STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	R-C 09/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5340	5340 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 09/17/2026, the bureau of assisted living southern regional office conduced a verification visit and complaint investigation at Sage Meadows a CBRF located in Middleton, WI. As a result of this survey, 4 violations of DHS Chapter 83 and 1 violation of DHS Chapter 50 was identified. The complaint was substantiated. 10 of 11 violations from previous statement of deficiency (SOD) 7VOL14 were corrected. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 41	{N 000}		
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 09/28/2023 to 09/18/2026, Surveyors identified 34 violations of DHS chapter 83, 1 violation of DHS Chapter 50, 7 repeat violations, and 9 substantiated complaints. This is a repeat violation from previous SOD	N 196		

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

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N 196	Continued From page 1 7VOL12 dated 08/22/2026. FINDINGS INCLUDE: Facility has a Class CNA non-ambulatory license with a capacity of 44 residents and serves advanced aged, irreversible dementia/Alzheimer's, developmentally disabled, and physically disabled. On 09/17/2026, Surveyors arrived at facility for a verification visit and complaint investigation. EXAMPLE 1: Obtain and maintain compliance with laws governing the CBRF: 1.) On 09/28/2023, Surveyor conducted a survey. As a result, 1 complaint was substantiated and 3 violations of DHS chapter 83 were identified in statement of deficiency (SOD) GLXI11: -83.35(3)(d) Service Plans Updated Annually Or On Changes -83.37(1)(i) Prn Psychotropic Medication -83.38(1) Supervision 2.) On 02/09/2024, Surveyor conducted a survey. As a result, 1 complaint was substantiated and 3 violations of DHS chapter 83 were identified in SOD GLXI12: -83.32(3)(h) Rights Of Residents: Receive Medication -83.35(3)(d) Service Plans Updated Annually Or On Changes -83.37(1)(i) Prn Psychotropic Medication 3.) On 05/02/2024, Surveyor conducted a survey. As a result, 1 complaint was substantiated and 2 violations of DHS chapter 83 were identified in SOD GLXI13: -83.35(3)(d) Service Plans Updated Annually Or	N 196		

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N 196	Continued From page 2 On Changes -83.43(1) Environment Safe, Clean, And Comfortable 4.) On 01/30/2025, Surveyor conducted a survey. As a result, 1 complaint was substantiated and 2 violations of DHS chapter 83 were identified in SOD 7VOL11: -83.32(3)(h) Rights Of Residents: Receive Medication -83.35(3)(b) Service Plan Development: Parties Involved 5.) On 04/29/2025, Surveyor conducted a survey. As a result, 1 complaint was substantiated and 1 violation of DHS chapter 83 was identified in SOD BKUT11: -83.35(3)(c) Implement, Follow The Individualized Service Plan 6.) On 08/22/2025, Surveyor conducted a survey. As a result, 1 complaint was substantiated and 5 violations of DHS chapter 83 were identified in SOD 7VOL12: -83.12(2)(a) Caregiver Investigating Abuse & Neglect -83.12(3)(a) Investigated Injuries Of An Unknown Source -83.14(2)(a) Licensee Ensures Facility Complies With Laws -83.32(3)(h) Rights Of Residents: Receive Medication -83.35(3)(d) Service Plans Updated Annually Or On Changes 7.) On 12/15/2025, Surveyor conducted a survey. As a result, 1 complaint was substantiated and 1 violation of DHS chapter 83 was identified in SOD 7VOL13: -83.12(3)(a) Investigated Injuries Of An Unknown	N 196		

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N 196	Continued From page 3 Source 8.) On 05/12/2026, Surveyor conducted a survey. As a result, 11 violations of DHS chapter 83 were identified in SOD 7VOL14: -83.22(1)-(4) Task Specific Training -83.32(3)(b) Rights Of Residents: Confidentiality -83.32(3)(h) Rights Of Residents: Receive Medication -83.35(3)(b) Service Plan Development: Parties Involved -83.35(3)(d) Service Plans Updated Annually Or On Changes -83.37(1)(e) Medication Regimen, Administration Review -83.37(3)(c) Medication Storage: Locked Cabinet -83.43(1) Environment Safe, Clean, And Comfortable -83.46(1)(c) Heating System Maintenance -83.48(3)(a) Fire Detection Systems Inspection Annually -83.59(2)(b) Solid Core Wood Door Or Equivalent 9.) On 07/14/2026, Surveyor conducted a survey. As a result, 1 complaint was substantiated and 2 violations of DHS chapter 83 were identified in SOD 0OKN11: -83.35(1)(a) Pre-Admission And Ongoing Assessments -83.35(3)(d) Service Plans Updated Annually Or On Changes 10.) On 09/18/2026, Surveyor conducted a survey. As a result, 1 complaint was substantiated, 4 violations of DHS chapter 83 and 1 violation of DHS Chapter 50 was identified in SOD 7VOL15: -83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 196		

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N 196	Continued From page 4 -83.32(3)(h) Rights Of Residents: Receive Medication -83.35(3)(c) Implement, Follow The Individual Service Plan As Written -83.38(1)(g) Health Monitoring -50.09(1)(L) Care EXAMPLE 2: Number of complaints substantiated: 1.) SOD GLXI11 dated 09/28/2023, 1 complaint substantiated 2.) SOD GLXI12 dated 02/09/2024, 1 complaint substantiated 3.) SOD GLXI13 dated 05/02/2024, 1 complaint substantiated 4.) SOD 7VOL11 dated 01/30/2025, 1 complaint substantiated 5.) SOD BKUT11 dated 04/29/2025, 1 complaint substantiated 6.) SOD 7VOL12 dated 08/22/2025, 1 complaint substantiated 7.) SOD 7VOL13 dated 12/15/2025, 1 complaint substantiated 8.) SOD 0OKN11 dated 07/14/2026, 1 complaint substantiated 9.) SOD 7VOL15 dated 09/18/2026, 1 complaint substantiated EXAMPLE 3: Number of repeat violations: 1.) 83.12(3)(a) Investigate Injuries Of An Unknown Source 2.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 3.) 83.32(3)(h) Rights Of Residents: Receive Medication 4.) 83.35(3)(b) Service Plan Development: Parties Involved 5.) 83.35(3)(d) Service Plans Updated Annually	N 196		

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N 196	Continued From page 5 Or On Changes 6.) 83.37(1)(i) Prn Psychotropic Medication 7.) 83.43(1) Environment Safe, Clean, And Comfortable INTERVIEWS: On 09/17/2026 at 3:50 PM, Surveyor discussed the above concerns with Administrator U and Director KK. Administrator U and Director KK acknowledged Resident 23 had multiple incidents of falling asleep while outside smoking and had an incident of being found in a non-responsive state secondary to over-heating in July 2026. Administrator U and Director KK acknowledged Resident 23's individualized service plan (ISP) documented staff were to accompany him/her while they were smoking, and that Resident 23's ISP wasn't followed as written. Administrator U and Director KK acknowledged Resident 23 was at risk of injury while falling asleep outside unsupervised while smoking. Administrator U and Director KK acknowledged residents medications were not being administered as prescribed to several residents. Administrator U and Director KK acknowledged multiple residents had reported extended call-light wait time during nighttime hours, and 2 of the 3 recorded call-light wait times had exceeded 30 minutes.	N 196		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication	{N 352}		

