STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019367	A. BUILDING: _____ B. WING _____	C 08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5330	5330 CENTURY AVE MIDDLETON, WI 53562

(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 07/14/2026 to 08/04/2026, Surveyors conducted 3 complaint investigations at Sage Meadows of Middleton. Six deficiencies were identified. Two of 6 deficiencies was a repeat violation. See Statement of Deficiency (SOD) FIB911 dated 09/15/2025 and SOD DMOH11 dated 08/29/2024. Three of 3 complaints were substantiated. Census: 45	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 ensure the legal representative of Resident 1 was immediately notified when there was an incident affecting the resident. Resident 1's guardian was not notified of a new injury first discovered on 05/30/2026 and 06/02/2026. The provider did not complete an investigation into the injuries until 06/12/2026.	N 169		

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

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This is a repeat deficiency. See Statement of Deficiency (SOD) FIB911, dated 09/15/2025.

Findings include:

On 06/30/2026, the Department received a complaint alleging the provider did not notify legal representatives of incidents/injuries.

On 07/14/2026, Surveyor reviewed Resident 1's closed record and identified the following:

Resident 1 was admitted to the facility on approximately 02/04/2026 with a diagnosis of dementia. Resident 1 had a legal guardian (Guardian P). Resident 1 discharged on 06/28/2026.

Resident 1's progress notes documented:
"06/02/2026 written by [Director F]: writer and med passer went to assist with getting the resident cleaned up for the day. The resident was resistant at first but began to cooperate. Writer and med passer were able to shower the resident, wash the resident's hair, and dress [him/her] in clean clothes. Resident was very appreciative and happy about [his/her] cares. Writer did observe scabbed scratches on the resident's left hand. Writer did not observe any redness, bruising, or discoloration on the resident. No concerns at this time."

Resident 1's incident report dated 06/09/2026 documented:
"As reported by [Guardian P]: I noticed the 4 marks on [his/her] left hand and the bruising associated with it on the top of [his/her] hand and down [his/her] fingers. Due to [his/her] aphasia, [s/he] was not table to tell me what had

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happened, aside from trying to act out someone or something hitting it, and also that it looks worse than it feels. Are there any details on what happened?"

On 08/04/2026, Surveyor reviewed email correspondences between Executive Director A, Guardian P, and Dementia Case Manager W. Dementia Case Manager W sent the following to Executive Director A and Guardian P on 06/05/2026 at 4:09 PM: " ... I stopped by for a visit today around 2:00. When I arrived [s/he] was sleeping on the couch ....I noticed the 4 marks on [his/her] left hand and the bruising associated with it on the top of [his/her] hand and down [his/her] fingers. Due to [his/her] aphasia, [s/he] was not able to tell me what had happened, aside from trying to act out someone or something hitting it, and also that it looks worse than it feels. Are there any details on what happened?"

Guardian P responded on 06/06/2026 at 11:18 AM: "I'm glad [s/he] woke up and you were able to have some good interaction with [him/her]. I am also looking forward to hearing what happened to [his/her] hand as I did not get contacted."

Executive Director A responded on 06/12/2026 at 6:05 PM: " ...I wanted to send a follow-up regarding [Resident 1's] marks noted on [his/her] hand during a visit. This was first noticed on 5/30 and then again during a shower on 6/2/2026. We have done our investigation which included interviewing all staff who have worked on [Resident 1's] unit. The investigation looked into the injuries of unknown origin. At this time, I do not have a definitive answer as to how the red marks/scratches occurred to [Resident 1's] hands. [Resident 1] wanders throughout the unit,

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and can be resistive with our staff including striking out at them. Our team attempts to redirect [Resident 1] or come back at another time to complete the task. [Resident 1] continues to be monitored throughout the day as outlined in his care plan."

Guardian P responded on 06/13/2026 at 11:38 AM: " .... If it was noted on May 30 and again on June 2, I am not sure why I was not contacted. I was made aware from [Dementia Case Manager W's] visit on June 5 and attached are the pictures from June 5 which show a lot of bruising, swelling, and the scratches. If this was due to [him/her] being combative, [s/he] would've had to really hurt someone with [his/her] hand. Are we doing a behavioral tracking because I would be curious to know if [s/he] is causing this level of physical aggression to the staff to cause this injury? It does not look like it was a simple bump to a door or dresser or something. I do acknowledge that there is probably at this point no way in knowing, but it is pretty concerning to me."

On 07/14/2026 at 1:30 PM, Surveyor interviewed Executive Director A regarding Resident 1's injury of unknown source. Executive Director A stated the provider completed an investigation after Guardian P brought up the concerns in early June. Executive Director A did not provide a reason why Guardian P was not notified about the above injuries when first observed by the provider on 6/2.

On 08/03/2026 at 1:49 PM, Surveyor interviewed Guardian P via phone. Guardian P reported s/he was the corporate guardian for Resident 1. Guardian P reported ongoing challenges with the provider informing him/her of injuries that were

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N 169	Continued From page 4 observed on Resident 1 and incidents. Guardian P reported the provider threatened to give Resident 1 a 30-day notice in May 2026, so s/he got Dementia Case Manager W involved to consultant and provide training to the facility. Guardian P reported when Dementia Case Manager W went to the facility on 6/5, s/he observed Resident 1's left hand bruised and notified the team including the provider. Guardian P reported the provider conducted an investigation which noted Resident 1's injury was first observed on 5/30 and 6/2. Guardian P stated the provider never notified him/her of Resident 1's injuries until Dementia Case Manager W observed on 6/5. Guardian P stated s/he was not notified about the investigation results until 6/12.	N 169		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. From 02/06/2024 to 07/21/2026, the provider did not comply with all the laws governing the CBRF as evidenced by 22 violations identified, 2 repeat deficiencies and 8 substantiated complaints. FINDINGS INCLUDE: Facility was issued a probationary license on	N 196		

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N 196	Continued From page 5 05/24/2023 and a regular license on 05/01/2024 is a Class CNA non-ambulatory facility and has a capacity of 52 residents which serves advanced aged, irreversible dementia & Alzheimer's, physically disabled and developmentally disabled. Example 1: Obtain and maintain compliance with laws governing the CBRF: On 02/06/2024, Surveyor conducted a survey. As a result of the survey 1 violation was identified in SOD 3PSC11: 1.) 83.35(3)(c) Implement, Follow The Individualized Service Plan On 08/29/2024, Surveyor conducted a survey. As a result of the survey 1 complaint was substantiated, and 1 violation was identified in SOD DM0H11: 1.) 83.32(3)(i) Rights Of Residents: Adequate Treatment On 09/25/2024, Surveyor conducted a survey. As a result of the survey 1 complaint was substantiated and 3 violations were identified in SOD MHFQ11: 1.) 83.20(2)(a)-(d) Department Approved Training Courses 2.) 83.21(1)-(3) All Employee Training 3.) 83.32(3)(d) Rights Of Residents: Free From Mistreatment On 09/15/2025, Surveyor conducted a survey. As a result of the survey 1 complaint was substantiated and 1 violation was identified in SOD FIB911: 1.) 83.12(5)(a) Notification: Incident, Injury, Changes On 01/20/2026, Surveyor conducted a survey. As	N 196		

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N 196	Continued From page 6 a result of the survey 1 complaint was substantiated and 2 violations were identified in SOD Y2BI11: 1.) 83.12(2)(c) Report To Law Enforcement And Coroner 2.) 83.33(1)(d) Grievance Procedure Written Summary On 05/12/2026, Surveyor conducted a survey. As a result of the survey 2 complaints were substantiated and 9 violations were identified in SOD Y2BI12: 1.) 83.22(1)-(4) Task Specific Training 2.) 83.32(3)(b) Rights Of Residents: Confidentiality 3.) 83.32(3)(h) Rights Of Residents: Receive Medication 4.) 83.32(3)(n) Rights Of Residents: Safe Environment 5.) 83.35(3)(d) Service Plans Updated Annually Or On Changes 6.) 83.37(3)(f) Medication Storage: Internals And Externals 7.) 83.38(1)(i) Behavior Management 8.) 83.44(2)(a) Rooms Clean And Free From Odors 9.) 83.46(1)(c) Heating System Maintenance On 07/21/2026, Surveyor conducted a survey. As a result of the survey 3 complaints were substantiated and 6 violations were identified in SOD 69OV11: 1.) 83.12(5)(a) Notification: Incident, Injury, Changes 2.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 3.) 83.14(2)(j) Not Permit A Condition Of Substantial Risk 4.) 83.31(6)(a) Return Refunds To Resident Within 30 Days	N 196		

