 433	Continued From page 63 Saw how [it] can be." 06/27/2025 4:00 PM "Resident hitting, biting, spitting at staff. Any attempt of giving medication [s/he] spits it out. [S/he] is lashing out at residents as well." 06/29/2025 10:30 AM "Per Families request, Lorazepam [PRN] has been discontinued. Elder is restless, agitated, standing up every few seconds. Due to [his/her] risk and continuous falls. Hospice requested to call Family in to 1:1 [him/her]." 06/30/2025 9:30 AM "Emailed [MCO] & left message for [POAHC H] about falls over weekend. That [Resident 1] [sic] had been a 1 on 1 most weekend. [sic]." Surveyor reviewed provider's June-July 2025 staff schedule and noted staffing with 2 staff from 6:00 AM - 2:00 PM, 2 staff from 2:00 PM - 10:00 PM, and 1 staff from 10:00 PM - 6:00 AM. No additional staff were listed on the schedule on the days referencing Resident 1 was a "1:1". Surveyor noted in May-July 2025 observation notes, there was mention of Resident 1 falling approximately 12 times, with 2 notes stating "multiple falls." Surveyor reviewed Resident 1's May-July 2025 fall/incident reports and noted 10 incident reports of 10 additional falls not on dates identified in observation notes, with 1 incident report referencing "multiple falls." Surveyor note: This does not include all falls, behaviors, and injuries. Surveyor reviewed Resident 1's Managed Care Organization (MCO) case notes. 05/22/2025 Member Support Manager (MSM) O "Call made to facility for monthly contact spoke to [Manager A]. [S/he] reports they have been	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 433	Continued From page 64	N 433		

discussing [Resident 1] today and have decided they will be providing a 30 day notice as they do not feel they are able to meet [his/her] needs at this time. [Manager A] is reporting they are providing 15 min [minute] checks, [s/he] continued to wander and escape ...up all night, falling reports ...No UTI [urinary tract infection] has been explored as this is not new and this behaviors has been going on for at least the last 6 months. [Manager A] reports the facility does not have locked doors and three doors are not alarmed and they do feel [Resident 1] needs a higher level of supervision to ensure [his/her] health and safety."
05/28/2025 RN Care Manager (RN) P "
...received email from [Manager A] ...reporting CBRF plans to outreach to POAHC H regarding 30-day notice for member. CBRF feels they are unable to meet member's needs with 15min checks, fall risk and elopement risk and member would be better suited at a skilled facility. [RN P] replied to email requesting what the skilled nursing need is as these fit the criteria of a CBRF placement. [RN P] again re-education facility [MCO] does not fund SNF [skilled nursing facilities] long term ..."
06/23/2025 "IDT [interdisciplinary team with MCO] received email from [Manager A] how [Resident 1] is now taking [his/her] clothes off and refusing to put them back on and member was found to have a bump above [his/her] right eye. There were a few occurrences over the weekend where member was found
on the floor. Staff unsure if this is r/t [related to] fall or if member is lowering [him/herself] to the floor. [RN P] sent reply to email requesting to coordinate a care conference to further support [Resident 1's] long term care needs."

On 07/15/2025 at approximately 11:00 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 433	Continued From page 65 Surveyors interviewed Manager A who acknowledged concerns with Resident 1's care and behavior management provided. On 07/22/2025 at approximately 3:00 PM, Surveyor interviewed Licensee B who described Resident 1 needing a 1:1 staff to assist with his/her behaviors. Licensee B stated Resident 1 was awake most of the night when other residents were asleep. Licensee B stated Resident 1 would express his/her needs by loudly moaning & screaming, wandering behaviors including many attempts to leave the facility on his/her own, and standing up from his/her wheelchair to walk independently, experiencing repeated falls. Licensee B acknowledged concerns with management of Resident 1's behaviors. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 83.12(3)(a) Investigate Injuries Of Unknown Source N0170 83.12(5)(b) Notification: Abuse And Neglect Allegations N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0277 83.25 Continuing Education N0351 83.32(3)(g) Rights of Residents: Physical Restraints N0397 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0407 83.37(1)(h) Scheduled Psychotropic Medication N0408 83.37(1)(i) PRN Psychotropic Medication N0409 83.37(1)(j) Proof-Of-Use-Record N0432 83.38(1)(h) Medication Administration N0454 83.42(1) Resident Record Maintained	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 454	Continued From page 66	N 454		
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); (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	N 454		

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	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 454	Continued From page 67 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 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 maintain Resident 1's record to include: documentation of significant incidents and illnesses; including the dates, times, and circumstances, documentation to accurately describe the resident's condition; significant changes in condition; and changes in treatment and response to treatment. Findings include: On 06/17/2025, the department received	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 454	Continued From page 68	N 454		

complaint information alleging resident care concerns and mismanagement of medications.

