Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021061	A. BUILDING: _____ B. WING _____	R-C 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MADISON	734 MESTA LANE MADISON, WI 53704

(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 From 08/12/2026 through 09/24/2026, Surveyor conducted a complaint investigation and verification visit at Traditions of Madison, a CBRF in Madison. One deficiency was identified. Three of 3 deficiencies were corrected from Statement of Deficiency (SOD) DVME11, dated 04/08/2026. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 17	{N 000}		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2's right of self-determination, to make decisions relating to care, activities, daily routines and other aspects of life which enhanced and supported their autonomy and decision making was recognized. Resident 2 was deemed ready for discharge by hospital providers on 06/15/2026. The assisted living facility did not feel they could manage care	N 355		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021061	A. BUILDING: _____ B. WING _____	R-C 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MADISON	734 MESTA LANE MADISON, WI 53704

(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 355	Continued From page 1	N 355		

for Resident 2. Resident 2 was not allowed to return to his/her home.

FINDINGS INCLUDE:

On 06/26/2026, the Department received a complaint related to resident care.

On 08/12/2026, Surveyor conducted a complaint investigation and verification visit. At approximately 1:30 PM, Surveyor requested the record for Resident 2.

On 08/12/2026 at approximately 2:00 PM, Surveyor Reviewed Resident 2's record. Resident 2 was admitted to the facility on 09/03/2024 with a diagnosis of ETOH (ethanol intoxication), bipolar, kidney disease, fatty liver, COPD, CHF, and pancreatitis. Resident 2 was his/her own person. Resident 2's Individual Service Plan (ISP) dated 06/09/2026 indicated the following:

-Resident 2 was on hospice care

-Resident 2 was on a behavior support plan for ETOH, anxiety, and depression. The ISP says "the resident gets very loud, rude, and yells out at staff and other resident when [s/he] is intoxicated. If anxiety gets to much for resident, may ask to call 911 to be evaluated. Resident has become very hard to calm down, resident usually just goes to [his/her] room and slams door if anyone says anything. Refuses rehab and AA, supplies other residents with alcohol against guardian permission and house rules. 30 day notice issued. Staff to report signs of intoxications to care team, remind to drink responsibly, redirect when anxious, empathetic communication. Remind [Resident 2] about house rules about sharing alcohol. Administer PRN (as needed)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021061	A. BUILDING: _____ B. WING _____	R-C 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MADISON	734 MESTA LANE MADISON, WI 53704

(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 355	Continued From page 2 Narcan for suspected overdose." Surveyor did observe a 30-day notice letter, dated 06/04/2026. The letter indicated that Resident 2 was given 30-day notice to vacate his/her room in the next 30 days. The letter says "This action is being taken because the level of medical care and supervision [Resident 2] requires is not available at our facility. We are unable to manage [his/her] excessive drinking and it's a disruption to other residents and harm to [himself/herself]. We also cannot have [him/her] asking other vulnerable residents to walk to the convenience store for alcohol purchases for [him/her]. On 08/12/2026, Surveyor reviewed facility documentation. The facility had the following progress notes in Resident 2's file: -05/06/2026 "[Resident 2] came back from the hospital from a fall the day before. Note staff observed [him/her] drinking and smelling of alcohol. Writer asked [Resident 2] about [his/her] drinking and that it is hurting [himself/herself] and [Resident 2] stated "I don't drink that much". Writer reminded of falls and it's a threat of [his/her] safety." -05/12/2026 "Writer noticed [Resident 2] giving [Resident 5] beer on the porch. Writer reminded [Resident 2] to not interfere with other residents care plans and facility guidelines ...Director observed the two coming back in and had bags of beer with them." -05/13/2026 "[Resident 2] came back from hospital" -05/14/2026 "Writer saw [Resident 5] walking on the sidewalk with a bag of beer. [Resident 5] states [s/he] was getting beer for [Resident 2]. Writer spoke to [Resident 2] about the beer and having [Resident 5] pick it up, and [Resident 2]	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021061	A. BUILDING: _____ B. WING _____	R-C 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MADISON	734 MESTA LANE MADISON, WI 53704