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N 196	Continued From page 7 5.) 83.32(3)(g) Rights Of Residents: Physical Restraints 6.) 83.32(3)(i) Rights Of Residents: Adequate Treatment Example 2: Repeat violations of laws governing the CBRF. 1.) 83.12(5)(a) Notification: Incident, Injury, Changes 2.) 83.32(3)(i) Rights Of Residents: Adequate Treatment Example 3: Number of Complaints Substantiated. 1.) SOD DMOH11 dated 08/29/2024, 1 complaint substantiated 2.) SOD MHFQ11 dated 09/25/2024, 1 complaint substantiated 3.) SOD FIB911 dated 09/15/2025, 1 complaint substantiated 4.) SOD Y2BI11 dated 01/20/2026, 1 complaint substantiated 5.) SOD Y2BI12 dated 05/12/2026, 2 complaints substantiated 6.) SOD 69OV11 dated 07/21/2026, 3 complaints substantiated EXIT INTERVIEW: On 07/14/2026 at 2:30 PM, Surveyors discussed the above concerns with Executive Director A and Regional Nurse H. Executive Director A and Regional Nurse H acknowledged Resident 3's ISP hadn't been updated with his/her changes in needs and physical condition including but not limited to changes in transfer status, compression fracture of the spine, acute kidney injury or admittance to hospice service. Executive Director A and Regional Nurse H acknowledged concerns	N 196		

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N 196	Continued From page 8 related to comprehensive assessments, adequate treatment, use of physical restraints without a provider order and sending refunds out to residents within 30 days.	N 196		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on record review and interview, the licensee permitted the existence or continuation of a condition which is or may create a substantial risk to the health, safety or welfare of any resident. Resident 1 had sexual behaviors towards Resident 2 on 06/21/2026 and 06/28/2026. The provider did not ensure adequate supervision was provided after the first incident and did not provide immediate measures necessary to keep Resident 2 safe. The provider did not mitigate risk to Resident 2 by assessing Resident 1's supervision level and updating Resident 1's individual service plan (ISP). In addition, Resident 2 was not assessed after the 06/21 incident. From April to June 2026, the provider staff documented substantial number of incidents related to Resident 1's sexual behaviors and intrusive behavior of entering other resident rooms. The provider did not take immediate steps to protect residents' health, safety, or welfare	N 205		

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resulting in 3 sexual incidents towards residents (Resident 2 (2x) and Resident 5) and incidents against 8 other residents (Resident 4, Resident 5, Resident 6, Resident 9, Resident 10, Resident 12, Resident 13, and Resident 14.)

Findings Include:

The provider is licensed to care up to 52 residents in the following client groups: developmentally disabled, physically disabled, irreversible dementia/Alzheimer's, and advanced age.

On 06/30/2026, the Department received a complaint alleging the provider was not managing a resident's behavior.

On 07/14/2026 to 08/04/2026, Surveyor reviewed resident records and identified the following:

Example 1: Resident 1's Sexual Incidents towards Resident 2 and Resident 5

Resident 1's incident reports documented:
"-06/28/2026: as reported to writer by care staff. Resident was found at 6:50 in another residents room. [S/he] was naked in the bed. Other resident was in the recliner. Other resident did not have anything on from the waist down. Resident had [excrement] on [his/her] legs backside and groin area. [Excrement] were in the dining room.

-06/21/2026 @ 1:40 PM: [Caregiver J] was doing my routine in the afternoon, but first I went to the bathroom, and when I came out of the bathroom in the Tuscan unit, [Resident 1] was leaving [Resident 2's] room. When I saw [him/her] leave, I went into the room to wake up the resident since during lunch [s/he] was very drowsy and didn't

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N 205	Continued From page 10 want to get up to eat. [His/her] [family member] ....tried to wake [him/her] up many times and [s/he] didn't want to get up. At two, I went into the room and found [him/her] in [his/her] recliner without clothes, with [his/her] shirt halfway on: the right side of the shirt was on [his/her] arm, and [s/he] didn't have the left side on. I immediately covered [him/her] with the sheet I had put on [him/her] to start dressing [him/her] while I asked [him/her] what happened, and [s/he] looked at me completely with a shocked face and at the same time confused. I started dressing [him/her], putting [his/her] arm into the shirt, and when [s/he] put it on, [s/he] touched the shirt and told me it was wet ....I kept asking [him/her] what happened because [s/he] had taken off [his/her] clothes and [s/he] wouldn't answer, [s/he] just stayed like I was too confused, I didn't know what was happening. I immediately gave [him/her] directions to leave the room so that I could have visual contact with [Resident 2] to find out what happened at that moment, but I realized when I asked [Resident 1] I asked [Resident 1] why [s/he] had gone into [his/her] room, and [s/he] just stayed quiet, didn't say anything, but the wet shirt smelled a lot like urine. The resident peed while the resident wasn't wearing clothes. [S/he] said [s/he] just went in to pee, and it was on [Resident 2]. While the resident was only wearing part of [his/her] blouse and had [his/her] [genital] exposed." Resident 1's progress notes: "-06/29/2026 @ 2:30 PM: 06/28/2026 writer was not able to chart yesterday due to poor wifi connection. Upon arrival resident was completely nude sitting in dining room ....Writer immediately grabbed some clothes for resident and asked [him/her] to put it on and [s/he] agreed. Resident put a fresh depend on with socks, shoes, shirt,	N 205		

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and pants. Resident sat in that spot for hours just looking around, not really like [him/her]. Resident would usually get up and go to other unit or walk around Tuscan but today [s/he] just sat there. Writer was told to keep [him/her] in sight. I would finish up little tasks getting the unit together but still keeping an eye on [him/her]. Resident finally got up and I followed. Resident was going down hallway past [Resident 8's] room. Writer was right behind [him/her] asking where [s/he] was going and if [s/he] needed help with anything. Resident did not respond. Resident kept going and stopped right in front of [Resident 2's] room. Writer told resident this isn't [his/her] room and I know where to find yours, lets got [sic] to yours. Resident continued walking with me to [his/her] room. Resident didn't stay long at all walked in and then out then sat back down in common area.

-06/21/2026: Spoke with guardian regarding incident of exiting other residents room and other resident was disrobed. Unwitnessed event. Other residents clothing had a urine soaked shirt. Guardian indicated that resident was admitted to [Hospice K] on 06/19 and the [Hospice K] RN was out on 06/20 to see resident.

Resident 2's incident reports and progress note documented:
"-06/28/2026: Per caregivers, resident was checked on at 6:50 am. [S/he] was in [his/her] room with [his/her] pajama top on and nothing on below the waist, and tennis shoes on [his/her] feet. Another resident was in [his/her] room without any clothes on. [Excrement] was on [his/her] lower belly and legs. Was treatment provided? Sent to [Hospital C] ER to evaluate for possible sexual assault.

-06/21/2026: incident notes: team member

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reported that other resident [Resident 1] was exiting resident's room. Resident was disrobed other than shirt on left arm. Clothing was wet. Other resident stated [s/he] urinated in the room. Incident was not witnessed."

Resident 5's progress notes documented: "-06/11/2026: writer spoked [sic] with the resident involved regarding the incident. The resident confirmed that the other resident [Resident 1] entered [his/her] room and touched [his/her] [expletive] without [his/her] consent. [S/he] stated that [s/he] yelled for help, at which time staff responded and removed the other resident from [his/her] room. The resident reported that [s/he] told the other resident don't touch me, but [s/he] did not stop until staff intervened. [S/he] stated that once staff arrived, the other resident stopped and moved toward the door. The resident also expressed that [s/he] understands the other resident has behavioral issues. Writer assessed the resident's well-being. Resident stated [s/he] is okay at this time. Writer apologized for the incident and encouraged the resident to report any further concerns or any unwanted contact immediately."

