

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017800	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 09/01/2026
NAME OF PROVIDER OR SUPPLIER AUBERGE AT OAK VILLAGE A MEMORY CARE COMM		STREET ADDRESS, CITY, STATE, ZIP CODE W128 N6900 NORTHFIELD DR MENOMONEE FALLS, WI 53051		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 08/25/2026 with information gathered through 09/01/2026, Surveyors conducted a verification visit and 1 complaint investigation at Auberge at Oak Village a Memory Care Community, a CBRF in Menomonee Falls, WI. Two deficiencies of Chapter DHS 83 were identified. Two of 2 deficiencies were repeat violations. See Statement of Deficiency (SOD) 3GKY11, issued on 11/20/2024, SOD 3GKY12, issued on 06/18/2025, and SOD 3GKY13, issued on 01/14/2026. Six of 8 violations from statement of deficiency (SOD) 3GKY14, dated 04/09/2026, were substantially corrected. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. The complaint was unsubstantiated. Census: 39	{N 000}		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, interview, and record	N 352		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 352	Continued From page 1 review, the provider did not ensure Resident 26 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 26 was administered erroneous, duplicative administration of ziprasidone (Geodon, a psychotropic medication) for 11 evenings from 08/14/2026 through 08/24/2026. This requirement is being cited for a fourth time. See Statement of Deficiency (SOD) 3GKY11, issued on 11/20/2024, SOD 3GKY12, issued on 06/18/2025, and SOD 3GKY13, issued on 01/14/2026. The findings are: On 08/25/2026 at approximately 8:30 A.M., Surveyor conducted an interview with Medication Technician (MT)/Caregiver OO. MT OO identified Resident 26 to Surveyor as Surveyor observed Resident 26 seated in a wheelchair eating breakfast in the dining room. MT OO told Surveyor Resident 26 had a history of aggressive behavior following admission to the facility. MT OO said Resident 26 did have a physical altercation with Resident 22 before being hospitalized related to this behavior. MT OO said Resident 26 has not exhibited resident to resident aggression since his/her discharge from the hospital back to the facility. MT OO said Resident 26's psychotropic medications have been recently adjusted related to behaviors. On 08/25/2026 at approximately 10:16 A.M., Surveyor conducted an interview with Health and Wellness Director (HWD)/Facility RN (registered nurse) QQ. HWD QQ told Surveyor Resident 26 was hospitalized for psychiatric evaluation and medication adjustment following Resident 26's	N 352		

Wisconsin Department of Health Services

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N 352	Continued From page 2 behavior including an aggressive incident involving Resident 22. HWD QQ said Resident 26 experienced a change in mobility while being hospitalized and has primarily utilized a wheelchair since his/her return to the facility. HWD QQ said Resident 26 has had no further aggressive behavior toward other residents but does continue to resist caregiver assistance during personal cares. HWD QQ said Resident 26 currently attempts to get out of his/her wheelchair without assistance and was currently a high risk for falls. On 08/25/2026, Surveyor reviewed Resident 26's record, as provided by HWD QQ. Resident 26 was admitted to the facility on 07/08/2026 with diagnoses including dementia. Resident 26's practitioner's orders included a prescription on 07/09/2026 by Nurse Practitioner RR for ziprasidone 20 milligram (mg) capsule to be administered to Resident 26 by mouth "one time per day at bedtime every day." Resident 26's July 2026 medication administration record (MAR) included documentation this medication was administered to Resident 26 at 8:00 P.M. from 07/10/2026 through 07/31/2026, as prescribed. Resident 26's August 2026 MAR included documentation this medication was administered to Resident 26 at 8:00 P.M. from 08/01/2026 through 08/04/2026. HWD QQ told Surveyor Resident 26 did not receive this medication, as prescribed, from 08/05/2026 through 08/11/2026 because Resident 26 was hospitalized, as documented as "LOA [leave of absence]" within the MAR. Following Resident 26's return to the facility, Resident 26's August 2026 MAR included documentation this medication was administered to Resident 26 every evening at 8:00 P.M. from 08/12/2026 through 08/24/2026.	N 352		