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{N 352}	Continued From page 6 is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider didn't ensure each resident received their prescribed medications in the dosages and intervals prescribed by a practitioner. From 09/01/2026 to 09/17/2026, Provider did not administer 214 doses of medication to residents as prescribed. This is a repeat violation from previous statement of deficiency (SOD) 7VOL11 dated 01/30/2025, SOD 7VOL12 dated 08/22/2025, and SOD 7VOL14 dated 05/12/2026. FINDINGS INCLUDE: On 09/17/2026, Surveyor arrived at the facility for a verification visit. OBSERVATION: On 09/17/2026 at 9:35 AM, Surveyor observed the contents of the facility medication cart with Caregiver OO. Caregiver OO reported s/he oversaw passing medication to the resident's residing on the first level memory care unit. Caregiver OO reported blister packs of medications are punched out from the number(#) 30 slot to #1 slot. Caregiver OO acknowledged many blister packs had different numbers of tablets/capsules present. Caregiver OO stated s/he knew all residents were administered their medications as prescribed when s/he was the individual passing medications. Caregiver OO could not describe how s/he could tell if residents had been receiving all their medications as	{N 352}		

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{N 352}	Continued From page 7	{N 352}		

prescribed between his/her shifts as med passer. Caregiver OO reported facility had switched to a new pharmacy and the transition between pharmacies was "rough." Surveyor asked Caregiver OO to open the medication cart laptop and display the current resident medication administration records (MARs). Surveyor reviewed multiple MARS that had documented medication as "waiting on pharmacy," or "not in med cart." Caregiver OO acknowledged facility medication cart did not contain a number of blister packs for several residents. Caregiver OO acknowledged multiple residents hadn't been administered all their medications as prescribed, just the medications available in the medication cart. Caregiver OO acknowledged Resident 20's morning dose of Tylenol nor fluticasone were available in the medication cart. Caregiver OO acknowledged Resident 17's morning doses of docusate, sertraline, vitamin D and calcium carbonate were not available in the medication cart. Caregiver OO acknowledged Resident 3's morning dose of escitalopram was not available in the medication cart. Caregiver OO acknowledged Resident 22's morning doses of levothyroxine, escitalopram, quetiapine and aspirin were not available in the medication cart. Caregiver OO acknowledged Resident 12's Lamisil foot powder were not available in the medication cart. Caregiver OO acknowledged Resident 13's morning dose of multivitamin and zinc oxide creams were not available in the medication cart.

On 09/17/2026 at 2:15PM, Surveyor interviewed Resident 21. Resident 21 needed to keep all light turned off and reported feeling very sick because s/he was in opioid withdrawal. Resident 21 stated s/he hadn't been well for the last day because his/her prescribed scheduled dose of oxycodone

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{N 352}	Continued From page 8	{N 352}		

hadn't been administered to him/her since approximately 5:00AM the day prior (09/16/2026). Resident 21 stated s/he rated the pain intensity 10 out of 10. Surveyor observed Resident 21 closing his/her eyes in the dark room and sitting in a guarded posture. Surveyor observed Resident 21's forehead was shiny with sweat. Resident 21 stated facility staff had called the pharmacy around noon on 09/16/2026 and requested a stat (rush) delivery of the oxycodone. Caregiver OO knocked on the door and entered Resident 21's room during the interview. Resident 21 asked if the pharmacy had delivered his/her oxycodone yet. Caregiver OO stated s/he didn't think so but s/he would go check then give Resident 21 an update. Caregiver OO left the room for approximately 10 minutes. Upon return, Caregiver OO reported s/he called the pharmacy who reported the oxycodone would be dropped off later in the afternoon.

RECORD REVIEW:

EXAMPLE 1: Resident 3

On 09/17/2026, Surveyor reviewed Resident 3's facility record. Resident 3 was admitted to the facility on 07/05/2024. Resident 3 had an activated power of attorney (APOA). Resident 3's individualized service plan (ISP) documented facility staff were to administer Resident 3's medications as prescribed.

On 09/17/2026, Surveyor reviewed Resident 3's September 2026 MAR. The following orders were documented:
1.) "ESCITALOPRAM 20 MG TABLET ...Take 1 tablet by mouth daily"
-09/10/2026 at 8:19AM ..."No Pass Reason: Waiting on pharmacy"

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{N 352}	Continued From page 9 -09/11/2026 at 7:34AM ..."No Pass Reason: Waiting on pharmacy" -09/12/2026 at 7:25AM ..."No Pass Reason: Waiting on pharmacy" -09/13/2026 at 8:00AM ..."No Pass Reason: Waiting on pharmacy" -09/14/2026 at 7:31AM ..."No Pass Reason: Waiting on pharmacy" -09/15/2026 at 7:38AM ..."No Pass Reason: Waiting on pharmacy" -09/16/2026 at 7:25AM ..."No Pass Reason: Waiting on pharmacy" -09/17/2026 at 7:40AM ..."No Pass Reason: Waiting on pharmacy" 2.) "POLYETHYLENE GLYCOL 3350 POWD ...GIVE 17 GM(S) BY MOUTH DAILY IN 8OZ OF LIQUID FOR CONSTIPATION: -09/01/2026 at 9:32AM ..."No Pass Reason: Waiting on pharmacy" -09/02/2026 at 7:47AM ..."No Pass Reason: Waiting on pharmacy" -09/03/2026 at 7:26AM ..."No Pass Reason: Waiting on pharmacy" -09/04/2026 at 7:33AM ..."No Pass Reason: Waiting on pharmacy" -09/05/2026 at 9:20AM ..."No Pass Reason: Waiting on pharmacy" -09/06/2026 at 8:44AM ..."No Pass Reason: Waiting on pharmacy" EXAMPLE 2: Resident 12 On 09/17/2026, Surveyor reviewed Resident 12's facility record. Resident 12 was admitted to the facility on 03/23/2023. Resident 12 had an APOA. Resident 12's ISP documented facility staff were to administer Resident 12's medications as prescribed.	{N 352}		

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{N 352}	Continued From page 10 On 09/17/2026, Surveyor reviewed Resident 12's September 2026 medication administration record (MAR). The following orders were documented: 1.) "LAMISIL AF DEFENS 1% SPRAY PWD ... SPRAY AEROSOL TOPICALLY TWICE DAILY TO THE BOTTOM OF BOTH FEET" -09/16/2026 at 07:45AM ..."No Pass Reason: Waiting on pharmacy" -09/17/2026 at 08:34AM ..."No Pass Reason: Waiting on pharmacy" 2.) "Tolnaftate1% Cream ...Apply 1 Application Topically Twice Daily for Tinea Pedis" -09/10/2026 at 7:26AM ..."No Pass Reason: Waiting on pharmacy" -09/11/2026 at 7:13PM ..."No Pass Reason: Waiting on pharmacy" EXAMPLE 3: Resident 13 On 09/17/2026, Surveyor reviewed Resident 13's facility record. Resident 13 was admitted to the facility on 01/12/2026. Resident 13 had an APOA. Resident 13's ISP documented facility staff were to administer his/her medications as prescribed. On 09/17/2026, Surveyor reviewed Resident 13's September 2026 MAR. The following medications were documented as not available for administration: 1.)"ZINC OXIDE 405 OINTMENT ...APPLY TOPICALLY THREE TIMES DAILY AFTER EACH INCONTINENCE OR TOILETING EPISODE TO PERINUEM AND BUTTOCKS ANY AREA OF REDNESS FOR SKIN PROTECTION" -09/01/2026 at 10:07AM ... "No Pass Reason: Waiting on pharmacy" -09/01/2026 at 1:57PM ... "No Pass Reason: Waiting on pharmacy"	{N 352}		

