STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525462	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood of Sauk Prairie	245 Sycamore St Sauk City, WI 53583

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure each resident received adequate supervision to prevent accidents for 1 of 3 residents (R3) reviewed for wandering and elopement potential out of a sample of 6 Residents.R3 was identified as having a behavior of exit seeking. R3's elopement risk assessment was not accurate or complete and R3's care plan did not contain interventions or goals related to exit seeking.When R3 eloped, staff did not follow the facility policy and procedures for a missing resident, for wandering/elopement, and for a code alert.The facility's failure to assess, care plan, and supervise a resident who was at risk for elopement, created a finding of immediate jeopardy that began on 3/16/26. Surveyor notified NHA A (Nursing Home Administrator) and DON B (Director of Nursing) of the immediate jeopardy on 6/23/26 at 1:21 PM. The immediacy was removed and corrected on 3/18/26; the deficient practice is being cited as past noncompliance. Evidenced by:Facility policy, titled Elopement and Wandering Residents Policy, revised 6/2025, includes: Monitoring and managing residents at risk for elopement or unsafe wandering: Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary team. The interdisciplinary team will evaluate the unique factors contributing to risk such as diagnoses, mental status, medications, and residents' physical appearance in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions and document accordingly. See the Missing Resident Policy for more information regarding elopements and the procedures to be followed when they do occur. See Code Alert Policy for the protocol for the use of the code alerts.Facility policy, titled Missing Resident Policy, revised/reviewed 6/2025, includes: Any staff member observing a resident attempting to leave the premises shall with proper conduct attempt to prevent such departure. When an exit alarm goes off, staff will respond in a timely manner and look for the source that triggered the alarm. If the source is not immediately found, it is a good idea for staff to leave the alarm sounding until additional staff come to aide in the search and can assist with notification of the charge nurse. Staff will walk around the immediate area of the building and grounds if the source for triggering the alarm is not found in the area of the alarm. If source for the alarm is found, staff will report this to the charge nurse. Upon notification that a resident has indeed left the premises or a resident is noted to be missing, the charge nurse shall alert all staff, via overhead page, to conduct a thorough search of the facility, including all resident rooms, bathrooms, closets, etc., and the exterior premises for the missing resident. Should this initial search of the facility and the premises or a resident is noted to be missing, the charge nurse shall alert the Administrator and Director of Nursing. While the charge nurse is notifying the Director of Nursing and Administrator, other staff will initiate a more extensive search of the surrounding area. If after 30 minutes the extensive search proves unsuccessful, the following people shall be notified: family, physician, local police department.Facility (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	policy, titled Code Alert Policy, reviewed/revised 6/2025, includes: Each resident who is deemed an elopement risk will have a code alert bracelet placed on their person, walker, or wheelchair. Assessment: an elopement risk assessment is completed on each resident on admission, annually, and with a significant change. The elopement risk assessment is located in the electronic charting system under the charting tab topic elopement risk. If a resident is determined to be at risk for elopement based on assessment, a code alert unit will be placed.Facility's Agency Orientation Packet, undated, includes, wandering and elopement policy, missing resident policy, and code alert policy. Indicating that new staff are educated on these operations.R3 admitted to the facility on [DATE] with diagnoses of unspecified dementia, Major Depressive Disorder, Alzheimer's disease, Chronic Obstructive Pulmonary Disease, and Insomnia.R3's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 3/13/26 indicates R3's cognition is severely impaired with a BIMS (Brief Interview for Mental Status) score of 3 out of 15.R3's Comprehensive Care Plan, initiated 7/14/23, includes: I am forgetful and need reminders because I have progressing Alzheimer's disease/dementia. I show this by: exhibiting poor short/long term memory, disorientation, decreased safety awareness, forgetfulness, reduced ability to recall prior events or conversations, statements of having poor memory, short attention span/distractibility, periodic exit seeking, insomnia/trouble falling asleep or staying asleep, benefitting from memory care programming with structured daily activities and care, mood lability. I need staff to . offer reminders as needed, establish/maintain consistent routine, encourage participation in daily cognitively stimulating activities, assess for potential