STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019367	A. BUILDING: _____ B. WING _____	R-C 10/15/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 09/17/2026 to 10/15/2026, Surveyor conducted 2 complaint investigations and a verification visit at Sage Meadows of Middleton. Ten deficiencies were identified. Seven violations from previous Statement of Deficiency (SOD) Y2BI12, dated 05/12/2026 were corrected. Four of 10 deficiencies were repeat violations. See SOD Y2BI12, dated 05/12/2026, SOD FIB911, dated 09/15/2025, SOD DMOH11, dated 08/29/2024, and SOD 3PSC11, dated 02/06/2024. Both complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed. Census: 43	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of	N 158		

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

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misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not conduct a thorough investigation after receiving allegations of neglect.

Director A received allegations of staff not providing overnight assistance on 07/04/2026. Director A provided an investigation dated 07/26/2026. In addition, the provider did not submit a misconduct incident report to the Department regarding the 7/4 allegation.

Findings include:

On 08/03/2026, the Department received a complaint alleging concerns with a resident's care.

On 09/17/2026, Surveyor conducted a complaint investigation and identified the following:

Resident 4 was admitted to the provider on 05/28/2026 with a diagnosis of Parkinson's disease. Resident 4's record indicated s/he had a legal guardian (Guardian P).

Resident 4's individual service plan (ISP) dated 06/21/2026 documented: "Required 24-hour supervision. Toileting-2 Person Assisted with Gait belt: Daily @ 2:00 AM, 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, 10:00 PM, As Needed, with method

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for delivering care/Who is responsible: For urinal use, one staff member will assist with positioning, use, and hygiene. For toileting, two staff members will assist [Resident 4] using a gait belt for safe transfers and provide support with clothing management and perineal care. Staff will monitor elimination patterns, skin condition, and tolerance to transfers, and report any concerns or changes to the Community Nurse promptly."

A review of the provider's investigation dated 07/26/2026 completed by Director A documented:
" ....Writer interviewed 11 different staff regarding the concerns from 7/4/26 through 7/25/2026.
7/4 and 7/5 - overnight - [Caregiver S] - stated [s/he] does [his/her] checks. Was able to verify that [s/he] had not gone into room. Employee terminated with this incident and similar issue on 7/8/2026."

A review of Resident 4's task administration record (TAR) dated July 2026 did not include staff notations indicating oral care and dressing was completed the evening of 7/4. Additionally, the TAR did not include staff initials indicating toileting assistance was completed on 7/4-6 pm and 10 pm, and 7/5-2 am and 6 am.

Surveyor reviewed an email sent by Guardian P to at least Director A, Assistant Director G, and Regional Nurse L on 07/08/2026 at 5:12 PM reporting concerns:
" ....As far as my notes go, [Director A] (perhaps with team), will:
-investigate entering at night and who that may be as well as use the two person system to improve that
-investigate this weekend in general (e.g. entering on 7/4 - which [Assistant Director G] will also do)."

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N 158	Continued From page 3 The provider's investigation did not include evidence a thorough investigation was completed until 07/26/2026. Surveyor verified with the Bureau for Integrity in Care (BIC) that a misconduct incident report was not submitted to the Department for the above incident. Interviews: On 09/17/2026 at 2:00 PM, Surveyor interviewed Director A. Director A reported the provider meets weekly with Guardian P to discuss ongoing concern s/he has with Resident 4's cares. Director A reported s/he had interviewed many staff for concerns reported in July and determined Caregiver S had not entered Resident 4's room during the overnight hours on 7/4 and 7/5. Director A reported s/he could not prove concerns related to 7/24. Director A acknowledged questions Guardian P had sent after the investigation, but reiterated staff documented Resident 4 had refused his/her medications, cares, and meals. Surveyor questioned why the investigation was not completed until 7/26. Director A reported during the weekly meetings the above concerns were discussed and Guardian P continued to email almost daily concerns. Surveyor noted there was no evidence the Department was notified of caregiver misconduct allegations reported for 7/4-7/5. No comment provided. On 09/24/2026 at 3:00 PM, Surveyor interviewed Guardian P via phone. Guardian P confirmed there was a camera in Resident 4's room. Guardian P reported s/he had video footage in which s/he had concerns with the staff not providing overnight assistance on many dates in	N 158		

