STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014758	A. BUILDING: _____ B. WING _____	C 08/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERY MEMORY CARE	**215 BIRCH STREET WEST AMERY, WI 54001**

(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 08/13/2026, Surveyor conducted a complaint investigation at Amery Memory Care. Data was collected through 08/24/2026. One of 3 complaints was substantiated. Two violations were identified. One of 2 violations was a repeat deficiency. See Statement of Deficiencies (SOD) Y2XJ11, dated 06/02/2025; SOD CQ9P11, dated 10/28/2022; and SOD T19F11, dated 10/29/2020. Census: 20	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify Resident 1's legal representative when there was an incident regarding medication. This is a repeat deficiency. See Statement of Deficiencies (SOD) Y2XJ11, dated 06/02/2025, SOD CQ9P11, dated 10/28/2022, and T19F11, dated 10/29/2020.	N 169		

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

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N 169	Continued From page 1 Findings include: On 05/06/2026, the Department received a complaint regarding medications. The provider is licensed for 68 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. On 08/17/2026 from 1:28 PM to 2:10 PM, Surveyor interviewed Power of Attorney (POA) A who stated that Resident 1 had refused his/her Escitalopram (Lexapro) 10 MG tablet for depression, but s/he was not informed until a week later. POA A stated Resident 1 stopped taking the medication and s/he believed this contributed to an increase in behaviors, and s/he was concerned this was a medication that needed to be tapered. On 08/13/2026 at approximately 1:45 PM, Surveyor interviewed Resident 1 who stated that s/he was not taking any medication for depression. On 08/17/2026, Surveyor reviewed Resident 1's record that included the following: -Resident 1's information sheet indicated s/he was admitted on 09/30/2025 and was diagnosed with depression. Resident 1 had an activated POA. -Physician orders dated 09/25/2025 indicated Escitalopram was ordered and it was for depression. -A medication administration record (MAR) from 02/2026 indicated Resident 1 was taking Escitalopram (Lexapro) 10 MG Tablet daily at bedtime and had refused the medication from	N 169		

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N 169	Continued From page 2 02/09/2026 through 02/16/2026. -An email communication from Administrator B, dated 08/18/2026 at 2:07 PM contained an email from Resident Health Coordinator (RHC) C to POA A, that read, in part, "...[Resident 1] reported ...hasn't been taking it [Escitalopram] at bedtime as scheduled and when I [RHC C] asked [him/her] why [s/he] reported that [s/he] has never been depressed a day in [his/her] life and doesn't need to take it ...I [RHC C] ...checked and [Resident 1] hasn't taken the medication for a week ..." The provider did not notify POA A when Resident 1 refused his/her depression medication for 8 days.	N 169		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the	N 410		

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N 410	Continued From page 3	N 410		

provider did not report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after Resident 1 refused a medication for 2 consecutive days.

Findings include:

On 05/06/2026, the Department received a complaint regarding medications.

The provider is licensed for 68 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged.

On 08/17/2026, Surveyor reviewed Resident 1's record. Resident 1's information sheet indicated s/he was admitted on 09/30/2025 and was diagnosed with depression. A medication administration record (MAR) from 02/2026 indicated Resident 1 refused Escitalopram (Lexapro) 10 MG Tablet from 02/09/2026 through 02/16/2026.

Surveyor requested documentation of Resident 1's Escitalopram (Lexapro) refusals being reported to the medical provider.

On 08/18/2026 at 12:43 PM and 1:52 PM, Surveyor received 2 email communications from Administrator B that read, in part:
-"[Administrator B] cannot find the fax but reached out to [sic] provider looking for documentation on updates to them ...I [Administrator B] know we updated provider when we were switching the order to AM since [Resident 1] didn't like taking medications at HS [bedtime] ..."
-" ...here is information from the clinic. But I [Administrator B] called the clinic on 02.16.2026 I [Administrator B] explained the refusals and

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N 410	Continued From page 4 requested the medication to be switched to AM shift ..." Administrator B was unable to find proof the medical provider was notified after Resident 1 refused Escitalopram (Lexapro) for 2 consecutive days. Administrator B could only find proof the medical provider was notified on the 8th day Resident 1 refused (Escitalopram (Lexapro). The provider did not notify Resident 1's physician when Resident 1 refused his/her Escitalopram (Lexapro) depression medication for 8 days.	N 410		