Wisconsin Department of Health Services

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N 352	Continued From page 3 Resident 26's practitioner's orders included a prescription on 08/14/2026 by Nurse Practitioner RR for ziprasidone 20 milligram (mg) capsule to be administered to Resident 26 by mouth "two times per day every day. Take 1 capsule by mouth twice daily." Resident 26's August 2026 MAR included documentation this medication was administered to Resident 26 at 8:00 P.M. on 08/14/026 and at 8:00 A.M. and 8:00 P.M. from 08/15/2026 through 08/24/2026. At approximately 3:15 P.M., Surveyor asked HWD QQ about Resident 26's two separate orders for ziprasidone and whether or not Resident 26 was to continue to receive 2 doses at 8:00 P.M. from 08/14/2026 through 08/24/2026, a total of 11 extra doses, following receipt of the practitioner's "twice daily" order on 08/14/2026. HWD QQ said doubling of Resident 26's 8:00 P.M. dose appeared to be an error that was missed and was not clarified with Nurse Practitioner RR. At approximately 4:10 P.M., HWD QQ provided a "Physician's Rounding Form" dated and signed by Nurse Practitioner RR on 08/20/2026. The form included the following documentation, "Duplicate ziprasidone 8:00 P.M. still on list w/[with] BID [twice daily]. Follow BID order please, and remove duplicate [order] in MAR." HWD QQ acknowledged this correction order was received by the facility on 08/20/2026 from Nurse Practitioner RR and HWD QQ was not aware of this correction until now. HWD QQ said it was found on a pile of documents to be processed. On 08/25/2026 at approximately 5:30 P.M., Surveyors conducted an interview with Administrator AA, HWD QQ, and Resident Care Coordinator [RCC]/Facility LPN (licensed practical nurse) SS. HWD QQ said a different system would be created to ensure practitioner's orders	N 352		

Wisconsin Department of Health Services

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N 352	Continued From page 4 were processed as soon as possible upon receipt. HWD QQ said Resident 26's August 2026 MAR would be corrected to include the correct "twice daily" dose of Resident 26's ziprasidone, as prescribed. HWD QQ told Surveyor Nurse Practitioner RR would be contacted immediately regarding the erroneous, duplicate administration of Resident 26's ziprasidone 20 mg capsule for 11 evenings from 08/14/2026 through 08/24/2026.	N 352		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

Wisconsin Department of Health Services

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N 431	Continued From page 5 This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 27's hand injury was provided treatment, as ordered by a practitioner. This requirement is being cited for a second time. See Statement of Deficiency (SOD) 3GKY11, issued on 11/20/2024. On 08/25/2026 at approximately 9:00 A.M., Surveyor observed Environmental Services Director D responding to Resident 27 attempting to stand independently from his/her wheelchair without assistance while in the facility's main common area. Environmental Services Director D was observed to summon a caregiver to assist Resident 27. On 08/25/2026 at approximately 9:48 A.M., Surveyor observed Resident 27 seated in a wheelchair being propelled by Resident 27's Legal Representative TT. Surveyor observed a dry, scabbed scar indicative of a recent wound to the palm of Resident 27's right hand. On 08/25/2026 at approximately 10:16 A.M., Surveyor conducted an interview with Health and Wellness Director (HWD)/Facility RN (registered nurse) QQ. HWD QQ told Surveyor Resident 27 was a recent admission to the facility, required the use of a wheelchair, and was a high risk for falls related to attempting to transfer and/or ambulate without assistance. HWD QQ said Resident 27 was recently sent the emergency room related to an injury to Resident 27's hand resulting from a fall. HWD QQ said Resident 27	N 431			