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N 158	Continued From page 4 July 2026. Guardian P reported s/he has weekly meetings with the facility regarding Resident 4's cares and this was reported during meetings in July. Guardian P reported s/he had sent Director A and Chief Operating Officer R several emails on how to access the video footage and asking for updates on their investigation. Guardian P reported Director A provided a summary of their investigation on 07/29/2026, but there was missing information and the provider failed to answer follow-up questions after Resident 4 was allegedly neglected for many hours. Guardian P stated s/he was concerned with the provider's investigation because all concerns were lumped into 1 grievance submitted on 7/24 even though caregiver misconduct was alleged. On 09/30/2026 at 10:00 AM, Surveyor conducted an exit conference and shared findings with Director A, Director of Operations B, Regional Nurse L, and Chief Operating Officer R. Director A reported s/he had investigated all misconduct allegations on the investigation dated 7/26. Surveyor re-questioned why the misconduct allegations were bundled with later concerns instead of being addressed through standalone investigations at the time of reporting. No comment provided. The Department published a resource for providers titled, "WISCONSIN BACKGROUND CHECK AND MISCONDUCT INVESTIGATION PROGRAM MANUAL" which reads in part, "All entities regulated by DQA must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: Collecting and preserving any physical and documentary evidence...; Interviewing alleged victims and witnesses; Collecting other	N 158		

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N 158	Continued From page 5 corroborating/disproving evidence; Involving other regulatory authorities who can assist (e.g., local law enforcement...)These steps should be taken as part of the entity's initial attempt to determine what, if anything, happened and to determine the complete factual circumstances surrounding the alleged incident...Protection of Clients - Immediately upon learning of the incident, the entity must take necessary steps to protect clients from possible subsequent incidents of misconduct or injury...Notifying Law Enforcement - In addition to DQA reporting requirements, entities are required to notify local law enforcement authorities in any situation where there is a potential criminal offense." Source: https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf, retrieval date 10/15/2026. .	N 158		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the legal representative and physician of Resident 4 was immediately	N 169		

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notified when there was an incident affecting the resident.

Resident 4's legal guardian (Guardian P) was not notified of 9 incidents related to falls and behaviors. Resident 4's physician was not notified of 17 incidents related to falls and behaviors.

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

Findings include:

On 08/03/2026, the Department received a complaint alleging concerns with a resident's care.

On 09/17/2026, Surveyor conducted a complaint investigation and identified the following:

Resident 4 was admitted to the provider on 05/28/2026 with a diagnosis of Parkinson's disease. Resident 4's record indicated s/he had a legal guardian (Guardian P).

Resident 4's record dated 05/30/2026-09/17/2026 documented the following incident reports with falls and behaviors:

-05/30/2026 10:30 PM Unwitnessed fall in bedroom. *Physician not notified.

-06/01/2026 1:12 PM Fall in bedroom. *Guardian not notified.

-06/04/2026 9:39 AM Fall in bedroom. *Physician not notified

-06/08/2026 8:00 AM and 2:50 PM Sexual behaviors towards staff. *Guardian and physician

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not notified.

-06/17/2026 2:06 AM Unwitnessed fall in bedroom. *Physician not notified.

-06/28/2026 7:06 PM Unwitnessed fall in bedroom. *Guardian and physician not notified.

-07/08/2026 10:03 PM Sexual behaviors towards staff. *Guardian and physician not notified.

-07/12/2026 8:25 AM Unwitnessed fall in bedroom. *Physician not notified.

-07/13/2026 10:56 AM Behavior-Aggressive towards another resident. *Physician not notified.

-07/24/2026 9:30 AM Unwitnessed fall in bedroom. *Physician not notified.

-07/24/2026 1:17 PM Behavior-Aggressive towards staff. *Physician not notified.

-08/11/2026 8:30 AM Unwitnessed fall in bedroom. *Physician not notified.

-08/13/2026 6:19 PM Fall "threw self on floor." *Guardian and physician not notified.

-08/16/2026 9:41 AM Behavior-Aggressive towards staff and property destruction. *Physician not notified.

-08/18/2026 10:15 AM Self-transfer resulting in fall. "Guardian and physician not notified.

-08/21/2026 7:05 PM Unwitnessed fall in resident bathroom. *Guardian and physician not notified.