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{N 352}	Continued From page 11 -09/02/2026 at 8:25AM ... "No Pass Reason: Waiting on pharmacy" -09/02/2026 at 1:52PM ... "No Pass Reason: Waiting on pharmacy" -09/03/2026 at 8:40AM ... "No Pass Reason: Waiting on pharmacy" -09/03/2026 at 2:04PM ... "No Pass Reason: Waiting on pharmacy" -09/04/2026 at 8:32AM ... "No Pass Reason: Waiting on pharmacy" -09/04/2026 at 1:55PM ... "No Pass Reason: Waiting on pharmacy" -09/05/2026 at 10:58AM ... "No Pass Reason: Waiting on pharmacy ...not in cart notified ED (Executive Director)" -09/05/2026 at 2:40PM ... "No Pass Reason: Waiting on pharmacy" -09/06/2026 at 8:47AM ... "No Pass Reason: Waiting on pharmacy" -09/06/2026 at 2:19PM ... "No Pass Reason: Waiting on pharmacy" -09/06/2026 at 7:04PM ... "No Pass Reason: Waiting on pharmacy" -09/07/2026 at 8:36AM ... "No Pass Reason: Waiting on pharmacy" -09/07/2026 at 1:38PM ... "No Pass Reason: Waiting on pharmacy" -09/08/2026 at 1:50PM ... "No Pass Reason: Waiting on pharmacy" -09/09/2026 at 10:34AM ... "No Pass Reason: Waiting on pharmacy" -09/09/2026 at 2:47PM ... "No Pass Reason: Waiting on pharmacy" -09/10/2026 at 1:34PM ... "No Pass Reason: Waiting on pharmacy" -09/11/2026 at 8:47AM ... "No Pass Reason: Waiting on pharmacy" -09/11/2026 at 1:30PM ... "No Pass Reason: Waiting on pharmacy" -09/12/2026 at 8:21AM ... "No Pass Reason:	{N 352}		

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{N 352}	Continued From page 12 Waiting on pharmacy" -09/12/2026 at 1:18PM ... "No Pass Reason: Waiting on pharmacy" -09/13/2026 at 9:53AM ... "No Pass Reason: Waiting on pharmacy" -09/13/2026 at 1:11PM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 8:30AM ... "No Pass Reason: Waiting on pharmacy" -09/14/1016 at 1:11PM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 9:43PM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 8:18AM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 1:26PM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 7:53AM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 1:14PM ... "No Pass Reason: Waiting on pharmacy" 2.) "MULTIVITAMIN WOMEN 50+ TAB ...Take 1 tablet by mouth daily" -09/01/2026 at 10:07AM ... "No Pass Reason: Waiting on pharmacy" -09/02/2026 at 8:24AM ... "No Pass Reason: Waiting on pharmacy" -09/03/2026 at 8:40AM ... "No Pass Reason: Waiting on pharmacy" -09/04/2026 at 8:32AM ... "No Pass Reason: Waiting on pharmacy" -09/05/2026 at 10:59AM ... "No Pass Reason: Waiting on pharmacy" -09/06/2026 at 8:47AM ... "No Pass Reason: Waiting on pharmacy" -09/07/2026 at 8:37AM ... "No Pass Reason: Waiting on pharmacy" -09/09/2026 at 10:34AM ... "No Pass Reason: Waiting on pharmacy"	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	R-C 09/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5340	5340 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 352}	Continued From page 13 -09/11/2026 at 8:44AM ... "No Pass Reason: Waiting on pharmacy" -09/12/2026 at 8:21AM ... "No Pass Reason: Waiting on pharmacy" -09/13/2026 at 9:53AM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 8:29AM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 8:18AM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 7:53AM ... "No Pass Reason: Waiting on pharmacy" -09/17/2026 at 8:43AM ... "No Pass Reason: Waiting on pharmacy" 3.) "Lidocaine Pain Relief 4% Patch ...Apply 1Patch Topically Daily to Area of Pain to Lower Back and Right Hip" -09/01/2026 at 10:07AM ... "No Pass Reason: Waiting on pharmacy" -09/02/2026 at 8:25AM ... "No Pass Reason: Waiting on pharmacy" -09/03/2026 at 8:39AM ... "No Pass Reason: Waiting on pharmacy" -09/04/2026 at 8:31AM ... "No Pass Reason: Waiting on pharmacy" -09/05/2026 at 10:59AM ... "No Pass Reason: Waiting on pharmacy ...Not in cart Notified ED" -09/06/2026 at 8:47AM ... "No Pass Reason: Waiting on pharmacy" -09/07/2026 at 8:38AM ... "No Pass Reason: Waiting on pharmacy" 4.) "Psyllium Husk Powder Pwd ...Dissolve 3.4 Gm(s) in 8 Oz Water or Juice by Mouth Daily to Assist in Bulking Stools" -09/01/2026 at 10:07AM ... "No Pass Reason: Waiting on pharmacy" -09/02/2026 at 8:25AM ... "No Pass Reason: Waiting on pharmacy"	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SAGE MEADOWS OF MIDDLETON - 5340	5340 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 352}	Continued From page 14 -09/03/2026 at 8:40AM ..."No Pass Reason: Waiting on pharmacy" -09/04/2026 at 8:32AM ..."No Pass Reason: Waiting on pharmacy" -09/05/2026 at 10:58AM ..."No Pass Reason: Waiting on pharmacy ...Not in cart Notified ED" -09/06/2026 at 8:47AM ..."No Pass Reason: Waiting on pharmacy" -09/07/2026 at 8:36AM ..."No Pass Reason: Waiting on pharmacy" -09/08/2026 at 8:44AM ..."No Pass Reason: Waiting on pharmacy" -09/09/2026 at 10:35AM ..."No Pass Reason: Waiting on pharmacy" -09/11/2026 at 8:47AM ..."No Pass Reason: Waiting on pharmacy" -09/12/2026 at 8:21AM ..."No Pass Reason: Waiting on pharmacy" -09/13/2026 at 9:53AM ..."No Pass Reason: Waiting on pharmacy" -09/14/2026 at 8:30AM ..."No Pass Reason: Waiting on pharmacy" -09/15/2026 at 8:18AM ..."No Pass Reason: Waiting on pharmacy" -09/16/2026 at 7:53AM ..."No Pass Reason: Waiting on pharmacy" -09/17/2026 at 8:52AM ..."No Pass Reason: Waiting on pharmacy" EXAMPLE 4: Resident 17 On 09/17/2026, Surveyor reviewed Resident 17's facility record. Resident 17 was admitted to the facility on 02/04/2026. Resident 17 had an APOA. Resident 17 was documented as being in hospice service and being a high fall risk. Resident 17's ISP documented facility staff were to administer his/her medications as prescribed. On 09/17/2026, Surveyor reviewed Resident 17's	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	R-C 09/18/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 352}	Continued From page 15 September 2026 MAR. The following orders were documented. 1.) "Fludrocortisone 0.1Mg tablet ...TAKE A HALF TABLET BY MOUTH EVERY MORNING FOR ORTHOSTATIC HYPOTENSION." -09/01/2026 at 9:45AM ... "No Pass Reason: Waiting on pharmacy" -09/03/2026 at 9:37AM ... "No Pass Reason: Waiting on pharmacy" 2.) "SERTRALINE HCL 50 MG TABLET ...Take 1 Tablet by Mouth Daily" -09/01/2026 at 9:45AM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 7:54AM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 8:12AM ... "No Pass Reason: Waiting on pharmacy" -09/17/2026 at 8:38AM ... "No Pass Reason: Waiting on pharmacy" 3.) "Vitamin D 50mcg (2000iu) Tab ...Take 1 Tablet by Mouth Daily With Food at Meals" -09/01/2026 at 9:46AM ... "No Pass Reason: Waiting on pharmacy" -09/03/2026 at 9:36AM ... "No Pass Reason: Waiting on pharmacy" -09/04/2026 at 8:21AM ... "No Pass Reason: Waiting on pharmacy" -09/05/2026 at 10:40AM ... "No Pass Reason: Waiting on pharmacy ...not in cart Notified ED" -09/07/2026 at 7:48AM ... "No Pass Reason: Waiting on pharmacy" -09/08/2026 at 7:52AM ... "No Pass Reason: Waiting on pharmacy" -09/09/2026 at 10:31AM ... "No Pass Reason: Waiting on pharmacy" -09/10/2026 at 8:52AM ... "No Pass Reason: Waiting on pharmacy" -09/11/2026 at 7:56AM ... "No Pass Reason:	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	R-C 09/18/2026

