STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018808	A. BUILDING: _____ B. WING _____	C 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORETUM (THE)	W 180 N7890 TOWN HALL RD 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 04/08/2026 to 04/14/2026, Surveyor conducted a complaint investigation at The Arboretum. One deficiency was identified. The complaint was substantiated. Census: 22	N 000		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not implement a written temporary service plan (TSP) that met the immediate needs of Resident 1. Resident 1's pre-admission (initial) assessment indicated s/he used a wheelchair/walker and required assistance with toileting and incontinence care. Resident 1's TSP indicated s/he required assistance with toileting/incontinence assistance, and fall intervention at least once per shift (shift I-AM, shift II-PM, shift III-NOC). Resident 1 was admitted to the facility on 12/31/2025. During shift III on 12/31/2025, staff did not provide toileting/incontinence care and fall intervention assistance. In addition, there were multiple dates when the above	N 385		

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

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cares/interventions were not completed.

Findings include:

The provider is licensed to care for 78 residents in the client groups of advanced age and irreversible dementia/Alzheimer's.

On 02/04/2026, the Department received a complaint alleging resident care concerns.

On 04/08/2026, Surveyor reviewed Resident 1's record and identified the following:

Record Review:

Resident 1 was admitted to the provider's memory care unit on 12/31/2025 with a diagnosis of dementia. Resident 1 had an activated healthcare power of attorney. Resident 1 had a stroke at the facility on 01/06/2026 and passed away at the hospital with hospice services on 01/10/2026.

Resident 1's pre-admission (initial) assessment dated 12/30/2025 documented:
-Mental Health Status: Remote-Poor, Recent-Poor, Attention Span-Poor.
-Identified as a high fall risk.
-What type of assistive device does the resident utilize, if any? Walker and Wheelchair.
-Toileting assistance: Resident requires assistance with incontinence care and toileting.

Resident 1's TSP dated 12/30/2025 documented:
-Incontinence Assistance-Total: Staff to change brief and clean up, frequency: daily, scheduled: shift I-AM, shift II-PM, shift III-Noc.
-Toileting Assistance: Assist resident to the restroom, no supervision while toileting, clean

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resident as needed, assist resident back to room, frequency: daily, scheduled: shift I-AM, shift II-PM, shift III-Noc.
-Fall Intervention: staff to actively implement interventions to prevent falls, frequency: daily, scheduled: shift I-AM, shift II-PM, shift III-Noc.
-The TSP did not address Resident 1's mobility needs including the use of a wheelchair and walker.

Resident 1's care tracking sheet dated 12/31/2025 to 01/06/2026 documented:
-Fall intervention was left bank for shift III on 12/31/2025. Additional blank entries were observed on 01/01/2026 (shift III), 01/03/2026 (shift III), 01/04/2026 (shift II and III), and 01/05/2026 (shift II).
-Incontinence Assistance-Total was left blank for shift III on 12/31/2025. Additional blank entries were observed on 01/01/2026 (shift III), 01/03/2026 (shift III), 01/04/2026 (shift II and III), and 01/05/2026 (shift II).
-Safety: Shift Wellness Check was left blank for shift III on 12/31/2025. Additional blank entries were observed on 01/01/2026 (shift III), 01/03/2026 (shift III), 01/04/2026 (shift II and III), and 01/05/2026 (shift II).
-Toileting Assist to/from x1 was left blank for shift III on 12/31/2025. Additional blank entries were observed on 01/01/2026 (shift III), 01/03/2026 (shift III), 01/04/2026 (shift II and III), and 01/05/2026 (shift II).

Interviews:

On 02/18/2026 at 4:07 PM, Surveyor interviewed Legal Representative E. Legal Representative E reported Resident 1 admitted to the facility on 12/31/2025 at approximately 2:00 PM. Legal Representative E reported frustration with getting

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N 385	Continued From page 3 Resident 1 admitted and the provider repeatedly pushing out the date Resident 1 could move in. Legal Representative E stated s/he called the provider on 12/31/2025 because s/he had received no information about the move in. Legal Representative E stated s/he talked to the receptionist who stated s/he could bring Resident 1 at any time and should drop off the paperwork at the front desk. Legal Representative E reported after Resident 1 arrived to his/her room, Charge Nurse F came into the room and told family that their aides assist with toileting and check with the resident every 2 hours to assist getting to the bathroom or changing their depends. Legal Representative E stated him/her and family asked Charge Nurse F when Resident 1 would get his/her call pendent. Legal Representative E stated s/he was informed by Charge Nurse F that memory care residents do not get one because they take them off, don't remember how to use them etc. Further, Charge Nurse F informed Legal Representative E and family, to compensate for no pendant, the staff check residents often and aides typically leave the apartment doors open at night so they can check in on the residents and s/he would talk to staff about checking on Resident 1 every hour instead of every 2. Legal Representative E stated due to family dynamics Resident 1 used a camera in their independent apartment prior to admission to the facility. Legal Representative E noted family had installed the same camera inside Resident 1's apartment at the facility on 12/31/2025. Legal Representative E stated the camera's view was placed to see the whole apartment including the door to the hallway, excluding the bathroom. Legal Representative E reported the camera was motion activated and would record for approximately 2 minutes once activated. Legal Representative E stated	N 385		

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Resident 1's son/daughter stayed with the resident until approximately 4:30 PM before leaving. Legal Representative E reported concerns with 3rd shift staff not assisting with toileting/brief changes. Legal Representative E reported after reviewing video footage for the evening of 12/31/2025 into the morning of 01/01/2026, staff had provided incontinence care at 9:14 PM, Resident 1's door remained closed all night and staff did not provide toileting or incontinence care again until 10:43 AM on 01/01/2026. Legal Representative E reported Resident 1 had a stroke at the facility on 01/06/2026 and ended up passing away at the hospital with hospice services on 01/10/2026. Legal Representative E stated s/he made multiple attempts to contact Former Administrator B after Resident 1's passing to discuss the incidents that had occurred while Resident 1 resided at the facility, but Former Administrator B never returned his/her calls.