-08/23/2026 4:06 AM Unwitnessed fall in resident

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N 169	Continued From page 8 bathroom. *Guardian and physician not notified. -09/03/2026 7:30 PM Fall in bedroom. *Guardian and physician not notified. On 09/24/2026 at 3:00 PM, Surveyor interviewed Guardian P via phone. Guardian P reported concerns with not being notified of falls and behaviors to assist in deescalation strategies. Guardian P confirmed there was a camera in Resident 4's room. Guardian P reported s/he would review video footage of falls and behaviors after they had occurred and many times s/he would not be notified. Guardian P reported concerns that staff would often call him/her off their personal cell phone and on a couple of occasions staff had called him/her off private numbers so s/he could not see who was calling. On 09/30/2026 at 10:00 AM, Surveyor conducted an exit conference and shared findings with Director A, Director of Operations B, Regional Nurse L, and Chief Operating Officer R. The management team acknowledged an understanding of the concerns. Surveyor asked if additional evidence existed of notifications to Resident 4's guardian and physician for the above dates. Chief Operating Officer R reported the provider might have faxes to prove notification requirements were completed. Surveyor noted additional evidence would need to be submitted by 1:00 PM today. The management team verbally agreed. On 09/30/2026 at 11:25 AM, Chief Operating Officer R sent the Surveyor 4 faxes with notification details, but the above dates were not included.	N 169		

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N 353	Continued From page 9	N 353		
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 each resident received prompt and adequate treatment appropriate to the resident's needs. On 09/15/2026, Resident 4's transfer status was updated to require an EZ stand/sit-to-stand lift via physical therapy (PT). There was no action taken on the lift until 09/17/2026, when the provider checked to see who was responsible for obtaining and paying for the lift. The provider did not order the lift until 09/18/2026, resulting in facility delivery on 09/21/2026. Resident 4 was not provided prompt treatment related to his/her transfer needs. Resident 4's dental report dated 07/09/2026 indicated Resident 4 presented with poor oral hygiene, had multiple areas of food impaction and generalized inflamed gingiva. Additionally, the report indicated due to Resident 4's oral hygiene state at this moment, the dentist was not able to place a composite restoration on #11 and #12 due to excessive gingival bleeding. The provider did not provide adequate oral hygiene to Resident 4 when as needed (PRN) mouth wash was not used and staff did not consistently document oral hygiene as completed.	N 353		

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On 07/06/2026, Resident 4 was not provided adequate treatment following a fall when s/he was transferred off the floor by a caregiver and Maintenance Person BB without the use of his/her gait belt and training requirements completed.

This is a repeat statement of deficiency (SOD) DMOH11 dated 08/19/2024.

Findings include:

On 08/03/2026, the Department received a complaint alleging concerns with a resident's care.

On 09/17/2026, Surveyor conducted a complaint investigation and identified the following:

Resident 4 was admitted to the provider on 05/28/2026 with a diagnosis of Parkinson's disease. Resident 4's record indicated s/he had a legal guardian (Guardian P).

Example 1: EZ stand/sit-to-stand lift concern

Resident 4's individual service plan (ISP) dated 09/17/2026 documented: "Two care staff will assist [Resident 4] with transfers using a gait belt. Staff will explain the transfer before beginning, ensure [Resident 4] is properly positioned, and monitor [his/her] tolerance throughout the transfer. Staff will report changes in [Resident 4's] ability to participate in or tolerate transfers to the nurse. As of 9/15/26, PT recommends [Resident 4] transfer with a sit-to-stand. MCO contacted to order the sit-to-stand."

Resident 4's progress notes documented: "-09/15/2026: Physical Therapy documentation

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reviewed regarding resident's transfer status. PT recommends use of an EZ Stand/sit-to-stand for transfers to and from the bathroom due to episodes of severe retropulsion with standing, increased assistance required for transfers, and fall risk. Care plan updated to reflect use of sit-to-stand with two-person assistance for transfers and current mobility needs. Staff to follow updated care plan and report changes or concerns to nurse.
-09/21/2026: Resident scheduled for medical evaluation today following behavioral changes noted last evening to assess for a possible underlying medical cause. Today, resident was observed leaning significantly to [his/her] left while seated. Per guardian request, resident will use [his/her] electric wheelchair for transportation to the appointment. Electric wheelchair is equipped with a seatbelt and will provide safer positioning and support during transportation given the significant left-sided leaning observed today.
-09/22/2026: 9:30 AM: Resident observed this morning in the dining room with continued left-sided leaning. At 11:15 AM: Received update from guardian regarding residents 9/21/26 appointment with [Physician T]. Labs and urinalysis were obtained. Guardian reported no outward signs of acute illness or infection were identified. Resident demonstrated significant fatigue, weakness, left-sided leaning, and decreased coordination during the visit. Guardian reported resident was in a good mood, with some hallucinations noted. Provider documentation and test results are expected to be faxed to the community."