physiologic causes of increased confusion, report any changes in overall care/status, offer simple choices,.R3 is noted to have periodic exit seeking behaviors, but R3's care plan does not contain interventions and goals related to exit seeking.R3's Medical Doctor Note, dated 12/17/25, includes: Seen today for a nursing home visit. Nursing staff has noted no concerns other than that she has had some elopement behaviors. They have just done more checks. No changes in medication. She was alert and appropriate today although did not recognize me, although with my stethoscope I think she determined that I was her doctor. She is obviously forgetful related to her dementia.Nursing staff demonstrated awareness of potential elopement as evidenced by the update given to the physician.R3's Elopement Risk Assessment, dated 1/23/26, includes: cognitively impaired: yes. Resident has a history of or attempted elopement while at home: no. Resident has a history of or attempted leaving the facility without informing staff: no. Resident has verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door: no. Resident wanders: no. Wandering behavior is a pattern or goal directed: no Resident wanders aimlessly or non- goal directed, confused, moves without purpose, may enter other's rooms and explore other's belongings: no. potential interventions: secured unit.The risk assessment is not complete as there is no score and is missing answers to some questions at the end.On 6/23/26 at 11:12 AM, Surveyor interviewed DON B (Director of Nursing) and NHA A (Nursing Home Administrator). NHA A, DON B, and Surveyor reviewed R3's elopement assessment, dated 1/23/26. NHA A and DON B indicated the elopement risk assessment is incomplete and inaccurate. NHA A and DON B indicated it is their expectation that assessments are to be accurate and complete. NHA A and Surveyor reviewed R3's comprehensive care plan noting R3 has a known behavior of periodic exit seeking but does not have interventions or goals related to the behavior. NHA A indicated R3's care plan should have contained goals and interventions related to exit seeking.R3's Nurse Notes, dated 3/16/26 at 11:34 PM, states, Resident was last seen by this nurse in another resident's room at approximately 8:15 PM on this day. She was sitting on another resident's bed having a conversation. This nurse left that area to continue the medication pass. This nurse was in a resident's room when I heard the back door alarm go off. This nurse went to check on the alarm. The door was open so I looked to see someone [sic]. There were no footprints or snow disturbance. I could not see anyone in the area. I pulled the door shut and turned the alarm off. CNA C (Certified Nursing Assistant) asked me where R3 was about 8:30 PM. I responded that the last time I saw her she was in another resident's room. CNA C and I looked in (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	because she has some abrasions on her forehead and face and some injury to her right fifth finger and left index finger she denies headache neck pain chest pain shortness of breath. Her temperature was only 95.8. temp (taken) orally by EMS. Clinical Impression: Exposure to environmental cold, Fall, Forehead contusion, Abrasion of face, Abrasion of right little finger, Contusion of left patella, Hypothermia, Odontoid fracture with type II morphology, Anterior displacement and delayed healing.According to The National Weather Service, on 3/16/26 at 8:00 PM, (the facility's location) experienced strong, brisk winds from the north/northwest, with sustained wind speeds of 25 to 35 miles per hour and frequent gusts ranging between 40 and 45 miles per hour. The estimated windchill was between 5 degrees F (Fahrenheit) and 10 degrees F. Snowfall accumulation ranged from 8 to 12 inches with winds causing drifts. In these conditions, frostbite can set in on exposed skin in 30 minutes or less. For an elderly woman, the risk is highly elevated because seniors and older adults lose core body heat much faster than younger adults, meaning hypothermia is an immediate and life-threatening concern even before frostbite occurs. A core body temperature drop to 95 degrees F or lower constitutes medical hypothermia.On 6/23/26 at 11:12 AM, NHA A and Surveyor reviewed R3's 15-Minute Check Form, dated 3/16/26. NHA A indicated CNA C signed out the form without having visualized R3.On 6/23/26 at 11:12 AM Surveyor interviewed DON B and NHA A. NHA A indicated LPN F and CNA G did not even step foot outside of the building when LPN F closed the door and deactivated the door alarm and the doorbell alarm. NHA A indicated the facility has camera footage and she would play it for surveyors. NHA A stated, You will see the staff did not follow the Missing Resident Policy, didn't follow the Wandering and Elopement Policy, and they didn't follow the Code Alert Policy.On 6/23/26 at 11:48 AM, surveyors reviewed video footage, dated 3/16/26. Surveyors observed the surroundings to have about 8 inches of snow, but the sidewalk and the parking lot had been plowed. Surveyors observed the sidewalk and parking lot to have patches of snow/ice on them. Surveyors observed R3 exit the building at 8:27:56 PM. R3 was observed to be wearing well fitted shoes, pants, and a