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SAGE MEADOWS OF MIDDLETON - 5340	5340 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 352}	Continued From page 16 Waiting on pharmacy" -09/12/2026 at 7:41AM ... "No Pass Reason: Waiting on pharmacy" -09/13/2026 at 9:49AM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 8:19AM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 7:54AM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 8:12AM ... "No Pass Reason: Waiting on pharmacy" -09/17/2026 at 8:38AM ... "No Pass Reason: Waiting on pharmacy" EXAMPLE 5: Resident 20 On 09/17/2026, Surveyor reviewed Resident 20's facility record. Resident 20 was admitted to the facility on 06/09/2025. Resident 20 had an APOA. Resident 20's ISP documented facility staff were to administer Resident 20's medications as prescribed. On 09/17/2026, Surveyor reviewed Resident 20's September 2026 MAR. The following orders were documented. 1.) "CEROVITE SENIOR TABLET ...Take 1 Tablet by Mouth Daily" -09/01/2026 at 9:44AM ... "No Pass Reason: Waiting on pharmacy" -09/02/2026 at 11:37AM ... "No Pass Reason: Waiting on pharmacy" -09/03/2026 at 7:49AM ... "No Pass Reason: Waiting on pharmacy" 2.) "LEVOTHYROXINE 100 MCG TABLET ...TAKE 1 TABLET BY MOUTH DAILY FOR HYPOTHYROIDISM" -09/01/2026 at 9:49AM ... "No Pass Reason: Waiting on pharmacy"	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	R-C 09/18/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 352}	Continued From page 17 -09/03/2026 at 7:49AM ... "No Pass Reason: Waiting on pharmacy" 3.) "OMEPRAZOLE DR 40 MG CAPSULE ...Take 1 Capsule by Mouth Daily" -09/01/2026 at 9:48AM ... "No Pass Reason: Waiting on pharmacy" -09/02/2026 at 11:37AM ..."No Pass Reason: Waiting on pharmacy" -09/03/2026 at 7:50AM ... "No Pass Reason: Waiting on pharmacy" -09/05/2026 at 11:06AM ..."No Pass Reason: Waiting on pharmacy" -09/06/2026 at 8:15AM ..."No Pass Reason: Waiting on pharmacy" -09/08/2026 at 7:32AM ..."No Pass Reason: Waiting on pharmacy" -09/11/2026 at 7:42AM ..."No Pass Reason: Waiting on pharmacy" 4.) "ASPIRIN 81 MG CHEWABLE TABLET ...TAKE 1 TABLET BY MOUTH DAILY FOR CARDIOVASCULAR RISK REDUCTION" -09/01/2026 at 9:44AM ..."No Pass Reason: Waiting on pharmacy" -09/02/2026 at 11:37AM ..."No Pass Reason: Waiting on pharmacy" -09/03/2026 at 7:48AM ..."No Pass Reason: Waiting on pharmacy" -09/04/2026 at 7:43AM ..."No Pass Reason: Waiting on pharmacy" -09/05/2026 at 11:04AM ..."No Pass Reason: Waiting on pharmacy" -09/06/2026 at 8:14AM ..."No Pass Reason: Waiting on pharmacy" -09/07/2026 at 7:34AM ..."No Pass Reason: Waiting on pharmacy" 5.) "ATORVASTATIN 20 MG TABLET ...TAKE 1 TABLET BY MOUTH DAILY"	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 352}	Continued From page 18 -09/01/2026 at 9:44AM ..."No Pass Reason: Waiting on pharmacy" -09/02/2026 at 11:37AM ..."No Pass Reason: Waiting on pharmacy" -09/03/2026 at 7:49AM ..."No Pass Reason: Waiting on pharmacy" -09/10/2026 at 7:53AM ..."No Pass Reason: Waiting on pharmacy" -09/11/2026 at 7:41AM ..."No Pass Reason: Waiting on pharmacy" 6.) "PRESERVISION AREDS SOFTGEL ...TAKE 1 CAPSULE BY MOUTH TWICE DAILY" -09/01/2026 at 9:49AM ..."No Pass Reason: Waiting on pharmacy" -09/01/2026 at 7:28PM ..."No Pass Reason: Waiting on pharmacy" -09/02/2026 at 11:38M ..."No Pass Reason: Waiting on pharmacy" -09/02/2026 at 7:43PM ..."No Pass Reason: Waiting on pharmacy" -09/03/2026 at 7:51AM ..."No Pass Reason: Waiting on pharmacy" -09/04/2026 at 7:47AM ..."No Pass Reason: Waiting on pharmacy" -09/04/2026 at 9:04PM ..."No Pass Reason: Waiting on pharmacy" -09/05/2026 at 11:05AM ..."No Pass Reason: Waiting on pharmacy" -09/05/2026 at 7:32PM ..."No Pass Reason: Waiting on pharmacy" -09/06/2026 at 8:15AM ..."No Pass Reason: Waiting on pharmacy" -09/07/2026 at 8:07AM ..."No Pass Reason: Waiting on pharmacy" -09/08/2026 at 7:48AM ..."No Pass Reason: Waiting on pharmacy" -09/08/2026 at 7:35PM ..."No Pass Reason: Waiting on pharmacy" -09/09/2026 at 8:22PM ..."No Pass Reason:	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 352}	Continued From page 19 Waiting on pharmacy" -09/10/2026 at 7:59AM ..."No Pass Reason: Waiting on pharmacy" -09/11/2026 at 7:42AM ..."No Pass Reason: Waiting on pharmacy" -09/11/2026 at 8:15PM ..."No Pass Reason: Waiting on pharmacy" -09/12/2026 at 7:36AM ..."No Pass Reason: Waiting on pharmacy" -09/13/2026 at 7:54AM ..."No Pass Reason: Waiting on pharmacy" -09/13/2026 at 9:27PM ..."No Pass Reason: Waiting on pharmacy" -09/14/2026 at 7:43AM ..."No Pass Reason: Waiting on pharmacy" -09/14/2026 at 7:01PM ..."No Pass Reason: Waiting on pharmacy" -09/15/2026 at 7:47AM ..."No Pass Reason: Waiting on pharmacy" -09/15/2026 at 7:40PM ..."No Pass Reason: Waiting on pharmacy" -09/16/2026 at 7:34AM ..."No Pass Reason: Waiting on pharmacy" 7.) "Novolin (Insulin) N 100 Unit/ml Flexpen ...INJECT 15 UNITS SUB-Q DAILY FOR TYPE 2 DIABETES MELLITUS" -09/01/2026 at 9:53AM ..."No Pass Reason: Waiting on pharmacy" -09/02/2026 at 11:37AM ..."No Pass Reason: Waiting on pharmacy" -09/03/2026 at 7:50AM ..."No Pass Reason: Waiting on pharmacy" -09/04/2026 at 7:45AM ..."No Pass Reason: Waiting on pharmacy" 8.) "PREDNISONE 5MG TABLET ...Take 1 Tablet by Mouth