Record Review: Resident 1 and Resident 2

Resident 1 was admitted to the facility on approximately 02/04/2026 with a diagnosis of dementia. Resident 1 had a legal guardian (Guardian P). Resident 1 discharged on 06/28/2026. Resident 1's ISP dated 06/16/2026 and 06/26/2026 documented: aggressive/combative behaviors and destructive sections: "Care staff to approach [Resident 1] in a calm manner. One care staff at a time to approach [Resident 1] so [s/he] does not become overstimulated. Care staff to frequent check on

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[Resident 1] to ensure safety. Care staff to try and approach from in front of [Resident 1] rather than behind [him/her] as [s/he] may be startled and react negatively. Care staff to offer choices to [Resident 1], such as folding laundry, setting the tables, and other task related activities. Resident best responds to redirection through helping others. Ask resident if [s/he] will come and "help" you. [S/he] often becomes upset when told "to do" things, such as "this is not your room, let's get out of this room." Redirect resident and allow resident to call [him/herself]." The ISP did not identify interventions to mitigate sexual behaviors Resident 1 expressed towards fe/male residents on 06/11/2026, 06/21/2026, and 06/28/2026.

Resident 1's record contained a change of condition assessment dated 06/16/2026 and this document did not assess Resident 1's supervision needs or sexual behaviors.

Resident 1's care task report dated June 2026 indicated safety checks completed for wandering/elopement risk on the following dates: 06/28 (PM shift), 06/27 (PM shift), 06/26 (PM shift), 06/23 (PM shift), 06/22 (PM shift), 06/20 (PM shift), 06/18 (PM shift), 06/17 (PM shift), 06/16 (PM shift), 06/15 (PM shift), 06/13 (PM shift), 06/11 (PM shift), 06/08 (AM shift), 06/06 (PM shift), 06/04 (PM shift), 06/03 (PM shift), 06/01 (PM shift). No other safety checks were indicated as a task for staff and the above entries were not recorded consistently and only 1x/day.

There was no evidence in Resident 1's record of Resident 1 having been assessed after the 06/21/2026 incident.

On 06/26/2026, the provider issued Resident 1 a 30-day notice due to "imminent risk of serious

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harm to the health and safety of the resident, other residents or employees, as documented in the resident's record. Resident has an incident today of possible sexual assault of another resident which is under investigation by [Police Department B]."

Resident 2 was admitted to the facility on 08/05/2024 with a diagnosis of dementia. Resident 2's record indicated s/he had an activated healthcare power of attorney (Legal Representative N). Resident 2's ISP dated 07/20/2026 documented: "Dressing: care staff will provide two seasonal appropriate clothing choices for [Resident 2] each morning. Care staff will encourage [Resident 2] to dress [him/herself] to the best of [his/her] abilities. Care staff will provide hands-on assistance to complete all dressing tasks in the morning and night. Mental Illness: [Resident 2] is experiencing worsening memory and depression. [His/her] short-term memory is "nearly gone" per family. [Resident 2] will require staff assistance to give [him/her] reminders and cues for all ADLs. Communication: [Resident 2] requires the ability to communicate effectively with needs and wants." Resident 2's ISP did not include safety measures related to sexual incidents occurring on 06/21/2026 and 06/28/2026. There was no evidence in Resident 2's record of Resident 2 having been assessed after the 06/21/2026 incident.

A review of Resident 2's care task report dated June 2026 did not include any tasks assigned to staff related to safety or supervision checks.

Third Party Records:

On 07/17/2026, Surveyor reviewed Police Department B case #MI26010735. The following

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was summarized:
"On June 28, 2026 at 7:59 AM, [Director F] from [provider's name] called to report a sexual assault involving two residents in the memory care unit. [Director F] reported there was a [fe/male] [Resident 1] naked in a [fe/male's] [Resident 2] room ...[Director F] stated the [Resident 1] was asleep in the [Resident 2's] bed in [his/her] room. [Director F] added, the [Resident 2] was also naked and asleep in [his/her] recliner in [his/her] room ...[Director F] said later, [s/he] spoke with [Resident 2] at 7:30 AM. [Director F] said [s/he] asked [Resident 2] if [s/he] was okay or hurt in any way. [Director F] said [Resident 2] denied being hurt, but later changed [his/her] mind and said [s/he] began to hurt. [Director F] stated [Resident 2] then non-verbally gestured toward [his/her] groin area and crossed [his/her] legs. [Director F] stated [s/he] felt based on the situation, that [Resident 2] had potentially sexually assaulted by [Resident 1]...Prior Call Activity: On June 22, 2026 [Executive Director A] reported to [Police Department B] an incident which had occurred on 6/21/2026. In that incident, it was reported that [Resident 1] was seen by [provider's name] staff exiting [Resident 2's] room."

Resident 2's hospital records dated 06/28/2026 documented: "Pt arrived via EMS for sexual assault nurse exam (SANE). Pt has notable hx of dementia. Lives in a memory care facility. Per EMS, pt was reportedly found naked in [his/her] room with another naked resident. Neither individual able to articulate events."

"Prehospital care report 06/28/2026 @ 9:15 AM: MIM34 (ambulance number) was paged out for sexual assault victim at the nursing home. Upon arrival staff greeted EMS and stated that they found the resident (pt) in [his/her] recliner naked,

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with another resident in [his/her] bed naked as well ...[Legal Representative N] wants the pt transported for a SANE. Pt is baseline mentation, awake/alert, and confused. Pt has a strong radial pulse, no signs of respiratory distress and visual trauma exposed to skin (head, hands, legs from knee down)... Staff not able to provide any further events beyond what is noted."

Important to note Resident 2's blood pressure was 190/82 at 9:34 AM and 188/86 at 9:54 AM.

"What Happened: [RN O] spoked with [Executive Director A] ...[Executive Director A] reports that the staff asked [Resident 2] if someone had hurt [him/her]. [Resident 2] responded "Yes" and was "crossing [his/her] legs" and "covering [his/her] privates." [RN O] spoke with the [Legal Representative N]. [RN O] asked [him/her] what [s/he] knew about the situation that took place this morning, 6/28/26 ...[Legal Representative N] reports "[s/he's] not good at taking [his/her] clothes off" and questions how [Resident 2] would have removed [his/her] depends on [his/her] own. Additionally, [Legal Representative N] reports on Sunday 6/21/28 [provider's name] staff had contacted [him/her] because [Resident 2] was crying. On this day, [Resident 2] had told a female staff member "If [late husband/wife name] was here this wouldn't have happened."... Upon receiving call from [provider's name] staff on 6/28/2026, [Legal Representative N] went to the facility to visit [Resident 2]. As [Legal Representative N] was walking to the patient's room, [s/he] noted [Resident 1] "stopping by [his/her] room, but [s/he] didn't go in." [Legal Representative N] stated "[s/he's] been obsessed with [Resident 2] over the last few weeks, and reports [Resident 1] has been wanting to have contact with [Resident 2]...Final impression: FNE

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exam per protocol with consent from pts POA [Legal Representative N], and assenting patient. Lack of acute genital injury does not rule out sexual assault."

Example 2: Resident 1's sexual behaviors and intrusive behavior of entering other residents' rooms:

Resident 1's incident reports documented: "-05/12/2026: resident entered another resident's room [Resident 4] while the resident was asleep in bed. Resident then walked to the common area pulled [his/her] pants down and attempted to urinate while in the common area. Staff redirected the resident several times to use [his/her] own bathroom; however, the resident became physically aggressive toward staff and then attempted to sit on another resident who was sitting on the sofa in the common area, while [his/her] pants were still down. Resident also scratched a staff member. Writer initiated a hand over hand for safety purposes in order to help the resident calm down. Once the resident was calm, writer asked if [s/he] would continue fighting staff and or other residents if released. Resident stated "no" and asked where writer [s/he] wanted [him/her] to go. Writer instructed the resident to return to [his/her] room. Resident walked to [his/her] room and got into bed. Staff then quietly returned belongings that the resident had left out in order to avoid disturbing [him/her] while [s/he] was lying down.

