STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015803	A. BUILDING: _____ B. WING _____	C 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY MANOR OF WEST BEND BUILDING 3	365 S FOREST AVE WEST BEND, WI 53095

(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 07/23/2025 with information gathered through 08/04/2025, Surveyor conducted a standard survey and complaint investigation at Ivy Manor of West Bend Building 3, a Community-Based Residential Facility (CBRF) in West Bend, WI. Three deficiencies identified. Complaint substantiated. Census: 17	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and staff interview, the CBRF did not send a written report to the Department within 3 working days after any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, welfare or residents or employees. Findings include: On 06/04/2025, the Department received a	N 164		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015803	A. BUILDING: _____ B. WING _____	C 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY MANOR OF WEST BEND BUILDING 3	365 S FOREST AVE WEST BEND, WI 53095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 164	Continued From page 1 complaint concerning medication management. On 07/23/2025 at 11:00 AM, Surveyor interviewed Administrator A. Administrator A stated it was reported to him/her by his/her lead caregiver around the end of May or early June that Resident 1's Oxycodone blister pack had been tampered with and replaced with other supplements and medications. Licensee A stated the blister pack had been taped on the back. On 07/23/2025 at 11:15 AM, Surveyor reviewed Resident 1's record for investigation of missing Oxycodone. Investigation stated the following: -"Team leads [Caregiver B] and [Caregiver C] reported the Oxycodone PRN card for [Resident 1] was crushed and did not seem like the right pills on evening of 05/29/2025. Half tabs had been crushed and back of card had been taped. They could see the letters S on a few of the halves. Cards were removed for the night and locked in office. [Administrator A] reviewed the cards on 05/30/2025 and came to the same conclusion. We could not ensure the pills in the pack were viable nor if they were actually the Oxycodone. Reviewed Narc count since delivery of the card around 03/27/2025. No discrepancies. Spoke to [Caregiver B] and [Caregiver C] who had been on meds during timeline and both remembered that the card had looked like that for awhile. Time frame is 03/27/2025 til discovery 05/29/2025. All other meds had narcotics in cart verified and no other signs of tampering. Hospice, MD and pharmacy notified. Hospice and MD were in process of changing med orders. West Bend Police Department sent officer to collect report and card on 06/02/2025. Case and all record turned over to detectives."	N 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015803	A. BUILDING: _____ B. WING _____	C 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY MANOR OF WEST BEND BUILDING 3	365 S FOREST AVE WEST BEND, WI 53095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 164	Continued From page 2 On 07/23/2025 at approximately 11:30 AM, Surveyor interviewed Administrator A. Administrator A stated s/he does not believe s/he self-reported the incident to the Department. Administrator A stated s/he had a lot going on and must have forgot to self-report the incident.	N 164		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was free from misappropriation of property. Resident 1 had 27 Oxycodone pills stolen from the facility. Findings include On 06/04/2025, the Department received a complaint stating a resident's Oxycodone had been tampered with and replaced with various other supplements. On 07/23/2025 at 11:00 AM, Surveyor interviewed Administrator A. Administrator A stated it was reported to him/her by his/her lead caregiver	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015803	A. BUILDING: _____ B. WING _____	C 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY MANOR OF WEST BEND BUILDING 3	365 S FOREST AVE WEST BEND, WI 53095

(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 348	Continued From page 3 around the end of May or early June that Resident 1's Oxycodone blister pack had been tampered with and replaced with other supplements and medications. Administrator A stated the blister pack had been taped on the back. Administrator A stated it was a total of 27 pills. Administrator A stated s/he had turned all of his/her documentation and information over the the local law enforcement and they are investigating and questioning staff. On 07/23/2025 at 11:15 AM, Surveyor reviewed Resident 1's record for investigation of missing Oxycodone. Investigation stated the following: -" Team leads [Caregiver B] and [Caregiver C] reported the Oxycodone PRN card for [Resident 1] was crushed and did not seem like the right pills on evening of 05/29/2025. Half tabs had been crushed and back of card had been taped. They could see the letters S on a few of the halves. Cards were removed for the night and locked in office. [Administrator A] reviewed the cards on 05/30/2025 and came to the same conclusion. We could not ensure the pills in the pack were viable nor if they were actually the Oxycodone. Reviewed Narc count since delivery of the card around 03/27/2025. No discrepancies. Spoke to [Caregiver B] and [Caregiver C] who had been on meds during timeline and both remembered that the card had looked like that for awhile. Time frame is 03/27/2025 til discovery 05/29/2025. All other meds had narcotics in cart verified and no other signs of tampering. Hospice, MD and pharmacy notified. Hospice and MD were in process of changing med orders. West Bend Police Department sent officer to collect report and card on 06/02/2025. Case and all record turned over to detectives."	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015803	A. BUILDING: _____ B. WING _____	C 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY MANOR OF WEST BEND BUILDING 3	365 S FOREST AVE WEST BEND, WI 53095