On 04/08/2026 at 9:50 AM, Surveyor interviewed Health Services Director A regarding Resident 1's admission. Health Services Director A reported Resident 1 was admitted for approximately 1 week. Health Services Director A stated there were no grievances filed during Resident 1's admission, and s/he was not aware of any concerns. At 11:45 AM, Surveyor shared Legal Representative E had reviewed video evidence from the NOC shift on 12/31/2025 showing staff did not provide overnight care. Health Services Director A stated s/he was unaware of these allegations and could not recall what Resident 1's TSP stated regarding overnight care.

On 04/08/2026 at 10:05 AM, Surveyor interviewed Charge Nurse F. Charge Nurse F explained s/he was the manager of the memory

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care unit. Charge Nurse F provided a short summary of Resident 1's care needs noting that staff assisted with transfers, dressing, bathing, toileting checks (every 2hours), and transport to meals. Charge Nurse F reported that when the provider gets a new admission, we use a TSP that is kept in the med cart so staff can review. Charge Nurse F reported staff document in their electronic health record (EHR) when cares are completed.
Surveyor shared Legal Representative E had reviewed video footage from a camera placed in Resident 1's room and it showed staff did not provide overnight care on 12/31/2025 into 01/01/2026. Charge Nurse F stated s/he unaware Resident 1 had a camera in his/her room and was unaware of any concerns regarding care.

On 04/08/2026 at 10:35 AM, Surveyor interviewed Caregiver G regarding Resident 1's admission. Surveyor reported after reviewing the provider's staff schedule, it indicated Caregiver G had worked the 1st shift (630-230pm) on 01/01/2026. Caregiver G confirmed s/he worked that day. Caregiver G reported 3rd shift staff had not reported any concerns. Caregiver G reported the provider does not always tell staff about new residents.

On 04/08/2026 at 1:20 PM, Surveyor interviewed Caregiver H. Caregiver H reported ongoing concerns with the provider not informing staff when new residents are admitted. Caregiver H stated s/he did not know how to access resident care plans, and we only use our care tracking sheets for resident cares, which only includes "Yes" or "No" prompts if care was completed. Caregiver H reported the provider used to print out care plans and placed them in a binder for staff review but not currently going on.

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N 385	Continued From page 6 On 04/08/2026 at 2:45 PM, Surveyor interviewed Caregiver D regarding Resident 1's admission. Caregiver D reviewed the staff schedule with the Surveyor and noted s/he was not assigned to Resident 1 on the 2nd shift (230-1030pm) but did work on the unit. Caregiver D stated s/he will chart for all residents on the unit even if not assigned to work with them to be a "team player" with staff. Caregiver D stated s/he will not document for other staff going forward. Caregiver D reported management does not always communicate when a new resident was admitted, the resident ends up on our daily assignment sheets and care tracker. Caregiver D reported not all staff used care tracker and will just ask the nurse what to do for that resident. Caregiver D stated s/he was not sure where resident care plans are located but noted maybe in the med cart. On 04/14/2026 at 1:26 PM, Surveyor interviewed Former Caregiver I regarding Resident 1's admission. Surveyor reported after reviewing the provider's staff schedule, it indicated Caregiver I had worked the 3rd shift (10:30pm-630am) from 12/31/2026 to 01/01/2026. Surveyor shared Legal Representative E had reviewed video footage from a camera placed in Resident 1's room and it showed staff did not provide overnight care on 12/31/2025 into 01/01/2026 and his/her door remained shut the whole night without staff coming into Resident 1's apartment. Former Caregiver I confirmed s/he worked that day. Former Caregiver I reported s/he could not recall details of that shift but noted concerns with management not informing staff when the provider got new residents. Former Caregiver I stated s/he was only trained for 2 days, and some staff were trained differently, for example if a	N 385		

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resident's door is closed, we do not check on them even if their care plan indicated to do so.

On 04/14/2026 at 2:30 PM, Surveyor conducted an exit conference and shared findings with Health Services Director A, Nurse C, and Interim Executive Director J. Surveyor shared concern for the lack of documentation on the provider's care tracking sheet for 12/31, 01/01, and additional dates above. Health Services Director A clarified within the care tracking sheet shift I, shift II, and shift III correlated with staff shifts. The management team acknowledged if cares were completed they should have been documented. Surveyor shared after reviewing Resident 1's pre-admission assessment, the document indicated Resident 1 used a walker and wheelchair as assisted devices, but Resident 1's TSP did not include this information. Nurse C reviewed Resident 1's TSP while on the call and confirmed this information was missing. Surveyor shared Legal Representative E had reviewed video footage from a camera placed in Resident 1's room and it showed staff did not provide overnight care on 12/31/2025 into 01/01/2026 and his/her door remained shut the whole night without staff coming into Resident 1's apartment. The management team stated they did not know Resident 1 had a camera in his/her room but acknowledged an understanding of the above concerns. The management team stated retraining would be provided.