-05/30/2026: caregiver found resident in another resident room [Resident 4] putting on their belonging.

-06/13/2026: I asked [Resident 6] what happened and [s/he] just said get [him/her] out of here. Staff

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N 205	Continued From page 18 came into the room to [Resident 1] lying in bed with [Resident 6]. -06/15/2026: resident went into another residents room [Resident 7] and wouldn't exit when other resident told them to leave. Other resident hit this resident with the cane into the arm." Resident 1's progress notes documented: "-06/21/2026: the resident entered [Resident 9's] room and [s/he] started screaming a lot, telling [him/her] to get out of the room, that [s/he] didn't want [him/her] there. [Resident 1] left the room, and the other resident kept yelling, saying [s/he] didn't like [him/her], that [s/he] comes in to bother [him/her], and [s/he] didn't want [him/her]. After a few minutes, the resident came back again, smiling, opened [Resident 9's] door, and then closed it. -06/20/2026: the resident dropped [his/her] [private part out] in front of [fe/male] residents on the farmhouse side during lunch. The resident then refused to let staff assist [him/her] with pulling them up and putting on underwear. -06/19/2026: Primary Care Physician (PCP) office called and stated that orders were placed and they will follow up with guardian to schedule an appointment to get them completed. -06/18/2026: geriatrics office called and updated on resident recent behaviors towards care staff and other residents. RN encourage to call PCP and request labs to be drawn to determine if there's any infections and/or imbalances before medication changes can be made. PCP office called to update on behaviors, informed that geriatrics office suggested labs to be completed to determine any issues before there's any	N 205		

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medication changes.

-06/13/2026: the resident went into [Resident 6's] room today and laid in the bed with [him/her] twice. Staff was helping another resident and heard [Resident 6] screaming "GET OUT, LEAVE ME ALONE!!" Staff redirected [him/her].

-06/12/2026: writer called PCP office and to update on resident's recent behaviors since medication change from quetiapine to mirtazapine. Resident continuing to refuse changes and become combative with staff, resident showering in other residents' room, and inappropriately touching another resident's breast without [his/her] consent. Per caller message will be sent triage nurses.

-06/09/2026: during the afternoon shift, staff found the resident in another resident's room [Resident 10]. [S/he] had been showering. Staff members took the resident to [his/her] room and helped [him/her] change [his/her] clothes.

-06/01/2026: late entry for 5/27/2026. Writer met with physician via telehealth regarding resident. From [Geriatric Clinic]. Explained issues that continue with resident, hitting staff when trying to change clothes, getting resident to come out of others rooms, and general redirection. Physician speaking with guardian is going to discontinue Seroquel and start mertazipine [sic]. Physician asked for us to contact clinic and guardian if behaviors continue and do not diminish.

-05/21/2026:...After dinner, resident continued walking around the facility. Staff later observed resident attempting to lay in another resident's bed [Resident 4]. Staff redirected resident and informed [him/her] that [s/he] was in another

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resident's bed. Resident responded appropriately, got up from the bed without issue, and resumed walking around the facility.

-05/20/2026: Writer communicated with [Managed Care Organization (MCO) L] , who was in the community completing a resident functional screening. The screening was initiated due to the previously unrecognized behaviors that were not identified during the initial assessment. The resident's POA requested that this reassessment be completed. Writer also spoke with [Home Health M] regarding palliative care services. The resident POA has reviewed and approved these services.

-05/17/2026: resident appeared somewhat irritable throughout the day. [S/he] was observed attempting to enter other residents rooms and trying to get into their beds, as if believing the rooms were for [his/her] own. When staff called [his/her] name, [s/he] paused and was able to be redirected away from the rooms.

-05/14/2026: resident required multiple redirections after entering other resident's rooms [Resident 12], [Resident 13], [Resident 14] without permission and attempting to exit through alarmed exit doors. Several residents reported that the resident entered their rooms and refused to leave. A few residents expressed distress and stated they wanted to contact police due to [his/her] refusal to exit their rooms. Resident was observed becoming physically aggressive toward staff when redirection was attempted. Behaviors included hitting and attempting to kick staff. Resident was resistant to leaving other resident's rooms and required repeated verbal cues (This resident needs privacy, We can go to your room , or let's go this way together.) Resident also

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attempted to push on alarmed exit door, causing door alarms to activate. Resident appeared agitated, confused, and not easily redirectable at the time of the incidents. Resident has also been trying to use the bathroom in residents laundry basket.

-05/12/2026:...During the afternoon shift, the resident was very aggressive, walking through hallways and entering other residents' bedrooms. [S/he] went to the farm house unit frequently and staff members tried to calm [him/her] down.

-05/10/2026:...Resident went into another resident room [Resident 5] and locked the door and resident was being loud and made other resident wake up ....Resident rest well in bed. Resident got up went in other resident room and the other resident was upset.

-05/07/2026:...During the afternoon/evening, the resident kept banging on doors and trying to enter other residents rooms except their own.

-05/04/2026: writer called and left voicemail messages for MCO's and guardian and spoke to PCP office that resident is becoming combative and taking other residents belongs. [S/he] is being aggressive with staff and not returning items that belong to other residents. Writer called and left a voicemail for the guardian to please call back last week about a situation and has yet to hear anything back. PCP office stated the resident had no appointment to see the provider and would call to re-schedule. Guardian called and inquired about the resident; [s/he] felt that the new medication was the that [sic] was recently started was the cause of the resident's behaviors. Writer stated that it very well could be or it could be a UTI. Writer asked the guardian if [s/he]

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would be able to take the resident in to meet with [his/her] new PCP and [s/he] would be, [s/he] would call and see when [s/he] could get the resident in.

-04/30/2026: writer called and left a voicemail for [Guardian P] as resident has become aggressive in activities with the pool noodles and the balloons hitting others on top of the heads including residents and staff. Activity director stated that last week [s/he] had hit [him/her] on the top of the head with a pool noodle and today [s/he] swung with [his/her] hand using the balloon and it hit another resident in the face.

-04/21/2026: ...the resident walked the hallways and entered other residents' rooms.

-04/08/2026: the resident refused to change [his/her] clothes. Several attempts were made, and [s/he] became defensive and aggressive. The resident tried to enter other room. [S/he] was told and directed back to [his/her] room on several occasions to rest, but [s/he] would go back out and walk in the hallways ....[Resident 1] keeps going into people room staring at them and when [s/he] sees me or someone else [s/he] runs. I told [him/her] to stay out of other people rooms and that was that, but this is a consistent thing [s/he] does."

Example 3: Resident 2's change of condition after sexual incidents

Resident 2's progress notes documented:
"-06/30/2026: resident came out lunch. [S/he's] been smiling all day and after [s/he] ate lunch [s/he] went to [his/her] room, [s/he] was toileted by writer. [S/he] was very normal and silent when writer was changing [his/her] underwear. Writer

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N 205	Continued From page 23 asked was [s/he] okay [s/he] smiled and said yes, [s/he] came back out to the common area with writer. -06/29/2026 @ 12:15 PM: 06/28/2026 writer wasn't able to do observation yesterday. Upon arriving in unit resident was in [his/her] room being checked out. Writer was not aware of what had happened. Resident ate breakfast in [his/her] room with [his/her] [Legal Representative N]. Resident was later taken to the hospital and arrived before lunch. Resident ate lunch in dining room with [Legal Representative N]. After [his/her] [Legal Representative N] writer noticed resident not like [him/herself]. Resident is very quiet, looking into space. Writer kept asking resident if [s/he] was okay or if [s/he] had any pain anywhere. Resident would reply no. Resident was like that all afternoon. Resident wouldn't get up as easy to simple direction which [s/he] usual does. Writer observed resident did not want to eat [his/her] dinner. It took [him/her] a minute to finally start and that was finally when everyone else was gone. Resident was later toilet and put in [his/her] pjs and to bed. Resident would usual get up after I do that and try to come back to dining table but [s/he] didn't. Writer went to check on [him/her] and [s/he] wasn't sleep but just laying there with [his/her] eyes open. I asked resident if [s/he] was okay or if [s/he] felt any pain anywhere and [s/he] said no. 06/29/2026: resident was brought down to dining area to eat breakfast. Resident just sat there. Resident sat there looking at [his/her] food for 40 minutes. Resident usually eats as soon as I set the plate down. To the point where writer tried to feed resident and [s/he] wasn't opening [his/her] mouth. Writer called residents name and asked if [s/he] was ready to eat and resident did not respond. After I got done cleaning up lunch and	N 205		

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all other residents were gone. Writer attempted to take plate from resident and [s/he] pulled it back. I said I'm going to save it for you if you don't want it right now [s/he] said I do. I heated it up for [him/her] and slowly but surely [s/he] started to eat. Resident finished all [his/her] breakfast and later for lunch did the same. Resident has been sitting in dining room all day unless [s/he's] getting toileted but [s/he] would just come back out. I observed just off working and knowing this resident for awhile that [s/he] was in fact not okay, not feeling like [him/herself] maybe and traumatized.