Daily" -09/01/2026 at 9:48AM ..."No Pass Reason: Waiting on pharmacy"	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 352}	Continued From page 20 -09/02/2026 at 11:38AM ..."No Pass Reason: Waiting on pharmacy" -09/03/2026 at 7:51AM ..."No Pass Reason: Waiting on pharmacy" -09/04/2026 at 7:47AM ..."No Pass Reason: Waiting on pharmacy" -09/05/2026 at 11:06AM ..."No Pass Reason: Waiting on pharmacy" -09/06/2026 at 8:15AM ..."No Pass Reason: Waiting on pharmacy" EXAMPLE 6: Resident 21 On 09/17/2026, Surveyor reviewed Resident 21's facility record. Resident 21 was admitted to the facility on 08/02/2023. Resident 21 was his/her own legal decision maker. Resident 21's ISP documented facility staff were to administer his/her medications as prescribed. On 09/17/2026, Surveyor reviewed Resident 21's September 2026 MAR. The following orders were documented. 1.) "OXYCODONE HCL (IR) 5MG TABLET ...TAKE ONE AND A HALF TABLETS BY MOUTH EVERY 6 HOUR(S) FOR CHRONIC PAIN" -09/16/2026 at 12:21PM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 5:55PM ... "No Pass Reason: Waiting on pharmacy" -09/17/2026 at 11:56AM ... "No Pass Reason: Waiting on pharmacy" 2.) "OZEMPIC 1MG/DOSE 4MG/3ML ...INJECT 1MG SUBCUTANEOUSLY EVERY WEEK ON MONDAYS" -09/07/2026 at 7:40AM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 8:49AM ... "No Pass Reason: Waiting on pharmacy"	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 352}	Continued From page 21 EXAMPLE 7: Resident 22 On 09/17/2026, Surveyor reviewed Resident 22's facility record. Resident 22 was admitted to the facility on 06/13/2024. Resident 22 had an APOA. Resident 22's ISP documented facility staff were to administer Resident 22's medications as prescribed. On 09/17/2026, Surveyor reviewed Resident 22's September 2026 MAR. The following orders were documented. 1.) "ACETAMINOPHEN 325MG TABLET ...TAKE 2 TABLETS (650MG) BY MOUTH THREE TIMES DAILY FOR PAIN ..." -09/01/2026 at 9:29AM ... "No Pass Reason: Waiting on pharmacy" -09/01/2026 at 2:03PM ... "No Pass Reason: Waiting on pharmacy" -09/02/2026 at 7:52AM ..."No Pass Reason: Waiting on pharmacy" -09/02/2026 at 2:01PM ... "No Pass Reason: Waiting on pharmacy" -09/03/2026 at 7:32AM ... "No Pass Reason: Waiting on pharmacy" -09/03/2026 at 2:10PM ... "No Pass Reason: Waiting on pharmacy" -09/04/2026 at 7:37AM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 1:31PM ... "No Pass Reason: Waiting on pharmacy" 2.) "QUETIAPINE FUMARATE 25MG TABLET ...TAKE 1 TABLET BY MOUTH TWICE DAILY IN THE EVENING AND AT BEDTIME" -09/13/2026 at 1:10PM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 1:22PM ... "No Pass Reason: Waiting on pharmacy"	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 352}	Continued From page 22 -09/14/2026 at 9:35PM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 1:28PM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 7:37PM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 1:31PM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 7:25PM ... "No Pass Reason: Waiting on pharmacy" 3.) "QUETIAPINE FUMARATE 50MG TABLET ...TAKE 1 TABLET BY MOUTH THREE TIMES DAILY" -09/05/2026 at 2:31PM ... "No Pass Reason: Waiting on pharmacy" -09/11/2026 at 1:41PM ... "No Pass Reason: Waiting on pharmacy" -09/12/2026 at 7:32AM ... "No Pass Reason: Waiting on pharmacy" -09/12/2026 at 1:21PM ... "No Pass Reason: Waiting on pharmacy" -09/13/2026 at 1:10PM ... "No Pass Reason: Waiting on pharmacy" -09/13/2026 at 1:10PM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 7:38AM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 1:22PM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 9:35PM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 7:42AM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 1:28PM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 7:37PM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 7:31AM ... "No Pass Reason: Waiting on pharmacy"	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 352}	Continued From page 23 -09/16/2026 at 1:31PM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 7:24PM ... "No Pass Reason: Waiting on pharmacy" -09/17/2026 at 9:15AM ... "No Pass Reason: Waiting on pharmacy" 4.) "LEVOTHYROXINE 50 MCG TABLET ...TAKE 1 TABLET BY MOUTH DAILY FOR HYPOTHYROIDISM" -09/12/2026 at 7:31AM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 7:37AM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 a 7:42AM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 7:30AM ... "No Pass Reason: Waiting on pharmacy" -09/17/2026 at 9:15AM ... "No Pass Reason: Waiting on pharmacy" 5.) "ESCIPTALOPRAM 20 MG TABLET ...TAKE 1 TABLET BY MOUTH DAILY FOR DEPRESSION" -09/12/2026 at 7:31AM ... "No Pass Reason: Waiting on pharmacy" -09/14/2026 at 7:37AM ... "No Pass Reason: Waiting on pharmacy" -09/15/2026 at 7:42AM ... "No Pass Reason: Waiting on pharmacy" -09/16/2026 at 7:30AM ... "No Pass Reason: Waiting on pharmacy" -09/17/2026 at 9:15AM ... "No Pass Reason: Waiting on pharmacy" EXIT INTERVIEW: On 09/17/2026 at 3:50 PM, Surveyor discussed the above concerns with Administrator U and Director KK. Administrator A and Director KK reported that facility had recently switched to a	{N 352}		