sweatshirt. R3 walked down the sidewalk, stepped over a pile of snow left by the plow, and entered the parking lot. The parking lot had no cars in it. At 8:30 PM, surveyors observed R3 to still be in the parking lot under a tall light and at the same time, surveyors observed an unknown staff member close the door without stepping outside. Surveyors observed the unknown staff member's shadow in the window, but the door never reopened. Surveyors observed R3 to continue walking out of the facility's parking lot and onto the street.The failure to accurately assess, create a care plan with goals and interventions, provide supervision, and follow facility policies and procedures created a reasonable likelihood for serious harm for R3, thus leading to a finding of Immediate Jeopardy. The facility removed the jeopardy on 3/18/26 and corrected the citation , when it had completed the following:NHA A implemented 15-minute checks on all residents residing on the (secured unit).NHA A removed both CNA G and LPN F (agency contracted staff) from working at the facility.Maintenance Manager ensured all alarms on doors were working correctly.Interdisciplinary Team verified that all staff carried a communication radio for immediate communication between staff.NHA A spoke with R3's family member at the hospital to follow up on R3's conditionNHA A viewed video footage of the incident and noted the proper procedures for wandering; potential eloped residents were not followed by CNA G and LPN F on wing.NHA A contacted staff that worked during the shift and completed a witness statement.NHA A spoke with RN I regarding situation and his knowledge of it.Director of Nursing ordered alarms on R3 upon return from hospital.Maintenance conducted alarms checks for all egress doors. All alarms are working correctly.Human Resources implemented a mandatory uniform requirement to have a radio on their person for immediate communication between staff, for residents' safety. Reminder signs posted at all nurse/CNA stations and break rooms.Director of Nursing B and Social Services conducted elopement assessments for all residents in the facility. Completed by nursing and social services.NHA A and Director of Nursing B posted and required employee signature of acknowledging Elopement and Wandering, Missing Resident Code Alert Policy and Procedures. This was placed in scheduling/Daily (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	book. To be completed before start of next shift working.Interdisciplinary Team made a consideration to move the secured unit from Evergreen to Elm. DON B created a Plans Moving Forward presented to IDT leadership. (Consequently, this change was not completed due to logistical complications.)Activities Dept was instructed to apply 3D appliques to the exit and entrance doors to create a distractive facade for future elopement risk.Administrator reached out to DHS DQA - Life Safety to discuss use of appliques on doors or frosted glass. - given approval if view at eyesight level was clear beyond the door.Maintenance instructed to apply a frosted film to the back Evergreen exit door to distract the look of the door.Maintenance placed black rubber mat next to door exit to further distract elopements.NHA A created Power Point education for Managing Wandering and Restlessness with residents.This education is included with all new employee orientationsDirector of Nursing B and NHA A developed an extensive Elopement Prevention and Management Policy for use on all resident wings.Social Services, to follow up on all care plans, and elopement risks for residents on Evergreen.Interdisciplinary Team brainstormed ideas discussed for ways to improve alerts for higher risk residents.Interdisciplinary Team implemented on going elopement and wandering auditsNHA A conducted elopement audit on each shift at 12:00am, 11:25 am, and 1630p,NHA A met with Board of Directors to discuss options to prevent further elopement risks.Board Member posed utilizing a fenced in area outside the door to slow the exit or wandering of an eloped resident.Fence was priced out and ultimately purchased. Fence was installed.Medical Records, Director of Nursing, and Social Services worked with the Electronic Health Record to updates to include elopement risk on the KardexMaintenance placed additional frosted film to the [NAME] wing exit door (just outside of the Evergreen wing) to distract from the use of the door.Clinical Managers assigned to each wing to ensure staff are following newly implemented and corrected procedures regarding resident risks for wandering, elopement, and restlessness.Interdisciplinary Team conducted QAPI meeting. Addressed need for procedural changes for staff and residents assessed as a high elopement wandering risk.Administrator conducted elopement drillStaff continue to conduct 15-minute checks on all Evergreen residents.Board of Directors President signed invoice for fence and gate to be constructed on the west emergency exit egress.Driftless Fence Solutions installed 36' fence line with a 5' gate entrance along west emergency exit egress on EvergreenOn 6/22/26 and 6/23/26, surveyors observed the facility's action plan items to be in place.