-06/29/2026 10:00 AM: writer mad [sic] contact with resident this morning, writer observed resident looking down, very quiet, writer went to touch residents' hand [s/he] was very jumpy, and resistant to touch. Writer tried to have a conversation with resident, resident remained quiet. Care staff gave resident [his/her] breakfast, writer tried to have resident eat some of [his/her] breakfast, resident would not eat. Writer notified ED and LPN nurse of concerns nurse informed writer [s/he] will make contact with resident as well ....Writer observed resident in the dining room sitting at the table. Vital sings obtained BP=114/65, P=69, R=18, T=97.6, O=97%. RA denied any pain or discomfort, bowel sounds present, lungs clear in all quadrants. When writer arrived, resident had [his/her] head down and appeared to be in [his/her] own world.

-06/25/2026 2 8:15 PM: resident came to the farmhouse dining room and sat quietly at one of the tables. Approximately 20 minutes earlier, a police officer had spoked with the resident regarding an incident involving another [fe/male] [Resident 1]. While in the dining room, staff heard the resident crying and observed [him/her]

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becoming visibly emotional. Staff approached the resident to assess [his/her] well being and asked what was wrong. The resident became increasingly tearful and repeatedly stated, "I wish my [husband/wife] was here. I really miss [him/her] so much." Staff remained with the resident, provided emotional support, actively listened, and offered reassurance while allowing the resident time to express [his/her] feelings. The resident continued to cry but remained seated in the dining room. The nurse/supervisor was notified of the resident's emotional distress. Staff will continue to monitor the resident's emotional status and provide support as needed. Prior to coming back to Tuscan to sit at the table, the resident's family members had also stopped by to visit [him/her] before [s/he] went to bed."

Interviews:

On 07/14/2026 at 12:00 PM, Surveyor interviewed Executive Director A. Surveyor asked who was responsible for updating resident ISPs. Executive Director A stated nursing was responsible.

On 07/14/2026 at 12:54 PM, Surveyor interviewed Executive Director A. Surveyor voiced concerns for Resident 1's ISP not being updated after 6/11 and 6/21 sexual incidents and repeated incidents of sexual behaviors. Executive Director A reported the building had a nursing change during this time and s/he would help where needed. Executive Director A acknowledged Resident 1's ISP did not address sexual behaviors and stated the team was focused on Resident 1's aggression and wandering. Executive Director A stated the provider was trying to get Resident 1 admitted but no one wanted to do in-patient. Executive Director A

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stated the provider investigated both incidents and completed all reporting requirements. Executive Director A stated after the 6/28 incident s/he spoke with Dane County crisis and was given directions to have the guardian agree to an in-patient psychiatric evaluation, where Resident 1 eventually went that day and never returned. Surveyor asked for clarification on Resident 1's ISP directing staff to complete "frequent checks" related to aggressiveness, combativeness, exit seeking/wandering behaviors. Surveyor shared that frequent checks was not a measurable intervention and vague. Executive Director A stated staff were expected to check on Resident 1 at least every 2-3 hours. Surveyor noted Resident 1's record contained a change of condition assessment dated 06/16 but this document did not assess supervision or sexual behaviors. Surveyor voiced concerns that Resident 1's supervision was not assessed after having a known history of repeated sexual incidents towards other residents. Executive Director A did not provide comments on why supervision was not assessed or why Resident 1's ISP was not updated.

On 07/14/2026 at 2:15 PM, Surveyor conducted an exit conference and shared findings with Executive Director A and Regional Nurse I. Executive Director A stated s/he had not received any police or medical records regarding the incident on 6/28. The management team acknowledged an understanding of the concern and did not provide any further comment.

On 08/03/2026 at 1:49 PM, Surveyor interviewed Guardian P via phone. Guardian P reported s/he was the corporate guardian for Resident 1. Guardian P reported ongoing challenges with the provider informing him/her of injuries that were

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observed on Resident 1 and incidents. Guardian P reported s/he did not know about Resident 1's 6/21 incident until s/he read the police report last week. Guardian P reported s/he kept asking the provider for a BSP but was told that it was Resident 1's managed care organization (MCO) responsibility to develop. Guardian P noted Resident 1's MCO told him/her that it was the provider's responsibility to develop a BSP, so s/he did not know the truth and both were not acting. Guardian P reported s/he met with Executive Director A and Regional Nurse Q virtually in June to discuss Resident 1's ISP but s/he never received a copy to sign. Guardian P reported Resident 1 moved to facility in February 2026 after having an elopement at the facility next door. Guardian P reported s/he warned the provider Resident 1 would have trouble remembering where his/her room was. Guardian P reported Resident 1 did not have a history of sexual behaviors but s/he started to worry about his/her safety and the safety of the other residents after the repeated incidents. Guardian P reported the facility never discussed assessing Resident 1's supervision with him/her. Guardian P stated Resident 1 had ongoing medication changes in June, but due to Resident 1's alcohol induced dementia s/he was having adverse effects to psychotropic medications that you would usually see prescribed to dementia residents. Guardian P reported s/he got palliative care and hospice involved and felt the provider kept saying things needed to change, implying "I needed to fix it." Guardian P stated s/he thought the provider was not doing enough to assist in Resident 1's health and safety.

On 08/04/2026 at 1:49 PM, Surveyor interviewed Legal Representative N regarding the above concerns. Legal Representative N reported s/he

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N 205	Continued From page 28 visits Resident 2, 3-4 times a week. Legal Representative N reported a few weeks before the 6/21 incident, s/he observed Resident 1 try to enter Resident 2's room when s/he was present, but when Resident 1 saw me [Legal Representative N], s/he immediately left the room. Legal Representative N reported another incident with Resident 1 trying to sit at the same dining room table as Resident 2 for meals, and this never had been witnessed before. Legal Representative N stated s/he never reported this to the provider because s/he did not know Resident 1 was a danger to other residents. Legal Representative N reported s/he was notified by the provider after both incidents. Legal Representative N reported after the 6/21 incident s/he went to the facility and observed Resident 2 more talkative than s/he usually was and had brought up to staff about his/her [late husband/wife] who had passed away 37 years ago. Legal Representative N stated s/he was concerned after the first incident because Resident 2 was vulnerable and unable to take his/her clothes off independently. Legal Representative N reported after the 6/28 incident s/he got angry and questioned how this could happen a 2nd time if staff had been supervising Resident 1. Legal Representative N stated there had been discussion from management to provide supervision for Resident 2, but nothing ever was put into place.	N 205		
N 332	83.31(6)(a) Return refunds to resident within 30 days Disbursement of funds. The CBRF shall return all refunds due a resident within 30 days of the date of discharge as required under s. DHS 83.29(3).	N 332		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not return all refunds due to Resident 15 and Resident 16 within 30 days after discharge.

Findings include:

On 06/04/2026, the Department received a complaint alleging concerns the provider did not timely refund all money due.

On 07/14/2026, Surveyor reviewed Resident 15's and Resident 16's closed records. Resident 15 and Resident 16 were admitted to the facility on 06/17/2025 and discharged on 04/28/2026. Both residents had the same activated healthcare power of attorney (Family Member T).