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{N 352}	Continued From page 24 new pharmacy, and they were having issues communicating with the pharmacy. Administrator A reported s/he will send medication requests to the new pharmacy via fax, but then the pharmacy will claim they never received the fax. Administrator A acknowledged several resident prescription medications were missing from the medication cart multiple days at a time. Administrator A and Director KK acknowledged Resident 21 was in active opioid withdrawal and that s/he hadn't received his/her scheduled doses of oxycodone in over 24 hours. Administrator A stated s/he had requested the pharmacy deliver Resident 21's oxycodone stat the day before and s/he was disappointed to hear it still hadn't been delivered.	{N 352}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure Resident 23's individualized service plan was implemented as written. On 07/09/2026, 07/10/2026, 07/11/2026 and 07/13/2026, Staff reported Resident 23 had fallen asleep while outside smoking his/her cigarettes. On 07/15/2026, Resident 23 was found non-responsive in the outside smoking area. Resident 23 had been outside for approximately 2 hours in the 90-degree Fahrenheit sunny weather. Facility staff and Hospice Nurse LL brought Resident 23 back inside the building	N 388		

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where cooling interventions were initiated and s/he returned to baseline. Resident 23 developed a 2nd degree sunburn to the back of his/her neck from the incident.

On 09/17/2026, Surveyor reviewed Resident 23's individualized service plan (ISP). The ISP documented staff were to accompany Resident 23 while s/he was outside smoking. Following ISP review Surveyor observed Resident 23 smoking outside without staff supervision.

FINDINGS INCLUDE:

Facility has a Class CNA non-ambulatory license with a capacity of 44 residents and serves advanced aged, irreversible dementia/Alzheimer's, developmentally disabled, and physically disabled.

On 09/04/2026, the Department received a complaint with allegations of inadequate staffing.

On 09/17/2026, Surveyors arrived at the facility for a complaint investigation.

RECORD REVIEW:

On 09/17/2026, Surveyor reviewed Resident 23's facility record. Resident 23 was his/her own legal decision maker. S/He was admitted to the facility on 06/26/2023. S/He was documented a receiving hospice service. Resident 23 was labeled as a fall risk. S/he was diagnosed with but not limited to chronic obstructive pulmonary disease (COPD), asthma, chronic kidney disease, and weakness.

On 09/17/2026, Surveyor reviewed Resident 23's individualized service plan (ISP). The ISP was

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signed by Resident 23 on 08/03/2026. Under the subsection titled, "NICOTINE DEPENDENCE," the following was documented, " ...[Resident 23] smokes cigarettes daily. Care staff will monitor [Resident 23] for safety. Care staff will accompany [Resident 23] while sitting outside ..."

On 09/17/2026, Surveyor reviewed Resident 23's observation notes from 07/01/2026 to 09/17/2026. The following entries were documented:
1.) On 07/09/2026 at 8:15 AM, Caregiver BB documented," Resident has been resting / nodding in and out of consciousness while sitting outside smoking. Multiple residents have came (sic.) to staff about it through out (sic.) the week. Resident denies it when asked about it by staff."

2.) On 07/09/2026 at 10:45 PM, Caregiver CC documented, "Resident talked to staff and had tears in [his/her] eyes. [S/he] was wondering why somebody told Hospice that [s/he] has fallen asleep before when smoking outside. Talked to resident, let [him/her] know that [s/he] has fallen asleep outside smoking before when going out to smoke before bed. Resident said [s/he] did not remember that, but after talking longer, resident said sometimes [s/he] has nodded off when smoking outside. Resident stated that after a certain time at night, [s/he] won't go outside to smoke, [s/he] will go right to bed."

3.) On 07/10/2026 at 5:00 PM, Previous Nurse EE documented, "Incident Notes: When getting ready for dinner, went to resident's room to see if [s/he] was coming out to eat. Resident not in [his/her] room, so went to check outside to see if resident was smoking. Saw resident hunched over [his/her] walker with head down, eyes closed, appeared to be asleep with a lit cigarette

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still in [his/her] right hand. Woke resident up. Resident stated [s/he] was not sleeping. Able to see burn holes in [his/her] walker. Resident immediately requested more oxycodone and Lorazepam. Told resident we would walk upstairs together first and then [s/he] could get more medication. Resident walked upstairs with staff. Resident refused to have vitals taken, and denied sleeping and smoking at the same time..."

4.) On 07/11/2026 at 3:00 PM, Caregiver DD documented, "went outside to look for resident and resident was outside smoking. residnt (sic.) couldn't even lift [his/her] head up, i (sic.) asked resident if [s/he] was okay or if [s/he] was dizzy but [s/he] said no and then lit [his/he]r cig again. i (sic.) went inside to get help and resident seemed dizzy. Resident (sic.) ststed (sic.) [s/he] was ok. resident left with [his/her] [family member] today."

5.) On 07/13/2026 at 8:15 PM, Caregiver CC documented, "Reported from staff working in downstairs unit, that resident was sleeping. Staff woke resident up. Writer went down to check on resident and [s/he] was awake, about to light another cigarette. Will monitor resident."

6.) On 07/15/2026 at 12:00 PM, Previous Nurse EE documented, "Writer was notified that resident was outside smoking, brought in by staff and hospice nurse. Staff stated that [s/he] appeared to have had a heat stroke. Writer called [Family Member FF] immediately as resident was taken up to [his/her] room by staff and hospice nurse. Writer will go in and look in on resident now."

7.) On 07/15/2026 at 2:45 PM, Caregiver BB documented, "Resident went out for a cigarette this morning and sat out there for way too long. A staff member from downstairs called writer to

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come help with resident outside. When writer got to resident and staff, resident was bent over and barely responsive. Another staff member was called to bring a wheelchair. Hospice had just arrived as well. Staff was trying to cool resident down with ice. Resident was moved up into [his/her] room, and set in [his/her] recliner laying back. Cool rags and ice were applied to residents forehead and neck. Nurse came up to assess resident along with the hospice nurse. [Family Member FF] was called but no answer. Resident was slowly becoming more conscious. Resident stated that [s/he] doesn't remember anything. Staff advised resident that it isn't a good idea for [him/her] to be going out to smoke anymore for the day since it is so hot outside. Resident refused and stated that [s/he] will still be going outside and [s/he] will bring [him/her] water and only go out for one cigarette at a time. Resident is now resting in [his/her] bed. Water at bedside."

8.) On 07/15/2026 at 9:15 PM, Caregiver GG documented, " ...Assisted resident into [his/her] bed, applied moisturizing cream in(sic.) [his/her] neck due to the sun burn from the morning, oxygen put on for the night.

9.) On 07/17/2026 at 4:00 PM, Caregiver CC documented, "Resident peer stated that resident was starting to fall asleep outside while smoking, and was woken up with another resident. Resident is upstairs in room now.

10.) On 07/20/2026 at 6:15 AM, Caregiver HH documented, "Resident has been found and reported by multiple other residents that [s/he] has been sleeping outside while smokingâ Euro¦ (sic.) staff also caught resident sleeping on the elevator when staff was (sic.) using the elevator.resident (sic.) stated [s/he] was

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supposed to be going down but was sleeping."
"

11.) On 07/26/2026 at 6:30 AM, Caregiver CC documented, "Supervised resident smoking and [s/he] nodded off and fell asleep while at the end of [his/her] cigarette, with it still being lit. Woke resident up and walked with [him/her] upstairs. Resident went to bathroom and nodded off and fell asleep on the toilet. Woke resident up again and assisted [him/her] into bed.