On 09/17/2026 at 12:00 PM, Surveyor observed Assistant Director G, Caregiver U, and Caregiver V perform a transfer on Resident 4 from his/her

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wheelchair to bed. The three staff used a gait belt and confirmed this was Resident 4's method of transferring. During the transfer, Resident 4 appeared unsteady during the pivot phase, required multiple cues, and the 3 staff had used the gait belt to complete the transfer.

On 09/24/2026 at 3:00 PM, Surveyor interviewed Guardian P via phone. Guardian P confirmed there was a camera in Resident 4's room. Guardian P reported s/he had video footage in which s/he had concerns with the availability of Resident 4's sit-to-stand since being delivered to the facility and how staff were using the device. Guardian P reported ongoing concerns with staff not following Resident 4's ISP related to transfers. Guardian P stated s/he would review the footage and provide the Surveyor with more information.

On 09/28/2026 at 4:56 PM, Guardian P sent the following email to the Surveyor: "Sit to stand only in [his/her] room only since late afternoon of 9/22 - after I saw it in the common room off the hall and asked [staff] if it was [his/her]. [S/he] had to verify and then brought it in. First used 9/23 @ 11:29. Wasn't until morning of 9/24 1123 that [Assistant Director G] came in and said the belt was too big and showed [staff] to have [him/her] order a smaller one. Not sure when the second one was procured but was available by 9/26 a.m. A few staff members are new and no one has been trained on using this specific device with [him/her]. [PT] said [s/he] would be in with [him/her] and it finally today. So we will see if we can have some suggestions added. However, I doubt the dissemination, training, and encouragement of any consistent things will happen."

On 09/29/2026, Surveyor reviewed e-mail

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correspondence provided by Guardian P with Director A, Regional Nurse L, Case Manager Q, Chief Operating Officer R, and RN Case Manager W, regarding Resident 4's sit-to-stand device, which included the following:

Chief Operating Officer R sent the following on 09/17/2026 at 12:23 PM: "All, I am being told by [Regional Nurse L] that PT recommends [Resident 4] be a sit to stand - do we know who is ordering this for [him/her]?

RN Case Manager W responded the following on 09/17/2026 at 1:06 PM: Talked with our supervisor and CBRFs are required to provide sit to stands and or hoyer lifts.

Director A responded the following on 09/18/2026 at 8:59 AM: Good afternoon - We will rent a sit-to stand for [Resident 4]. This is not standardly provided by CBRFs. Many families will rent their own. Most often hospice is on board when and individual has declined to the point of needing a sit-to-stand they provide this. When none of those are in place, we rent one. I will contact a DME company today and rent one.

Director A responded the following on 09/21/2026 at 2:30 PM: All-The sit-to-stand arrives this afternoon. I had one rented. After getting [Resident 4] ready to go to the doctor today, and [his/her] leaning, I am very curious if [Resident 4] is ready for hospice and not just palliative care."

On 09/25/2026 at 12:37 PM, Surveyor sent the following email to Director A and Chief Operating Officer R: " ...With [Resident 4's] transfer status changed to EZ stand on 09/15, I'm concerned [s/he] was not provided prompt treatment with the device not being available until 9/21. Emails

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shows 9/17 MCO notifying the facility is responsible for providing the device, per contract. Device not available until 9/21. I observed staff transfer [Resident 4] using the gait belt on 9/17, [s/he] appeared unsteady during the pivot phase, required multiple cues, and 3 staff had to provide upward lifting force via the gait belt to complete the transfer. Also, provided pictures from 9/21 show [him/her] heavy leaning to the left and notes in the record about [his/her] troubles with transfers.

On 09/28/2026 at 10:02 AM, Regional Nurse L with Director A, Director of Operations B, and Chief Operating Officer R included: Answer: We do not have an EZ stand on site. MCO refuses to rent one; community rented one. It arrived on 9/21/2026. "

Resident 4's record did not include evidence of prompt follow up regarding the sit-to-stand lift from 09/15 when the order was placed, ISP updated, until 09/17 when Chief Operating Officer R followed up with Resident 4's care team, despite the provider being responsible for supplying the device.