Resident 15's and Resident 16's admission agreement dated 06/17/2025 and signed by Family Member T documented:
"F. Amount of Refund:
Following this Agreement's termination, the Community shall pay You or your estate a refund equal to any unused prorated portion of your final Basic Services Fee and Level of Care Fee, minus the following: (1) amount of any unpaid Basic Services Fees, Level of Care Fees, fees for optional services, or other charges that You owe to the Community under this Agreement; (2) the costs of repairing any of the Community's property that was damaged by You or your visitors, excluding normal wear and tear; and (3) any expense incurred by the Community to remove and/or store any of your property that was not removed when You vacated your Apartment. You or your estate will receive any refund that is

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due under this Agreement within (30) business days following the date of your discharge, transfer, or death. If the amount You owe to the Community exceeds the sum of the combined total of your final Basic Services Rate Fee and Level of Care Fee, the Community will bill You for the difference. Community will send any refund or difference to the resident, the resident's personal representative, or the resident's estate."

Surveyor reviewed email correspondences between Executive Director A, Director F, Accountant S, Family Member T, and Chief Operating Officer (COO) U:
"From Family Member T to Director F and COO U dated 04/28/2026: ...Having completed the removal of [Resident 15's and Resident 16's] personal belongings from [provider name] today, Tuesday April 28, 2026, following receipt of the April 24, 2026 eviction notice from [COO U], I am requesting a refund of payments made for the last two days of April per paragraph F, page 15 of the Admissions Agreement from June 17, 2025, between [provider's name] and [Resident 15] and Resident 16]. Payments totaling $8888 were made to the facility for the month of April. Accordingly, we are expecting a refund of 2 days/30 April days times $8888=$592.53. As described in paragraph F, page 15, please send the refund within 30 days to me at the address below."

"From Family Member T to Director F and COO U dated 06/02/2026: ...I am writing in follow up to my letter from April 28, 2026, copied below. It is now more than 30 days since [Resident 15 and Resident 16] have vacated their room at [provider's name] following the eviction notice from [COO U]. As noted in my letter, the Admission Agreement is very clear that a refund

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N 332	Continued From page 31 is to be issued for any unused prorated portion of services fees, per paragraph F, page 15. For the last 2 days of April, that prorated amount comes to $592.53 that should have been refunded to us within 30 days. To avoid fines and legal fees, please send the refund to me at the address below. If we do not receive the full refund within 3 days, we will need to pursue legal action." "From Executive Director A to Accountant S dated 06/03/2026: ...Good morning. Please know the refund check for [Resident 15] is now out of compliance with regulatory requirements under DHS 83. Please make sure this check is paid today. [Business Office Director V] had notified right after the family left (about April 29). Can you please let us know when this is paid so that we may notify the family that the check was sent. Please overnight this check to the family. Accountant S responded: good morning [Executive Director A], no I did not because we have not been able to process a refund until this week due to payroll, it'll go out today and it cannot be overnighted we do not have the ability to do this." On 07/14/2026 at 11:14 AM, Surveyor interviewed Executive Director A regarding the above concerns. Executive Director A reported the refund owed to Resident 14 and Resident 15 had been paid in June but acknowledged the refund was not issued within 30 days. Executive Director A reported the provider used a third-party vendor to issue checks and the company did not issue Resident 14's and Resident 15's in time.	N 332		
N 351	83.32(3)(g) Rights of Residents: Physical restraints	N 351		

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N 351	Continued From page 32 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from physical restraints. Be free from physical restraints except upon prior review and approval by the department upon written authorization from the resident ' s primary physician or advanced practice nurse prescriber as defined in s. N 8.02(2). The department may place conditions on the use of a restraint to protect the health, safety, welfare and rights of the resident. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1 was free from physical restraint. Findings include: On 07/14/2026, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on approximately 02/04/2026 with a diagnosis of dementia. Resident 1 had a legal guardian (Guardian P). Resident 1 discharged on 06/28/2026. Resident 1's individual service plan (ISP) dated 06/16/2026 and 06/26/2026 documented: aggressive/combative behaviors and destructive sections: "Care staff to approach [Resident 1] in a calm manner. One care staff at a time to approach [Resident 1] so [s/he] does not become overstimulated. Care staff to frequent check on [Resident 1] to ensure safety. Care staff to try and approach from in front of [Resident 1] rather than behind [him/her] as [s/he] may be	N 351		

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startled and react negatively. Care staff to offer choices to [Resident 1], such as folding laundry, setting the tables, and other task related activities. Resident best responds to redirection through helping others. Ask resident if [s/he] will come and "help" you. [S/he] often becomes upset when told "to do" things, such as "this is not your room, let's get out of this room." Redirect resident and allow resident to call [him/herself]." The ISP did not identify use of a physical restraint as an intervention for aggressive behaviors.

Resident 1's progress notes documented: "-05/12/2026 at 10:15 PM written by [Caregiver R]: resident entered another resident's room while the resident was asleep in bed. Resident then pulled [his/her] pants down and attempted to urinate. Staff redirected the resident several times to use own bathroom; however, the resident became physically aggressive toward staff and attempted to sit on another resident while [his/her] pants were still down. Resident also scratched staff members. Writer initiated a physical hold for safety purposes in order to help the resident calm down. Once the resident was calm, writer asked if [s/he] would continue fighting staff or other residents if released. Resident stated "no" and asked where writer wanted [him/her] to go. Writer instructed the resident to return to [his/her] room. Resident walked to [his/her] room and got into bed. Staff then quietly returned belongings the resident had left out in order to avoid disturbing [him/her] while [s/he] was lying down.

-05/12/2026 at 10:30 PM written by [Caregiver R]: resident was fighting staff resident sat on staff whole arm causing it to be im [sic] seveer [sic] pain. Resident was hitting other resident, resident came out of [his/her] room naked no clothes or

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N 351	Continued From page 34 underpants on." Resident 1's incident report dated 05/12/2026 completed by [Caregiver R] documented: -"05/12/2026: resident entered another resident's room while the resident was asleep in bed. Resident then walked to the common area pulled [his/her] pants down and attempted to urinate while in the common area. Staff redirected the resident several times to use [his/her] own bathroom; however, the resident became physically aggressive toward staff and then attempted to sit on another resident who was sitting on the sofa in the common area, while [his/her] pants were still down. Resident also scratched a staff member Writer initiated a hand over hand for safety purposes in order to help the resident calm down. Once the resident was calm, writer asked if [s/he] would continue fighting staff and or other residents if released. Resident stated "no" and asked where writer [s/he] wanted to go. Writer instructed the resident to return to [his/her] room. Resident walked to [his/her] room and got into bed. Staff then quietly returned belongings that the resident had left out in order to avoid disturbing [him/her] while [s/he] was lying down. Contact information Physician Notified? "No" was checked ....Recommended steps to help prevent a recurrence of event: staff will continue to closely monitor the resident during overnight hours and redirect [him/her] when attempting to enter other residents' rooms. Staff will encourage the resident to use [his/her] own bathroom and provide verbal redirection before behaviors escalate. Resident's environment will be kept calm and safe and staff will maintain awareness of the resident's whereabouts to reduce future incidents. Staff will also continue using de-escalation techniques and follow the care plan to prevent aggressive behaviors	N 351		

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N 351	Continued From page 35 towards residents and staff. How was neglect and abuse ruled out? Neglect and abuse were ruled out because staff responded immediately to ensure the safety of all residents involved. Staff provided redirection, close supervision, and physical intervention only when necessary to prevent harm to the resident, other residents, and staff members. The intervention used was for safety purposes and discontinued once the resident was calm and compliant. Staff continued monitoring the resident afterward and assisted in returning [him/her] safely to [his/her] room. There was no signs that staff acted with intent to harm, neglect, or improperly handle the resident during the incident. Supervisor wanted staff to make an incident report on what happened with the resident and contact residents POA." On 07/14/2026, Surveyor reviewed the provider's facility e-file. Surveyor did not observe evidence of a prior review and approval by the Department for authorized use of a restraint. On 07/14/2026 at 12:00 PM, Surveyor interviewed Executive Director A. Surveyor reviewed Resident 1's progress note and incident report entries from 05/12/2026. Surveyor voiced concerns that staff used a physical restraint to restrict Resident 1's movements. Executive Director A stated staff are not supposed to perform physical holds on the residents ever. Executive Director A asked what staff wrote the progress note and incident report, Surveyor noted Caregiver R. Executive Director A stated due to Resident 1's aggressions, staff would provide blocking when s/he exhibited aggressive behaviors but not any holds. Executive Director A stated the Surveyor would need to talk to Director	N 351		

