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MCFARLAND VILLA ASSISTED LIVING	5206 PAULSON CT MC FARLAND, WI 53558

(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 07/30/2026, the bureau of assisted living southern regional office conducted 2 complaint investigations at McFarland Villa a CBRF located in McFarland, WI. As a result of this survey, 2 violations of DHS Chapter 83 were issued. Two of 2 complaints were substantiated. Census: 30	N 000		
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 is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 2's practitioner ordered Fentanyl transdermal patch 75 MCG/HR to be replaced every 3 days. On 05/17/2026, Provider realized Resident 2's last Fentanyl Patch 75MCG/HR had been applied on 05/14/2026. On the afternoon of 05/18/2026 pharmacy delivered new Fentanyl Patches for Resident 2. Provider didn't apply the new Fentanyl Patch to Resident 2 until 05/19/2026.	N 352		

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

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N 352	Continued From page 1 FINDINGS INCLUDE: On 06/18/2026, the Department received a complaint about pain management. On 07/30/2026, Surveyors arrived at facility for a complaint investigation. On 07/30/2026, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted to facility on 12/17/2025. Resident 2 was his/her own decision maker. Resident 2 moved out of facility on 07/09/2026. Resident 2 was diagnosed with but not limited to: diaphragmatic hernia, spinal stenosis, intervertebral disc degeneration, and fibromyalgia. On 07/30/2026, Surveyor reviewed Resident 2's individualized service plan (ISP) signed by Resident 2 on 12/17/2025. Under the subsection titled, "Medication/Pharmacy," the following was documented, " ...Staff performs medication administration ..." The ISP documented Resident 2 was receiving hospice care by outside agency. On 07/30/2026, Surveyor reviewed an incident report. On 05/17/2026 at 10:00 Administrator A documented, "Medication aide discovered that there was (sic.) no fentanyl patches to replace [Resident 2] patch. Staff contacted Guardian Pharmacy who advised that the patch was out of refills. Med aide called [Name Of Hospice Agency] who sent over refill request. Patch arrived on Monday (05/18/2026) afternoon and was place (sic.) on [Resident 2] on 5/19 ..." On 07/30/2026, Surveyor reviewed Resident 2's progress notes: On 05/19/2026 at 10:00 AM, Administrator A documented, "Medication aide	N 352		

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was not able to replace fentanyl patch due to not having in house. [Name Of Pharmacy] was contacted for refill. Patch was replaced on 5/19"

On 07/30/2026, Surveyor reviewed Resident 2's May 2026 medication administration record (MAR). The following order, "FENTANYL DIS 75MCG/HR (CII) APPLY 1 PATCH TO UPPER TORSO EVERY 3 DAYS. REMOVE OLD PATCH BEFORE APPLYING NEW ..." The following was documented:
1.) The 05/17/2026 7:00 AM, dose was documented as, "Hold-See Nurse Notes."
2.) No, documentation of the 05/19/2026 patch being placed.
3.) The 05/20/2026 7:00 AM, dose was documented as administered.
4.) The 05/23/2026 7:00 AM, dose was documented as administered.

On 07/30/2026, Surveyor reviewed Resident 2's, "INDIVIDUAL RESIDENT CONTROLLED SUBSTANCE RECORD," for 5 Fentanyl patches delivered on 05/18/2026. The following was documented:
1.) On 05/19/2026, Med Aide C documented removal of the Fentanyl patch from pharmacy packaging.
2.) No, documentation of a Fentanyl patch being removed on 05/20/2026.
3.) The next patch was documented as removed from pharmacy packaging on 05/23/2026 at 7:12 AM.

On 07/30/2026, Surveyor looked up Fentanyl Citrate in the nurses drug handbook, "PEARSON NURSE'S DRUG GUIDE." From Page 655 to 665 the following was written, "FENTANYL CITRATE ...Classifications: ANALGESIC; NARCOTIC ...Controlled Substance: Schedule II ...ACTION &

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N 352	Continued From page 3 THERAPEUTIC EFFECT Synthetic, potent narcotic agonist analgesic that causes analgesia and sedation...PHARMACOKINETICS ...Duration: ...72 h (hour) transdermal ..." (PEARSON NURSE'S DRUG GUIDE, Ed., 2015, p. 655 - 656) EXIT INTERVIEW: On 07/30/2026 at 11:48 AM, Surveyors discussed the above concerns with Administrator A. Administrator A acknowledged Resident 2 didn't receive his/her fentanyl patch as prescribed on 05/17/2026. Administrator A acknowledged pharmacy had delivered new fentanyl patches to facility on 05/18/2026. Administrator A stated medication passing staff didn't have access to the new fentanyl patched until the following morning until after it had been checked in by the wellness coordinator. Administrator A didn't know why staff didn't report utilizing the last Fentanyl patch on 05/14/2026. Administrator A stated s/he re-trained staff on prompt re-ordering of medications.	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., 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 ensure Resident 1 received prompt and adequate treatment appropriate to his/her needs.	N 353		