On 07/02/2025, Surveyors conducted a complaint investigation.

On 07/14/2025 at approximately 8:00 AM, Surveyor interviewed Nurse Practitioner (APNP) I who reviewed Resident 1's case notes and noted Resident 1 had been on hospice in the past, which is where Resident 1's PRN (as needed) standing orders for lorazepam and morphine sulfate were prescribed. These medications were not discontinued upon hospice discharge. APNP I indicated when s/he learned that Resident 1 was still prescribed morphine and staff were administering it, s/he discontinued it since Resident 1 had other prescription orders for pain management.

Surveyor reviewed Resident 1's record and did not locate any documentation of Resident 1's history with being on hospice and/or the medications ordered by hospice.

On 07/15/2025 at approximately 11:00 AM, Surveyors interviewed Manager A who stated Resident 1 was on hospice prior to him/her working at the facility, but s/he was unaware of what agency and when s/he was discharged from it. Manager A stated s/he was unable to locate the original order for morphine.

On 07/14/2025 at approximately 8:00 AM, APNP I indicated Resident 1 was in immense pain and had a history of chronic pain. APNP I reviewed Resident 1's hospital documentation from 05/27/2025 and stated it was his/her interpretation that Resident 1 had current or new fractured ribs and stated the discharge summary

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	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 454	Continued From page 69	N 454		

listed - "fractures of the lateral left fourth through seventh ribs with callus formation, compatible with subacute to chronic fractures." Chest x-ray showed "irregularity of several left lateral ribs new from comparisons and worrisome for acute fractures without pneumothorax or effusion."
APNP I stated on 06/15/2025, Resident 1 went to the emergency room for low blood pressure. APNP I reviewed the discharge documentation from the hospital and noted the following listed under "impressions:"
"1. Few fluid-filled, minimally dilated small bowel loops demonstrate
mesenteric venous congestion. There is no pneumatosis. Findings may reflect
an infectious or inflammatory enteritis. Ischemia felt less likely but not
entirely occluded. Consider correlation with serum lactate.
2. Colonic diverticulosis.
3. Healing left anterolateral 4th through 7th rib fractures."

On 07/15/2025 at approximately 11:00 AM, Surveyors interviewed Manager A who stated s/he did not have any documentation or awareness of Resident 1 fracturing his/her ribs on 05/27/2025. Manager A indicated s/he was aware of Resident 1 having fractured ribs from a fall in 2024, but not recently. Manager A stated Resident 1 fell so many times.

05/29/2025 11:30 AM "[APNP I] was in today and observed [Resident 1] increase in pain. [S/he] ordered verbally as well as a written order to give an extra Oxycodone at 11:30am. Elder received 1 at 8:10am which was not effective. Will continue to monitor pain."

Surveyor reviewed Resident 1's record and was

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ARBOR VILLAGE INC	620 HARPER AVE PESHTIGO, WI 54157

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N 454	Continued From page 70	N 454		

unable to locate any documentation identifying Resident 1 had a fall on 05/27/2025, went to the emergency room (ER) on 05/27/2025, and anything about the diagnoses of left lateral rib fractures. Surveyor noted documentation of Resident 1 going to the ER on 06/15/2025 related to blood pressure, but diagnoses of infection or inflammation of the large intestines, colonic diverticulosis, or 4 left rib fractures. Because of this, there was no follow up or documentation to address side effects and symptoms of these conditions.
Surveyor note: Per Resident 1's May 2025 MAR, morphine was started on 05/29/2025 upon discharge from the hospital. It was still unknown whether morphine was actually ordered in relation to Resident 1's diagnoses post ER visit on 05/27/2025.

In addition, Surveyor reviewed Resident 1's medication administration records and noted missing documentation of prescriptions to include start dates, discontinue dates, medication changes, etc. prior to January 2025.

On 07/22/2025, at approximately 3:00 PM, Surveyor interviewed Licensee B, who discussed facility records being disorganized and acknowledged the records were not maintained.

Cross Reference:
N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws
N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect
N0407 83.37(1)(h) Scheduled Psychotropic Medication
N0408 83.37(1)(i) PRN Psychotropic Medication
N0409 83.37(1)(j) Proof-Of-Use-Record
N0415 83.37(2)(d) Documentation of Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016677	A. BUILDING: _____ B. WING _____	C 07/22/2025

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N 454	Continued From page 71 Administration N0433 83.38(1)(i) Behavior Management N0161 83.12(3)(a) Investigate Injuries Of Unknown Source	N 454		