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N 351	Continued From page 36 F regarding the above incident. On 07/14/2026 at 12:30 PM, Surveyor interviewed Director F. Director F demonstrated how staff would perform a blocking intervention if Resident 1 exhibited aggressive behaviors. Director F stated Resident 1 would be standing up against a wall, arms crossed over chest, and staff holding his/her hands against his/her chest so s/he did not hit staff. Surveyor noted conflicting statements made by Caregiver R in Resident 1's progress note from 5/12, which indicated a "physical hold" was used and in Resident 1's incident report from 5/12, Caregiver R indicated a "hand over hand" was initiated for safety purposes. In addition, Surveyor noted Resident 1's record indicated s/he was held until s/he was calm. Director F stated the above demonstration is what Caregiver R reported was done. Director F did not provide further comment. On 07/14/2026 at 2:15 PM, Surveyor conducted an exit conference and shared findings with Executive Director A and Regional Nurse I. The management team acknowledged an understanding of the concern. Executive Director A stated staff would be retrained. On 08/03/2026 at 4:03 PM, Surveyor interviewed Guardian P via phone regarding the above concern. Guardian P reported s/he was informed of Resident 1's behaviors on 5/12, but was never told a hold was used. Guardian P stated s/he was surprised to hear this news.	N 351		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats.,	N 353		

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N 353	Continued From page 37 each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide Resident 3 with prompt and adequate treatment that was appropriate to his/her needs. On 03/24/2026, Resident 3 experienced a fall and was sent to a local emergency room (ER). Where s/he was diagnosed with fracture of the vertebrae. Discharge instruction from ER included Resident 3 to return to ER if unable to transfer at his/her baseline, unable to urinate or experiencing severe pain. From 03/25/2026 to 04/09/2026, Resident 3 demonstrated inability to transfer or ambulate at his/her baseline. Resident 3 experienced 2 falls. On 04/10/2026, Resident 3 was sent to ER due to recent falls and increased weakness. From 03/24/2026 to 05/01/2026, Provider did not complete a comprehensive assessment upon changes in Resident 3's condition, nor update his/her individualized service plan (ISP). This is a repeat statement of deficiency (SOD) DMOH11 dated 08/19/2024. FINDINGS INCLUDE: On 05/28/2026, The Department received a complaint with allegations of inadequate treatment.	N 353		

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N 353	Continued From page 38 On 07/14/2026, Surveyors arrived at the facility for a complaint investigation. RECORD REVIEW: On 07/14/2026, Surveyor reviewed Resident 3's facility record. Resident 3 was admitted to the facility on 03/04/2024. Resident 3 had an activated power of attorney. Resident 3 was diagnosed with but not limited to: chronic kidney disease, unsteady gait and reduced mobility. On 07/14/2026, Surveyor reviewed Resident 3's individualized service plan (ISP). The ISP wasn't signed by Resident 3 or his/her legal guardian. The ISP was documented as, "Current Ongoing Care Plan..." The subsection titled, "AMBULATION - 1 PERSON ASSIST," the following needs were documented, "[Resident 3] ambulates short distances with 1 person assist using [his/her] wheelchair. The subsection titled, "TRANSFERRING- 1 PERSON ASSIST" the following needs were documented, "[Resident 3] requires one person assistance with pivot transferring ..." The subsection titled, "FALL RISK - HIGH," the following was documented, " ... [Resident 3] has been identified as a high fall risk individual. Care staff are to monitor [him/her] frequently and reminds residents to use [his/her] pendant ...Resident's Desired Goals: [Resident 3] to be free from falls. The subsection titled, "TOILETING - 1 PERSON ASSIST," the following was documented, " ...Partial assistance needed with toileting ...Care staff will assist [Resident 3] as needed with toileting cares. Care staff will monitor and notify community RN with any changes and concerns. On 07/14/2026, Surveyor reviewed Resident 3's	N 353		

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N 353	Continued From page 39 assessments documented from 03/01/2026 to 05/01/2026: 1.) On 03/24/2026, Staff G documented a fall risk assessment. Under the subsection titled, "INTERVENTIONS in place," the following was documented, "Care staff to ensure resident is steady on feet when transferring in and out of shower. Staff are encouraged to remind resident to ask/ call for help. Increased fall risk checks added. Added safety checks keep area clean from clutter. Remind resident to use call light for assistance. [Resident 3] educated on continuing/using [his/her] call light to call for help when wanting to get up to the bathroom during the night. Care staff to document and notify community RN of changes or concerns. 1/8/26-Resident was being assisted to bathroom and was next to toilet when [s/he] leaned into the wall and bumped [his/her] forehead on the wall and slid to the floor on [his/her] knees. OT will eval and treat ..." 2.) On 04/04/2026, Practical Nurse H documented a fall risk assessment. Under the subsection titled, "INTERVENTIONS in place," the following was documented, "Staff are encouraged to remind resident to ask/ call for help. Increased fall risk checks added. Added safety checks. Keep area clean from clutter. Remind resident to use call light for assistance. [Resident 3] educated on continuing/using [his/her] call light for help when wanting to get up to the bathroom during the night. Care staff to document and notify community RN of changes or concerns. 1/8/26-Resident was being assisted to bathroom and was next to toilet when [s/he] leaned into the wall and bumped [his/her] forehead on the wall and slid to the floor on [his/her] knees. OT will eval and treat ..."	N 353		

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N 353	Continued From page 40 3.) On 04/05/2026, Staff G documented a fall risk assessment. Under the subsection titled, "INTERVENTIONS in place," the following was documented, "Awaiting approval orders from PT/OT from PCP to assist resident with transfer and help gain strength. Staff are encouraged to remind resident to ask / call for help. Increased fall risk checks added. Added safety checks. Keep area clean from clutter. Remind resident to use call light for assistance. [Resident 3] educated on continuing/using [his/her] call light to call for help when wanting to get up to the bathroom during the night. Care staff to document and notify community RN of changes or concerns. 1/8/26-Resident was being assisted to bathroom and was next to toilet when [s/he] leaned into the wall and bumped [his/her] forehead on the wall and slid to the floor on [his/her] knees. OT will eval and treat ..." On 07/14/2026, Surveyor reviewed Resident 3's observation notes from 03/01/2026 to 05/02/2026: 1.) On 03/24/2026 at 11:15 AM, Caregiver E documented, "Resident is not getting [himself/herself] up from thr (sic.) bed canaet (sic.) turn [himself/herself] anymore and staff is having to pull [him/her] up with no assistance from the resident [s/he] is started to bare on staff back ..." 2.) On 03/24/2026 at 2:00 PM, Director F documented, "Incident Notes:Writer (sic.)was giving resident an emergency shower once the shower was over. Writer grabbed a wheelchair. Put a towel down on the seat resident sat down writer asked resident was [s/he] ready resident stated yes. So writer began to unlock wheelchair and move backwards. Resident began to slip out of chair onto the shower floor. [S/He] did not hit	N 353		

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[his/her] head, but [s/he] did slide from on [his/her] bottom, so [s/he] has redness on [his/her] bottom and lower back. Writer called two staff to help get resident off the floor. We used Hoyer writer called AED (assistant executive director) and writer called a POA to let [him/her] know what happened [s/he] asked was resident in pain. Writer stated yes lower back pain and stated that resident refused to go out ...."

3.) On 03/25/2026 at 10:30 PM, Caregiver D documented, "Resident was in too much pain to give a shower [s/he] barely could help the writer walk [him/her] to the bathroom. Writer had to go and get a second staff just to get [him/her] in (sic.) the toilet ..."