Example 2: Oral hygiene concerns

On 09/28/2026 at 4:14 PM, Guardian P provided Resident 4's dental report dated 07/09/2026. Resident 4's dental report dated 07/09/2026 documented: "Patient presented with poor oral hygiene today, multiple areas of food impaction and generalized inflamed gingiva. Completed full mouth debridement to be able to perform restorative treatment. Clinically evident decay visually and with stick of explorer ... Patient also presented with Crown on #16 off, recemented with NE self curing resin cement. Due to patient's

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oral hygiene state at this moment, was not able to place composite restoration on #11 and #12 due excessive gingival bleeding. Decided to place Fuji IX after caries removed. Will monitor oral hygiene. [Guardian P] reported lack of oral care at the facility where patient resides, recommended that the staff would aid the patient in oral hygiene and brushing (2 times per day minimum and floss 1 time per day) and use of electric tooth brush."

On 09/29/2026 at 9:23 AM, Surveyor sent the following email to Guardian P: "Did [Resident 4] see the dentist again since 07/09? If so, please send any reports.
Do you have email evidence that the provider was given a copy of the dentist report, not just verbally?"

On 09/29/2026 at 12:08 PM, Guardian P sent the following email: "Did [Resident 4] see the dentist again since 07/09? If so, please send any reports.
Yes, but it was just a limited eval (due to a concern with [his/her] crown falling out, for the 3rd time) and by a different dentist than previous. The thing that was so striking 7/9 is that that wasn't for cleaning (just follow up with fillings). [S/he] was seen for cleaning right after moving in (same dentist 6/2 as 7/9) and despite only having 52 hrs max of Supportive Home Care (SHC) prior when living independently, and the last month only 20-30hr/wk, and therefore being on [his/her] own the vast majority of the time as well as the SHC aides not even scheduled over bed time often ... 7/9 was surprisingly WORSE than any of that time. The dentist was so surprised (as well as concerned since it affected the type of fillings [s/he] was able to do) that [s/he] thought [Resident 4's] care was extremely neglectful. And that is why I specifically requested [s/he] write

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something for me to bring back to reinforce them providing any sort of mouth care, since any they had was obviously subpar.
Do you have email evidence that the provider was given a copy of the dentist report, not just verbally? Please see the "after 7_15 mtg..." attachment. This is after the dental issue was discussed in the mtg 7/15, and #1 mentioned the mouthwash (which is specifically for sores in [his/her] mouth where [s/he] bites [his/her] cheeks, lips, or tongue) as well as requested that they take my request that day (7/16) to provide it with brushing that evening and if I should get a scheduled order. [No response was ever received to this email...and most of what was discussed in that meeting re care plan was only ever updated finally 8/3."

Surveyor verified emails provided by Guardian P dated 06/16/2026 and 07/15/2026 that Resident 4's oral hygiene was discussed as a concern with the provider.

On 09/17/2026, Surveyor reviewed Resident 4's occupation therapy discharge report dated 08/06/2026: "Pt has made modest progress this POC, reaching maximum rehab potential for the HH setting at this time... Pt requires Max support for grooming, e.g. brushing teeth, d/t sequencing, ability to see items, and VC to initiate task. Pt has reached maximum rehab potential for the HH setting at this time and appropriate for DC to [his/her] ALF, where [his/her] ADL and IADL needs are being met. Pt to DC with ST."

Resident 4's ISP dated 05/29/2026 documented: "Oral Care-1 Person Assist: Care staff will encourage [Resident 4] to complete oral care to the best of [his/her] ability and provide 1 assist as needed. Staff will ensure oral care is completed

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twice daily and monitor for any concerns, reporting changes to the community nurse."

Resident 4's ISP dated 06/21/2026 documented: "Oral Care-1 Person Assist: Use Magic mouthwash with daily oral care. Care staff will encourage [Resident 4] to complete oral care to the best of [his/her] ability and provide 1 assist as needed. Staff will ensure oral care is completed twice daily and monitor for any concerns, reporting changes to the community Nurse. Use Magic Mouthwash with oral care."

Resident 4's physician orders included:
-Magic Mouthwash with instructions to swish and spit 5 ml by mouth every 4 hours as needed, with a start date of 05/28/2026 and end date of 08/01/2026.
-Magic Mouthwash with instructions to swish and spit 5 ml at bedtime, with a start date of 06/19/2026.