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview and record review, the facility did not include as part of its QAPI (Quality Assurance and Performance Improvement) program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program for 5 of 5 randomly sampled Certified Nursing Assistants (CNA). This had the potential to affect all residents who reside in the facility.CNA J, CNA K, CNA L, CNA M, and CNA N did not receive and have documented mandatory yearly QAPI in-service training. Evidenced by:The Facility Assessment, last reviewed 1/2026, states in part:. Staff Training/Education and Competencies/Recruitment/Retention: 3.4 Staff will be provided with training and education to assure competent care is provided to residents in the facility. Training/education will be provided upon hire with the orientation process, routinely on a yearly basis and as needed if issues arise. The following training topics will be included in this process (this is not an all-inclusive list):*Communication.*Resident Rights.*Abuse.*Infection Control.*Culture Change.The following competencies be reviewed (this is not an all-inclusive list):*Person-centered care.*Activities of Daily Living.*Disaster.*Infection Control.*Caring for persons with Alzheimer's or another Dementia.Surveyor noted that QAPI training was not included in the topics in the training plan.On 7/02/26 at 1:00PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked how many in-service/education hours are required yearly for CNAs. NHA A indicated 12 hours. Surveyor reviewed the Nurse Aide In-Service Records for CNA J, CNA K, CNA L, CNA M, and CNA N with NHA A. Surveyor asked NHA A if CNA yearly in-service/education should include QAPI. NHA A indicated yes. NHA A indicated the facility does not provide QAPI training directly titled QAPI but presents interventions and actions put in place for issues identified.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. Based interview and record review, the facility did not include as part of its compliance and ethics program an effective way to communicate the program's standards, policies, and procedures through a training program for 5 of 5 CNAs (Certified Nursing Assistants) randomly sampled. This had the potential to affect all residents who reside in the facility.CNA J, CNA K, CNA L, CNA M, and CNA N did not receive and have documented yearly compliance and ethics in-service training.Evidenced by:The Facility Assessment, last reviewed 1/2026, states in part:. Staff Training/Education, and Competencies/Recruitment/Retention: 3.4 Staff will be provided with training and education to assure competent care is provided to residents in the facility. Training/education will be provided upon hire with the orientation process, routinely on a yearly basis and as needed if issues arise. The following training topics will be included in this process (this is not an all-inclusive list):*Communication.*Resident Rights.*Abuse.*Infection Control.*Culture Change.The following competencies be reviewed (this is not an all-inclusive list):*Person-centered care.*Activities of Daily Living.*Disaster.*Infection Control.*Caring for persons with Alzheimer's or another Dementia. On 7/02/26 at 1:00PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor reviewed the Nurse Aide In-Service Records for CNA J, CNA K, CNA L, CNA M, and CNA N with NHA A. Surveyor asked NHA A if CNA yearly in-service/education should include compliance and ethics. NHA A indicated yes.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based interview and record review, the facility did not ensure the continuing competence of nurse aides must be no less than 12 hours per year and did not include dementia management training and resident abuse prevention training for 5 of 5 CNAs (Certified Nursing Assistants) randomly sampled. This had the potential to affect all residents who reside in the facility.CNA J, CNA K, CNA L, CNA M, and CNA N did not receive and have documented yearly 12 hours of continuing education including dementia management and abuse prevention training. Evidenced by:The Facility Assessment, last reviewed 1/2026, states in part:. Staff Training/Education, and Competencies/Recruitment/Retention: 3.4 Staff will be provided with training and education to assure competent care is provided to residents in the facility. Training/education will be provided upon hire with the orientation process, routinely on a yearly basis and as needed if issues arise. The following training topics will be included in this process (this is not an all-inclusive list):*Communication.*Resident Rights.*Abuse.*Infection Control.*Culture Change.The following competencies be reviewed (this is not an all-inclusive list):*Person-centered care.*Activities of Daily Living.*Disaster.*Infection Control.*Caring for persons with Alzheimer's or another Dementia. On 7/02/26 at 1:00PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked how many in-service/education hours are required yearly for CNAS. NHA A indicated 12 hours. Surveyor reviewed the Nurse Aide In-Service Records for CNA J, CNA K, CNA L, CNA M, and CNA N with NHA A. NHA A agreed the total hours on the Nurse Aide In-Service Record sheets did not meet the 12 hours required yearly. Surveyor asked NHA A if CNA yearly in-service/education should include dementia and abuse NHA A indicated yes.