(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 355	Continued From page 3	N 355		

stated "Mind you own [expletive] business ..."
-05/18/2026 "[Resident 2] walked out of [his/her] room with only a shirt on and writer noticed bruising from right flank to right posterior thigh. [Resident 2] said [s/he] fell in [his/her] room. Writer asked if [s/he] wanted to got to ER (emergency room). [Resident 2] "No, I don't want to go to ER it's only a bruise." Staff report [s/he] has been drinking all weekend. Writer reminded [Resident 2] to drink in moderation to keep reduce risk of falls. Writer suggested to [Resident 2] if [s/he] would like to go to a rehab/ [Resident 2] stated "No I don't need that I can stop when I want."
-06/03/2026 "[Resident 2] is still drinking excessively and have another fragile [Resident 5] go to the store crossing the highway to get this resident alcohol, cigarettes and THC smoke products, putting other residents at risk ... [Resident 2] has been knocking on doors in the middle of the night so they don't sleep. [Resident 2] screams and cusses at staff and other residents. [Resident 2] will not do cares. Hospice help [him/her] change clothes and clean [himself/herself] up. Refuses to slow down on drinking. Is smoking in [his/her/ room. Resident thinks [s/he] can no what [s/he] wants, not caring about outcome ....We had rescinded her 30-day notice."
-06/04/2026 "Writer handed [Resident 2] a 30-day notice for repeated behaviors that put [himself/herself] and other residents in danger ... [Resident 2] responded with a "pfft" and walked away without taking the letter. The letter was then sent to the rest of the care team."
-06/12/2026 "[Resident 2] call me to [his/her] room [s/he] said [s/he] need help to call 911 because [s/he] is sick ...I suggested to call hospice but [s/he] said no [s/he] said hospice people dot (sic) anitingh (sic) to help me. [s/he]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021061	A. BUILDING: _____ B. WING _____	R-C 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MADISON	734 MESTA LANE MADISON, WI 53704

(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 355	Continued From page 4 was very upset I call hospice anyway they said they was coming but I left idk if they came." -06/14/2026 "[Resident 2] called 911 [himself/herself] stated [s/he]'s having pain in [his/her] upper stomach, diarrhea and nausea. [S/he] was admitted and we suspect pancreatitis." On 08/12/2026 at approximately 2:30 PM, Surveyor interviewed Regional Director A. Regional Director A confirmed that Resident 2 did not return to the facility from his/her hospital visit on 06/14/2026. Regional Director A stated that hospice had been involved but they let the facility know the week of 06/14/2026 that they would no longer be providing services due to noncompliance from Resident 2. Regional Director A stated that the facility had rescinded the 30-day notice from August 2025 when Resident 2 went on hospice in the spring of 2026. Regional Director A said 'we thought [Resident 2] was declining fast and we did not want [him/her] to not have a place to live. When hospice started [s/he] had really started to not drink as much." On 08/12/2026 at 3:15 PM, Surveyor discussed Resident 2's most recent admission to the hospital with Licensee B. Licensee B stated there were many issues concerning Resident 2 and the facility could not meet [his/her] needs. Licensee B confirmed that a 30-day notice had been issued on 06/04/2026. Licensee B confirmed that s/he had been in contact with the hospital and advocacy team and stated that facility was not willing to take Resident 2 back from his/her hospital stay on 06/14/2026. Licensee B stated that the facility did not go to the hospital to assess Resident 2's needs. Licensee B stated that the facility did take some of Resident 2's belongings to the hospital.	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021061	A. BUILDING: _____ B. WING _____	R-C 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MADISON	734 MESTA LANE MADISON, WI 53704

(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 355	Continued From page 5 On 08/20/2026 at 1:57 PM, Surveyor interviewed Case Manager D. Case Manager D stated that the facility had given 30-day notice 2 times on Resident 2. The first notice was given in August of 2025, due to the same concerns of drinking excessively. Case Manager D stated that s/he was unable to find any placement for Resident 2. Case Manager D stated that in the spring of 2026, Regional Director A had rescinded the notice due to [Resident 2]'s needs changing and bringing hospice in. Case Manager D stated that Resident 2 started having behaviors and buying alcohol again in May of 2026. Case Manager D confirmed that the facility gave 30-day notice on 06/04/2026. Case Manager D stated that the facility would not take Resident 2 back after his/her 06/14/2026 hospital stay, which caused Resident 2 to have to stay in the hospital for additional days. Case Manager D said the facility did not assist in finding placement but did bring items to the hospital. On 09/24/206 at 1:10 PM, Surveyor shared concern that Resident 2 was not allowed to return to his/her home after his/her hospital stay. Licensee B acknowledged that the situation with Resident 2 was unfortunate. Licensee B stated that the facility did not feel like they could not meet the needs of Resident 2's addiction issues.	N 355		