(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 348	Continued From page 4 On 07/23/2025, Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 09/23/2024 with diagnoses including hypothyroidism, hyperlipidemia, unspecified dementia, depression, essential hypertension, metabolic encephalopathy, cutaneous abscess of buttock and history of falling. Surveyor reviewed Resident 1's physician order for Oxycodone 5 MG tab (2.5mg) by mouth daily as needed for moderate pain with a start date of 03/27/2025. On 08/04/2025, Surveyor reviewed police report dated 06/05/2025. Police report stated the following: -"On 06/05/25 at approximately 1117 hours, I was dispatched to Ivy Manor for the report of a theft complaint. [Complainant] advised nurses have been stealing [his/her family members] Oxycodone. Upon arrival, I met with the Administrator, [Administrator A]. [Administrator A] said on 05/29/25 at around 1900 hours [s/he] received a phone call from a team lead at Ivy Manor, [Caregiver B] [Administrator A] said [Caregiver B] advised [s/he] was concerned the medications in [Resident 1's] blister pack looked to be tampered with. [Administrator A] said [Caregiver B] told [him/her] there was tape placed over each pill opening to the blister pack. [Administrator A] said [Caregiver B] told [him/her] the pills appeared to be different throughout the pack and other identifiable. [Administrator A] said on 05/30/25, [s/he] looked at the pack and called [pharmacist]. [Administrator A] said [s/he] confirmed with [pharmacist] that some pills were not what was supposed to be in the blister pack. [Administrator A] said the pack was only suppose to contain Oxycodone. [Administrator A] said the blister pack came with 30 half Oxycodone	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015803	A. BUILDING: _____ B. WING _____	C 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY MANOR OF WEST BEND BUILDING 3	365 S FOREST AVE WEST BEND, WI 53095

(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 348	Continued From page 5 (2.5MG) pills. [Administrator A] said no one would have needed to cut the pills in half because they were already in half when the blister pack arrived at Ivy Manor. [Administrator A] said [Resident 1] was only supposed to take the Oxycodone as needed. [Administrator A] said the last time [Resident 1] took an Oxycodone pill was on 05/25/25. [Administrator A] said the blister pack was sent to Ivy Manor by [pharmacist] on 3/27/25. [Administrator A] said an investigation was started. [Administrator A] said the timeline that the pills went missing was from 3/27/25-5/30-25. [Administrator A said it was unknown who the suspect is. [Administrator A] said narcotic checks are conducted each time keys to the med cart are passed, which is typically three times a day. [Administrator A] said [s/he] made contact with each caregiver that has been in charge of passing medications and all said the blister pack was been taped for a while. [Administrator A] said no one had permission to tamper with [Resident 1's] blister pack. I confiscated the blister pack that was tampered with. I responded back to the West Bend Police Department and photographed the blister pack. I observed 5/24 pill #30 was issued on 5/25 pill #29 was issued. Pill #26 as empty and did not indicate when it was issued. Pill #31 was empty, however, it comes empty when delivered from [pharmacist]. The blister pack should have a total of 30 half (2.5MG) Oxycodone pills when it is new. I went through each individual pack on the blister pack and annotated the following: pill # 1,2,6,7,9,10,11, and 17 were all unknown half pills. I could not tell what the markings were on the pills as it was cut in half right where the marking were. Pill #3,4,5,8,12,13,14,15,16,18,19,20,21,22,23,24,25, 27 and 28 had the marking "337" on it. A search through Drugs.com indicated the pill was	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015803	A. BUILDING: _____ B. WING _____	C 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY MANOR OF WEST BEND BUILDING 3	365 S FOREST AVE WEST BEND, WI 53095

(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 348	Continued From page 6 quetiapine fumarate which is what [Administrator A] thought was in the blister pack when [s/he] spoke with [pharmacist] about the tampering. [Resident 1] was also prescribed quetiapine fumarate which meant someone had to of removed those pills from a separate blister pack, cut them in half, and placed them in the Oxycodone blister pack. [Administrator A] said there was a camera on the med cart at all times, however, when medications are being distributed to the patients, the med cart goes to the patients room. [Administrator A] said [s/he] does not have video surveillance of this incident." CROSS REFERENCE N0164 DHS 83.12(4)(b) Reporting When Law Enforcement is Called	N 348		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner for 1 of 1 resident reviewed. Resident 1 did not receive 23 doses of Pro-Stat Liquid.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015803	A. BUILDING: _____ B. WING _____	C 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY MANOR OF WEST BEND BUILDING 3	365 S FOREST AVE WEST BEND, WI 53095

(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 352	Continued From page 7 Findings include: On 07/23/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 09/23/2024, with diagnoses including hypothyroidism, hyperlipidemia, unspecified dementia, depression, essential hypertension, metabolic encephalopathy, cutaneous abscess of buttock and history of falling. The following was identified: -Individual Service Plan (ISP), dated 10/28/2024, stated, "Medication Management, Resident Concerns/Observations: Unable to understand or consistently manage medication independently. Hospice comfort pack. Resident's Desired Outcome/Goals: Resident will accept medications from staff. Interventions: Pills whole. Provide medication at scheduled times." -Active Orders As of 04/01/2025, identified Resident 1 was prescribed Pro-Stat Liquid, Take 30 ml by mouth twice a day. Resident 1's April 2025 (date range 04/01/2025 through 04/30/2025) Medication Administration Records (MARs) identified the following: -Pro-Stat Liquid, give 30 ml by mouth twice a day at 8:00 AM and 8:00 PM. The medication was not available on 04/07, 04/08, 04/09, 04/10, 04/11, 04/12, 04/13, 04/14, 04/15, 04/16, 04/17, 04/18 for 8:00 AM and 8:00 PM. The medication was not available on 04/19 at 8:00 AM. Resident 1 missed 23 doses. On 07/23/2025, at 12:10 PM, Surveyor interviewed Administrator A. Administrator A reported if the MAR stated it was not available, then it meant the resident did not receive the medication because they were out of it. Administrator A stated typically a lead caregiver will check weekly on medications to make sure they are all there but s/he was not sure what	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015803	A. BUILDING: _____ B. WING _____	C 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY MANOR OF WEST BEND BUILDING 3	365 S FOREST AVE WEST BEND, WI 53095

(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 352	Continued From page 8 happened in this case but confirmed Resident 1 did miss 23 doses of Pro-Stat Liquid.	N 352		