4.) On 03/27/2026 at 10:45 PM, Caregiver AA documented, "Residents briefs changed 10 20 pm (sic.), writer found little amount of urine in briefs ..."

5.) On 04/01/2026 at 7:30 PM, Caregiver E documented, "Resident lost balance 3 times while staff was trying to stand [him/her] up ...also having a hard time sitting up on [his/her] own ..."

6.) On 04/03/2026 at 10:15 AM, Practical Nurse H documented, "Writer spoke to resident this morning with another staff member present and asked [Resident 3] if [s/he] felt if [s/he] was having a hard time getting in and out of bed. [S/He] stated yes, [s/he] was ...[Resident 3] was in agreeance for writer to call PCP (primary care provider) to obtain an order for additional anti-depressant, a E-Z stand/sit-to-stand for PRN use and to continue PT/OT for strengthening, as [s/he] is getting weaker r/t [his/her] last fall ..."

7.) On 04/04/2026 at 6:15 PM, Director F

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documented, "Incident Notes:residents (sic.) were given shower by staff asked [him/her] to stand still while staff dry [him/her] off, [s/he] tried to sit on the toilet and slid down to [his/her] bottom, Resident did not hit [his/her] head. resident (sic.) slide down to the floor peers help resident off the floor ..."

8.) On 04/05/2026 at 7:15 PM, Director F documented, "Incident Notes:Writer (sic.) and Care staff was (sic.) toileting resident While (sic.) standing resident, spoke out and stated, "I'm losing my grip, residents legs gave out staff assisted resident down to the floor. While holding to gate (sic.) belt. Resident did not hit [his/her] head; resident did not sustain any injuries ..."

9.) On 04/06/2026 at 8:00 PM, Caregiver E documented, "When writer changed resident [s/he] was having a hard time trying to stand, [s/he] also [his/her] kneeae (sic.) were giving out writer was able to pull up underwear and fix when [s/he] was lying on [his/her] back."

10.) On 04/07/2026 at 3:15 PM, Practical Nurse H documented, " [Family Member X] came to see [Resident 3] today and let staff know that [s/he] was in pain in [his/her] back. Writer went to speak to [Resident 3] about [his/her] back pain, encouraged [Resident 3] to let [him/her] know that [s/he] had PRN (as needed) Tylenol and should ask for it as staff would give it to [him/her]. Writer also provided ice for [him/her] to the area that was in pain 3-4/10 for [his/her] back pain. Writer then called [Family Member X] to let [Family Member X] know about the pain situation, that [Resident 3] would need to ask for this as it was PRN, not scheduled. Writer also encouraged resident and [Family Member X] that lying in bed several days in a row was not the best as [his/her]

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N 353	Continued From page 43 body would begin to go into atrophy." 11.) On 04/07/2026 at 8:15 PM, Caregiver Y documented, "residents has bruises on right side and smell of yeast" 12.) On 04/102/2026 at 8:30 AM, Practical Nurse H documented, "Writer received a phone call from [Clinical Staff] and [Doctor Z's] office r/t (related to) [Resident 3] and [his/her] pain. [Doctor Z's] office had received a call that [s/he] was in (sic.) back pain from [his/her] HCPOA [Family Member X]. Writer explained that [Resident 3] had not been asking for pain medication until [s/he] was reminded of it until earlier in the week as it was PRN. [Family Member X] was inquiring if [Resident 3] could have something stronger. Writer and [Clinical Staff] continued discussing [Resident 3's] condition as well as [him/her] not getting out of bed, hospice being called in, and the falls over the weekend. It was discussed that resident might need to be taken to the ER to have an MRI or X-Ray on [his/her] back due to osteoarthritis as the fall in March had developed the compression fracture." 13.) On 04/10/2026 at 1:15 PM, Practical Nurse H documented, "Writer was notified by [Doctor Z's] office that resident should be sent out and have the MRI/X-ray to see if one of falls (sic.) from the (sic.) over the weekend had re-injured of [s/he] had an additional compression fracture to [his/her] back. Staff called the ambulance service to have resident be taken and seen in the ER ..." 14.) On 04/13/2026 at 11:15 AM, Practical Nurse H documented that Resident 3 was admitted to hospice service.	N 353		

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N 353	Continued From page 44 15.) On 04/25/2026 at 7:00AM, Practical Nurse H documented, "Incident Notes:went (sic.) to check resident and was laying on the floor ..." 16.) On 05/01/2026 at 10:38 AM, Resident 3 was documented as deceased. On 07/14/2026, Surveyor reviewed ER after visit summaries: 1.) On 03/24/2026, Resident 3 was admitted to the ER at 5:17 PM. Under the subsection titled, "Instructions," the following was documented, " ...You were seen in the Emergency Department for: fall resulting in back pain ...We found you fractured a bone in your back but your back remains stable and you do not need specialist treatment, braces or surgery. Your back will heal without these ...What to expect and do at home: You may need to schedule Tylenol 650-1000 mg three times daily for pain for the next three weeks, then as needed, up to three times a day ...Heat or cold may help with your symptoms: try both if your back is bothering you ...Reasons to return to the Emergency Department: Severe pain, Unable to urinate, Unable to transfer at your baseline ..." 2.) On 04/10/2026, Resident 3 was admitted to the ER 3:12 PM, under the subsection titled, "Instructions," the following was documented, " ...You were seen in the Emergency Department for: frequent falls and weakness ...We found acute kidney injury or higher sodium likely from dehydration. No brain bleeds seen on imaging. [S/He] did have a large right flank (lower back) hematoma (bruise) without definite active extravasation (without active internal bleeding) ...What to expect and to do at home: Follow up with hospice on Monday, 4/13 ..."	N 353		

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N 353	Continued From page 45 INTERVIEWS: On 07/14/2026 at 11:15 AM, Surveyor interviewed Caregiver E. Caregiver E reported that prior to his/her fall on 03/24/2026. Resident 3 required 1 staff assist with transfers and ambulation. Caregiver E reported Resident 3 needed help from him/her to reposition in bed and required 2 caregivers to help him/her ambulate from the bed to the bathroom. Caregiver E stated s/he helped Resident 3 with a shower around noon, and described how s/he helped Resident 3 transfer from the shower back to his/her wheelchair afterwards. Caregiver E remembered s/he had locked both wheels of the wheelchair prior to that transfer. Caregiver E said right after Resident 3 was sitting in the wheelchair s/he screamed, "I'm sliding," as they slid from the wheelchair to the floor. Caregiver E stated s/he yelled for help, and 2 more caregivers assisted Resident 3 with a Hoyer lift off the floor. Caregiver E stated Resident 3 was resistive to going to the ER, and his/her activated power of attorney was contacted. Caregiver E stated Resident 3's activated power of attorney originally didn't want to force Resident 3 to go to the ER. Caregiver E stated Resident 3's pain seemed to increase and so a couple hours later it was decided Resident 3 would go to the ER. Caregiver E reported Resident 3 returned from the ER that same evening. Caregiver E reported Resident 3's had increased pain and weakness after s/he returned from the ER. On 07/14/2026 at 12:55 PM, Surveyor interviewed Practical Nurse H. Practical Nurse H acknowledged Resident 3's record did not contain documentation of a comprehensive assessment from 03/01/2026 until his/her passing on 05/01/2026. Practical Nurse H acknowledged	N 353		

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N 353	Continued From page 46 Resident 3 had multiple changes in condition including transfer status changes, compression fracture of the spine, AKI, frequent falls and admission to hospice service. Practical Nurse H acknowledged that Resident 3 increased weakness documented by staff on 03/24/2026 prior to his/her fall. On 07/14/2026 at 2:30 PM, Surveyors discussed the above concerns with Executive Director A and Regional Nurse H. Executive Director A and Regional Nurse H acknowledged Resident 3's ISP hadn't been updated with his/her changes in needs and physical condition including but not limited to changes in transfer status, compression fracture of the spine, acute kidney injury or admittance to hospice service. Executive Director A and Regional Nurse H acknowledged concerns related to comprehensive assessments in relation to adequate treatment.	N 353		