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N 353	Continued From page 4 Provider did not follow physician order to report blood glucose levels over 300 mg/dl from 05/26/2026 to 05/27/2026. On 05/27/2026, Resident 1 was sent to the local emergency room and diagnosed with hyperglycemia, sepsis, delirium and gangrene of 1st and 2nd toe of right foot On 07/02/2026, palliative care team and Guardian B decided after 33-days of aggressive medical interventions for acute kidney injury superimposed on chronic kidney injury without meaningful recovery to have Resident 1 transferred to inpatient hospice facility. FINDINGS INCLUDE: The Mayo Clinic Website defines hyperglycemia as, "High blood sugar, also called hyperglycemia, affects people who have diabetes ...Skipping doses or not taking enough insulin or other medication to lower blood sugar also can lead to hyperglycemia ... Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL) ...Long-term complications Keeping blood sugar in a healthy range can help prevent many diabetes-related complications. Long-term complications of hyperglycemia that isn't treated include: ... Kidney damage (diabetic nephropathy) or kidney failure ...Feet problems caused by damaged nerves or poor blood flow that can lead to serious skin infections, ulcerations and, in some severe cases, amputation ..." (Source: The Mayo Clinic Website, Hyperglycemia, 1998-2026, https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631	N 353		

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N 353	Continued From page 5 (retrieval date - August 19,2026).) On 07/29/2026, the Department received a complaint regarding adequate treatment. On 07/30/2026, Surveyor arrived at facility for a complaint investigation. RECORD REVIEW: On 07/30/2026, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 11/04/2020. Resident 1 had a guardian (Guardian B). Resident 1 was diagnosed with but not limited to: type 2 diabetes mellitus and hypertension. On 07/30/2026, Surveyor reviewed Resident 1's clinical after visit summary dated 05/22/2026. The following was documented, " ...Today's Visit You saw [Doctor E] on Friday May 22,2026. The following issues were addressed: Open wound of toe, subsequent encounter and Type 2 diabetes mellitus with diabetic nephropathy, with long-term use of insulin ...Instructions ...continue current wound care ...Fax glucose log to PCP and/or diabetic education ..." On 07/30/2026, Surveyor reviewed Resident 1's individual service plan (ISP) dated 06/11/2026. ISP wasn't signed by Resident 1 nor his/her legal guardian (Guardian B). In the subsection titled, "Medication/Pharmacy," the following was documented, " ...Staff performs medication administration ..." In the subsection titled, "Diabetes," the following was documented, " ...Monitor blood sugar levels as directed by MD ...Monitor for signs and symptoms of hyper/hypoglycemia ..."	N 353		

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N 353	Continued From page 6 On 07/30/2026, Surveyor reviewed Resident 1's May 2026 medication administration record (MAR). Blood sugar monitoring order was written, "BLOOD SUGAR CHECKS three times a day for blood sugar test. notify MD is less then 70 or greater than 300 -Order Date- 04/19/2021 2124 (9:24 PM) ..." The following values over 300 mg/dl were documented as follows: 1.) 05/13/2026, HS (bedtime), 410 mg/dl 2.) 05/15/2026, HS, 387 mg/dl 3.) 05/20/2026, HS 340 mg/dl 4.) 05/26/2026, AM (morning), 334 mg/dl 5.) 05/26/2026, NOON, 424 mg/dl 6.) 05/26/2026, HS, 488 mg/dl 7.) 05/27/2026, AM, 444 mg/dl 8.) 05/27/2026, NOON, 478 mg/dl 9.) Documented as "hospitalized," from 05/27/2026 HS to 05/31/2026 HS. On 07/30/2026, Surveyor reviewed Resident 1's progress notes. The following entries were documented: 1.) On 05/26/2026 at 10:25 AM, Administrator A documented, " Spoke with Guardian who advised that resident is stating [s/he] is in pain and not given [his/her] Tylenol. Resident has PRN (as needed) Tylenol, called and spoke with PCP to see if Tylenol (sic.)" 2.) On 05/26/2026 at 1:06 PM, Coordinator D documented, "Resident was assisted out of recliner and into bathroom to get toileted and dressed for lunch. Resident walked to lunch and while at lunch had difficulty feeding [himself/herself] and getting drink glasses to [his/her] mouth. Vitals were taken and all in normal range. Resident was asked if [s/he] was feeling ok, if anything was wrong or if [s/he] thought [s/he] needed to be evaluated. Resident said [s/he] felt perfectly fine, [s/he] thought [s/he]	N 353		

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fed [himself/herself] fine [s/he] was just tired and wanted to lay in bed. Resident was assisted back to room and laid in bed. [Administrator A] notified."

3.) On 05/26/2026 at 7:20 PM, Caregiver F documented, "Residents blood sugars have been on the high side this evening. Have brought them down per resident drinking water. Did wound care on [him/her] with no issues. Also, [s/he] ate a small meal on pms."

4.) On 05/31/2026 at 4:18 PM, Administrator A documented, " ...resident is also currently admitted to [Name Of Hospital] for high blood sugars and altered mental status ..."

On 07/30/2026 at 9:30 AM, Surveyor requested all comprehensive assessments completed on Resident 1 from 05/20/2026 to present. Zero, comprehensive assessments were documented.