12.) On 08/21/2026 at 10:00 PM, Caregiver CC documented, "Resident went down to smoke at 9 50 PM. Went down to check on [him/her] at 10 PM and resident was with peer, peer stated resident had fallen asleep and was woken up. Had resident sit on [his/her] walker while staff brough (sic.) [him/her] upstairs into [his/her] room and assisted [him/her] into bed."

On 09/29/2026, Surveyor reviewed Resident 23's hospice record:
1.) On 07/15/2026 at 6:24 PM, Hospice Nurse LL documented, "[Resident 23] is on [Name Of Hospice Provider] with a terminal diagnosis of COPD. Upon arrival at the facility for a routine nurse visit, writer found patient outside, surrounded by facility staff. The patient appeared acutely ill, was minimally responsive, and was unable to keep [his/her] head up or [his/her] eyes open. Facility staff reported that the patient had experienced a syncopal episode while outside in the sun. It is believed that the patient was outside in the for ~2 hours with temperatures above 90F ...The patient was assisted into a wheelchair and transported back to [his/her] room. Cooling measures were initiated, including air conditioning, a fan, ice packs, and oral fluids. The patient gradually became more responsive and returned to [his/her] baseline mental status. The

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patient was unable to recall the syncopal event vital signs obtained: ...temp 97.7F (previously 99.2F while outdoors in the sun) ...[Previous Nurse EE] is working on coordinating closer monitoring of the patient to reduce the risk of future incidents ..."

2.) On 07/17/2026 at 11:15 AM, Hospice Nurse MM documented, " ...Upon arrival, [Resident 23] is received to be walking outside to smoke a cigarette Two days ago, [Resident 23] was found unresponsive outside and appeared to have heat stroke. [Resident 23] explained how "scary" that situation was. Writer offered emotional support. [Resident 23] mentioned "I'm only coming outside to smoke one cigarette and then I'll go back in." "That Lorazepam medication was making me fall asleep out here so Im (sic.) not taking that as much either." Writer provided some additional education regarding [his/her] safety with smoking and being outside in the heat advisory. [Resident 23] expressed understanding and was in agreement to suggestions like letting a caregiver know when [s/he's] going outside and when [s/he] returns back inside. [Resident 23] has been at [his/her] baseline following the incident. At the end of the visit, writer and [Resident 23] walked inside as it was time for lunch. Writer updated [Previous Nurse EE] following the visit ..."

3.) On 07/24/2026 at 1:29 PM, Hospice Nurse NN documented, " ... [Resident 23] was visited today at [Family Member FF's] home. [Resident 23] sustained a sunburn last week when [s/he] passed out while outside in the sun. [Family Member FF] reported the blisters have opened and are painful. Writer removed bandages placed by [Family Member FF]. Wounds cleansed and a non-adherent dressing was applied. [Resident 23]

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expressed severe pain during wound care. Writer encouraged use of PRN oxycodone, which [Resident 23] agreed to ..."

4.) On 07/31/2026 at 5:44 PM, Hospice Nurse MM documented, " ... [Resident 23] will go outside several times a day to smoke cigarettes. On average, [Resident 23] will go through a pack of cigarettes in 2-3 days. Over the last 3 months, [Resident 23] has been falling asleep while smoking outside frequently. One instance, [Resident 23] was outside during the severe temperatures and passed out due to heat stroke. Per FCG (Facility Caregiver) report, [Resident 23] was outside for approximately 2 hours and obtained a 2nd degree sunburn to [his/her] neck/upper right back ..."

OBSERVATION & INTERVIEW:

On 09/17/2026 at 12:45 PM, Surveyor interviewed Caregiver II in the second-floor medication room. Caregiver II explained Resident 23 was presently outside to smoke his/her cigarettes. Caregiver II reported Resident 23 lived on the 2nd floor and took the elevator down to the first floor, then had to exit the facilities' main entrance to the outside smoking area. Caregiver II reported Resident 23 smoked on an hourly basis during waking hours. Caregiver II reported that Resident 23 would find a staff member, tell them s/he was going out to have a cigarette, and then go out to smoke. Caregiver II reported there were not enough staff available to accompany Resident 23 during his/her cigarette breaks. Caregiver II reported Resident 23 had a history of falling asleep while smoking outside. Caregiver II stated Resident 23 had gone out for his/her most recent cigarette about 15 minutes ago. Caregiver II reported usually Resident 23's peers would let

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staff know if s/he had fallen asleep outside, and then staff would go help Resident 23 get back up to the unit.

On 09/17/2026 at 1:00 PM, Surveyor went outside to the first-floor outdoor smoking area. Surveyor observed Resident 23 alert and smoking a cigarette with peers. Zero, staff supervision observed. Resident 23 stated s/he will notify staff that s/he is going out for a cigarette. Resident 23 stated staff usually did not accompany him/her outside while s/he was smoking. Resident 23 reported s/he had a history of falling asleep while outside smoking. Resident 23 reported s/he had been outside for approximately 30 minutes. Resident 23 denied staff coming out to check on him/her during the 30 minutes s/he had been outside. Surveyor observed Resident 23 used a 4 wheeled walker for ambulation and the seat cushion had multiple circular burned indentions. Resident 23 reported the burned indentions in the cushion were burns from lit cigarettes.

On 09/17/2026 at 3:50 PM, Surveyor discussed the above concerns with Administrator U and Director KK. Administrator U acknowledged Resident 23 in July 2026 had been found outside the facility in a non-responsive state. Administrator U acknowledged Resident 23 had sustained a sunburn to the back of his/her neck from the incident. Administrator U acknowledged facility staff and hospice had reported multiple incidents where Resident 23 had fallen asleep outside while smoking cigarettes unsupervised. Administrator U acknowledged Resident 23's walker seat cushion had been burned multiple times by lit cigarettes. Administrator U stated Resident 23 was his/her own decision maker and wanted to smoke on a consistent basis.

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N 388	Continued From page 33 Administrator U reported facility didn't have the staff available to accompany Resident 23 on all his/her cigarette breaks. Administrator U acknowledged staff on the second floor do not have a direct line of sight to monitor the lower level smoking area. Administrator U acknowledged Resident 23's ISP had documented staff were to accompany Resident 23 while smoking outside. Administrator U acknowledged Surveyor observed Resident 23 smoking outside without staff supervision at approximately 1:00 PM.	N 388		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any	N 431		

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N 431	Continued From page 34 changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure health monitoring services were arranged adequate to Resident 20's needs. From 09/01/2026 to 09/10/2026, Resident 20's blood glucose levels were not measured 9 times as ordered by their physician. FINDINGS INCLUDE: On 09/04/2026, the Department received a complaint with allegations of inadequate staffing. On 09/17/2026, Surveyors arrived at the facility for a complaint investigation. RECORD REVIEW: On 09/17/2026, Surveyor reviewed Resident 20's facility record. Resident 20 was admitted to the facility on 06/09/2025. Resident 20 had an APOA. Resident 20 was diagnosed with but not limited to: diabetes mellitus II and cognitive impairment. On 09/17/2026, Surveyor reviewed Resident 20's individualized service plan (ISP). Under the subsection titled, "DIABETIC," the following was documented, " ... [Resident 20] requires staff to manage diabetes per physician orders ..." On 09/17/2026, Surveyor reviewed Resident 20's September 2026 medication administration record. An order for blood glucose test strips was	N 431		