Wisconsin Department of Health Services

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N 431	Continued From page 6 sustained a laceration to his/her right hand and required sutures. On 08/25/2026, Surveyor received an "Assisted Living Facility Self-Report" document regarding Resident 27 from Administrator AA. Administrator AA said this self-report was not submitted to the department, as required, and s/he would be submitting the report on this day, 08/25/2026. The document included date of incident, "08/09/2026 at 2:15 A.M." The documentation included, "On 08/09/2026 [Resident 27] had a [sic] unwitnessed fall reported by NOBI [an AI (artificial intelligence) fall detection system]. [Resident 27] found sitting on their bottom on the floor by their sink." The documentation included, "Staff noticed [Resident 27's] right hand (palm) was bleeding. [Resident 27] sustained a very deep 1 in [inch] cut." The documentation included, "[Resident 27] was sent to the hospital for evaluation..." The documentation included, "Upon nursing call to the ER [emergency room] for follow-up, nursing was made aware [Resident 27] received three staples to [his/her] right hand and with anticipation of [Resident 27] returning to the community." On 08/25/2026, Surveyor reviewed Resident 27's record, as provided by HWD QQ. Resident 27 was admitted to the facility on 07/24/2026 with diagnoses including dementia, "neurocognitive disorder with Lewy bodies," and weakness. Surveyor asked HWD QQ to review Resident 27's hospital emergency department discharge documentation related to Resident 27's fall with injury on 08/09/2026. HWD QQ provided Surveyor with Resident 27's "After visit summary" dated 08/09/2026 from a local hospital's emergency department. The documentation included, "Diagnoses: Minor head injury, initial	N 431			

Wisconsin Department of Health Services

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N 431	Continued From page 7 encounter (and) Laceration of right hand without foreign body, initial encounter." The documentation included, "[Resident 27 was] seen in the emergency department today for laceration (cut). [Resident 27's] wound was cleaned and closed with stitches. 4 stitches were placed. These should come out in 10 days. [Resident 27's] regular doctor, urgent care, or [hospital] can remove them. To minimize scarring: Apply Vaseline twice daily for 2 weeks..after 3 weeks, may massage lacerations daily to soften scar tissue." Surveyor asked HWD QQ if these orders were processed within Resident 27's record and implemented by care staff at the facility. HWD QQ said this documentation was just located in a pile of paperwork to be filed and was the first time HWD QQ was aware of this documentation. HWD QQ said s/he believed it was added to a pile and not placed in the facility's internal mailbox for nursing review because it was received when Resident 27 returned to the facility from the emergency room on Sunday, 08/09/2026. HWD QQ said s/he believed Resident 27's emergency room discharge documentation was kept for filing instead of being forwarded to nursing because it was received during a weekend when nursing management was not typically available onsite at the facility. Surveyor reviewed documentation between Resident Care Coordinator [RCC]/Facility LPN (licensed practical nurse) SS and Nurse Practitioner RR, as provided by HWD QQ. Documentation dated 08/12/2026 at 11:24 A.M. from RCC SS to Nurse Practitioner RR included, "[RCC SS] wanted to let you know that [Resident 27] sustained a cut to the palm of [his/her] hand during a fall on [08/09/2026]. At the E.R. [his/her] wound was closed with sutures. On the discharge summary it was stated to f/u [follow-up] with her PCP [primary care practitioner] to have	N 431		

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N 431	Continued From page 8 them removed in around 10 days. Is that something [Nurse Practitioner RR] are able to help with?" Documentation dated on 08/12/2026 at 1:42 P.M. from Nurse Practitioner RR to RCC SS included, "Yes - it may not be exactly 10 days, but should be able to." A "wound" note documented within Resident 27's record, as provided by HWD QQ included, "Date discovered, cut/laceration/skin tear on right palm (1), 1 time per day, every week on Monday at 6:30 A.M." HWD QQ said Resident 27's hand wound was observed by RCC SS on Monday, 08/17/2026, before being removed on 08/24/2026 by Nurse Practitioner RR, as documented. HWD QQ said Vaseline, nor any other treatment, was provided to Resident 27's right palm wound. On 08/25/2026 at approximately 5:30 P.M., Surveyors conducted an interview with Administrator AA, HWD QQ, and RCC SS. HWD QQ said a different system would be created to ensure practitioner's orders, including those within emergency room discharge summaries, were processed as soon as possible upon receipt.	N 431		