On 08/07/2026 at 5:03 PM, Guardian B emailed Surveyor a copy of a letter sent from Resident 1's Palliative Nurse Care Practitioner (Nurse Practitioner M), "07/20/2026 ...To Whom It may Concern ...The purpose of this letter is to provide clarification regarding the complex medical decision-making undertaken by [his/her] Legal Guardian, [Guardian B], which has resulted in the establishment of a comfort-focused plan of care, including Do Not Resuscitate (DNR) and Do Not Intubate (DNI) orders ...Over the course of [Resident 2's] 33-day hospitalization, all appropriate and available medical interventions were utilized in an effort to treat [his/her] serious medical conditions and improve [his/her] clinical improvement ...The Inpatient Palliative Care Team was consulted on July 2, 2026, in the setting of worsening acute kidney injury

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superimposed on chronic kidney disease requiring hemodialysis ...This decision was consistent with the recommendations of [his/her] treating medical teams based on [his/her] overall clinical condition and lack of meaningful recovery despite aggressive medical treatment ..."

On 08/19/2026, Surveyor reviewed Resident 1's hospital record:
1.) On 05/27/2026 at 3:33 PM, the emergency room doctor (Doctor G) signed the following documentation, ...[man/woman] with extensive past medical history including developmental delay, type 2 diabetes, A-fib and flutter, pacemaker, HTN, seizure disorder, is brought to the ED by EMS for from nursing facility for elevated glucose, and increased confusion. EMS reports patient has not been able to get out of bed today which is not usual for [him/her]. Reports glucose at the nursing home was in the 400s. Patient is alert and oriented to self and place but not year. [S/He] reports [s/he] does not feel well but is not able to further elaborate. Per chart review [s/he] was seen here s/p fall 3 days ago and EMS reports the abrasion on [his/her] head was sustained at that time ..."

2.) On 05/28/2026 at 5:44 PM, Social Worker H signed the the following documentation, "Reason for contact: discharge planning ...Patient is a resident at McFarland Villa, today [Guardian B] states [s/he] will not be returning to McFarlnad (sic.) villa, CBRF. [MCO Case Manager I] ...[MCO Nurse J] ....states they have been searching for alternative living now looking outside of Madison but within Dane county, including adult family homes. [S/he] states APS [Adult Protective Services] in following, from falls and bruising reported from ER visit. APS worker following ...Per Guardian there also is protective placement

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in place, this was confirmed by both [Name Of MCO Provider] (sic.) and APS ...Discharge goal identified: guardian does not want patient to return to McFarland villa ..."

3.) On 05/28/2026 at 5:11 PM, Doctor N signed Resident 1's discharge summary to a inpatient hospital unit at a hospital in neighboring city, "
Discharge date: 05/28/26
...Admission Diagnoses:
Glucose, hyperglycemia
Discharge Diagnoses:
Principal Diagnosis
Gangrene of 1st and 2nd toe of right foot
Sepsis due to staph epidermidis
Stress induced hyperglycemia
Delirium ... Hospital Course:
...[Resident 1] ... who presents reporting elevated glucose levels and increased confusion ...
Gangrenous toes ...- pt has increased erythema at the base of the dry gangrene of his 1st and 2nd toe on [his/her] right foot when compared to prior pictures ..."

4.) On 05/27/2026 at 5:47 PM, Podiatrist L signed the following documentation, "Assessment:
...Cellulitis of great toe of right foot (primary encounter diagnosis) ...Altered mental status, unspecified altered mental status type ...Supratherapeutic INR ...Hyperglycemia ...Fall, initial encounter ...Gangrene of toe of right foot...Gangrene of toe of left foot (HCC) ...Course and Plan:-[Resident 1] was seen at bedside for evaluation of bilateral foot wounds. [S/He's] had worsening of dry gangrenous changes to 1.) toes of bilateral feet with new drainage and malodor to the right great toe and cellulitis to the right 1st and 2nd toes ...We discussed [Resident 2's] condition at length including conservative and surgical treatment options. Given [his/her] recent

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N 353	Continued From page 10 worsening of the dry gangrene which progressed with wet gangrene on the right hallux with cellulitis extending into the distal forefoot, I would recommend MRI to further evaluate proximal extension of infection. We discussed poor prognosis without surgical intervention including amputation of the infected toes on the right foot ...." INTERVIEWS: On 07/30/2026 at 11:48 PM, Surveyor discussed the above concerns with Administrator A. Administrator A reported facility did not report blood glucose levels over 300 mg/dl to Resident 1's doctor from 05/25/2026 to 05/27/2026. Administrator A acknowledged Resident 1's blood glucose levels were critically high. Administrator A acknowledged Resident 1 hadn't been provided with a comprehensive assessment from 05/20/2026 to 05/27/2026. Administrator A acknowledged Resident 1's had passed away recently at an inpatient hospice facility. On 08/05/2026 at 9:50 AM, Surveyor spoke on the phone with APS Investigator O. APS Investigator O reported Resident 1 had received an acute kidney injury and had been placed on dialysis for 33 days before being transferred to an inpatient hospice facility where s/he passed away from his/her injuries.	N 353		