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N 431	Continued From page 35 started 08/11/2026, "USE 1 STRIP TWICE DAILY MORNING AND NOON FOR DIABETES MELLITUS.." From 09/01/2026 to 09/04/2026, Resident 20's blood glucose level wasn't measured twice daily as ordered. The reason documented was that facility was waiting for the test strips to come from the pharmacy. On 09/09/2026, Resident 20's blood glucose level was measured once. INTERVIEW: On 10/01/2026 at 1:28PM, Surveyor emailed Administrator U. Surveyor reported Resident 20's facility records showed his/her blood glucose levels weren't measured as ordered by their physician. Surveyor requested Administrator U contact him/her if Resident 20's blood glucose levels were measured as ordered on 09/01/2026, 09/02/2026, 09/03/2026, 09/04/2026 or 09/09/2026. On 10/02/2026 at 11:34AM, Surveyor checked his/her email account. No, further correspondence was sent from Administrator U.	N 431		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility.	Y3244		

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	0019366	A. BUILDING: _____ B. WING _____	R-C 09/18/2026

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Y3244	Continued From page 36	Y3244		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure residents were provided adequate and appropriate care within the capacity of the facility.

FINDINGS INCLUDE:

Facility has a Class CNA non-ambulatory license with a capacity of 44 residents and serves advanced aged, irreversible dementia/Alzheimer's, developmentally disabled, and physically disabled.

On 09/04/2026, the Department received a complaint with allegations of inadequate staffing.

On 09/17/2026, Surveyors arrived at the facility for a complaint investigation.

INTERVIEWS:

On 09/17/2026 at 1:00 PM, Surveyor went outside to the first-floor outdoor smoking area. Surveyor observed Resident 23 alert and smoking cigarettes with Resident 18. Resident 23 and Resident 18 gave Surveyor permission to interview them together in a public space. Resident 23 stated that the daytime and evening staff are working themselves crazy, but after

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Y3244	Continued From page 37 11:00 PM it is like there are no staff available. Resident 23 stated that after 11:00PM, " ...you can push your button until [expletive] freezes over, and no one will come." Resident 23 identified Caregiver PP as a night-shift caregiver who does not respond to resident call lights. Resident 23 stated s/he has come out of his/her room looking for help to find Caregiver PP sleeping on the couch. Resident 23 reported that a bad incident happened a couple weeks ago. Resident 23 was screaming in pain, pressing his/her call light can no staff answered. Instead, another resident had to help Resident 23 call 911. Resident 23 stated that s/he was screaming and puking for approximately 30 minutes before EMS arrived. Resident 23 reported s/he was hospitalized for a week due to a bowel obstruction, stated s/he had an NG (nasal gastric) tube and PICC (peripherally inserted central catheter) were placed to help relieve the blockage. Resident 23 reported that it was scary to know all of these people don't have any staff to help at night and stated " ...I could have died!" Resident 18 stated s/he also doesn't feel like the second floor has any staff at night. Resident 18 reported s/he had fallen in the bathroom, s/he had slid out of his/her wheelchair onto the floor. Resident 18 reported s/he pressed his/her call light for approximately 2 hours between 1:30AM and 3:30AM before Caregiver PP came into his/her room. Resident 18 stated Caregiver PP stated s/he was in the other building, and his/her pager didn't buzz. On 09/17/2026 at 2:15PM, Surveyor interviewed Resident 21. Resident 21 reported s/he remembered the night Resident 23 went to the hospital. Resident 21 stated s/he woke up to Resident 23 screaming out of his/her room.	Y3244		

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Resident 21 stated s/he helped Resident 23 back to their bed and then went to look for staff. Resident 21 stated s/he looked all over the 2nd floor unit and couldn't find any staff members. Resident 21 stated it took an hour before staff came to the help them. Resident 21 stated the staff member gave Resident 23 a pill for his/her vomiting and then left the unit again. Resident 21 stated that s/he then called Family Member FF to let him/her know that Resident 23 was sick. Resident 21 reported that staff did call 911 and EMS arrived. Resident 21 stated nightshift caregivers bring pillows and blankets with them, because they plan to sleep on the couch all night. Resident 21 stated s/he has woken staff up for assistance.

RECORD REVIEW:

On 09/17/2026 at 2:00PM, Surveyor requested the call light log record from Administrator U. Administrator U stated s/he can only view the call light log for the last 24 hours. Surveyor requested to see all that was currently available.

On 09/17/2026 at 3:00PM, Administrator U emailed Surveyor the call light log. Surveyor reviewed the 09/17/2026 call light log. Surveyor found only 3 calls were documented. Administrator U acknowledged the 3 documented calls and verified that were the only data s/he had access to. Two of the 3 calls had over 30 minute wait times.
-From 1:03AM to 1:53 AM, 49-minute duration
-From 12:50PM to 1:23PM, 33-minute duration

On 09/18/2026, Administrator U emailed Surveyor Caregiver PP's disciplinary record. Surveyor reviewed the following, "[Administrator U] and [Assistant Director F] spoke to [Caregiver

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PP] about all lights not answered, laying down on the couch and prompt response to residents. First discussion was on 8/5/2026 and again on 9/10/2026. All call lights are to be answered promptly. Expectation is 10 minutes of less to answer a light. 5 or less is preferable to provide prompt care to our residents ...[Caregiver PP] was in agreement on both 8/5 and again on 9/10 ... We have adjusted [Caregiver PP] to locations where there are always 2 staff present in the event [s/he] has to assist another unit with an issue. Effective immediately ..."

On 09/17/2026, Surveyor reviewed Resident 18's facility record. Resident 18 was his/her own legal decision maker. S/he was admitted to the facility on 06/02/2023. Resident 18 was documented as, "high fall risk." Resident 18 was diagnosed with but not limited to monoplegia (paralysis) of the lower right limb.

On 09/17/2026, Surveyor reviewed Resident 18's observation notes. On 09/10/2026 at 6:00AM, Caregiver PP documented, "resident was on the floor when writer arrived resident said [s/he] did not want writer to call for help so I informed the resident I needed to get help resident said [s/he] was not hurt that [s/he] only slide to the floor writer called two staff for help and writer and staff could not get resident get [him/her] up writer called manger and 911, did all proper steps and resident is back in bed ..."

EXIT INTERVIEW:

On 09/17/2026 at 3:50 PM, Surveyor discussed the above concerns with Administrator U and Director KK. Administrator U acknowledged that Resident 23 reported during a resident council meeting that s/he had fallen and had difficulty

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Y3244	Continued From page 40 getting a response from Caregiver PP. Administrator U reported that multiple members of resident counsel had reported Caregiver PP had not been responding to his/her call light. Administrator U stated in response s/he did have a disciplinary conversation with Caregiver PP. Administrator U had purchased new call-light connected pagers for staff to utilize. Administrator U and Director KK acknowledged 2 of the 3 calls documented on the daily report were over 30 minute wait times.	Y3244		