Resident 4's May and June 2026 medication administration record (MARs) did not include administrations of his/her PRN Magic Mouthwash. The scheduled magic mouthwash was documented as administered from 06/19 to 07/31.

Resident 4's May, June, and July TARs did not consistently record oral hygiene as being completed. The following dates were missing staff notations indicating the task had been completed:
May: 05/29 (evening), 05/30 (evening)
June:
Morning: 6/1, 6/3-6/5, 6/8-6/10, 6/12, 6/14, 6/15, 6/17, 6/19, 6/20, 6/22, 6/23, 6/25-6/27, 6/29, 6/30
Evening: 6/2, 6/4, 6/6-6/8, 6/15, 6/16, 6/19-6/21, 6/22, 6/23, 6/25-6/27, 6/29, 6/30

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N 353	Continued From page 18 July: Morning: 7/1, 7/3, 7/5, 7/7, 7/10, 7/13, 7/17-7/20, 7/22, 7/23, 7/26, 7/30, 7/31 Evening: 7/2-7/6, 7/8-7/12, 7/14, 7/16-7/18, 7/21-7/27, 7/29-7/31 The facility did not ensure Resident 4 was provided adequate oral hygiene from 05/28/2026 to 07/31/2026. Example 3: Fall on 7/6 Resident 4's ISP dated 06/21/2026 documented: "Transferring: Care staff (2 persons) will assist [Resident 4] with all transfers using a gait belt at scheduled times and as needed. Staff will ensure proper positioning, secure application of the gait belt, and resident comfort during transfers. Staff will monitor [Resident 4's] tolerance, balance, and strength, and report any concerns or changes to the Community Nurse promptly." Resident 4's progress notes dated 07/06/2026 at 11: 15 AM documented: "Writer was called to resident's room by care staff as [s/he] was found on the floor. Resident denied hitting [his/her] head on the floor. Vital signs were obtained by care staff; resident denied any pain or discomfort. When writer arrived, resident had already been assisted by care staff to [his/her] chair. There was no visible bleeding or bruising to [his/her] head or any other skin that was not covered that writer could see." Additional note: There's no evidence in Resident 4's record vitals were recorded by care staff. On 09/24/2026 at 3:00 PM, Surveyor interviewed Guardian P via phone. Guardian P confirmed there was a camera in Resident 4's room. Guardian P reported s/he had video footage in	N 353		

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which s/he had concerns with the staff not transferring Resident 4 correctly including on 7/6. Guardian P reported the video footage showed a non-caregiver performing a transfer after Resident 4 was on the floor. Guardian P reported s/he shared the video with management.

On 09/30/2026, Surveyor reviewed Maintenance Person BB's employee record.

Maintenance Person BB was hired on 11/24/2025. Maintenance Person BB record did not include evidence of training in personal cares.

Wis. Admin. Code ch. 83 defines "Personal care" as assistance with activities of daily living, but does not include nursing care & "Activities of daily living" as bathing, eating, oral hygiene, dressing, toileting and incontinence care, mobility and transferring from one surface to another such as from a bed to a chair.

Follow up interviews:

On 09/30/2026 at 10:00 AM, Surveyor conducted an exit conference and shared findings with Director A, Director of Operations B, Regional Nurse L, and Chief Operating Officer R. Surveyor expressed concern for the lack of prompt follow up from 9/15 to 9/17 regarding Resident 4's EZ stand device. Chief Operating Officer R reported the current licensee would not share MCO contracts so we did not know who was responsible for supplying Resident 4's device. The management team reported Resident 4's device was ordered on 09/18 and delivered to the facility on 09/21. Surveyor shared the allegation of the device not being used until 9/23, per Resident 4's camera. No comment was provided. Surveyor reviewed Resident 4's dental report

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dated 7/9 with the management team. Surveyor shared Resident 4's TAR for May, June, and July showed staff not consistently recording oral hygiene as completed. Surveyor asked for clarification on Resident 4's PRN mouthwash not being used until 06/19. The management team acknowledged oral hygiene was discussed in July as a concern from Guardian P. Regional Nurse L stated staff had been administering the scheduled magic mouth since 6/19 until discontinued. No comment was provided for lack of PRN usage. Director A stated Resident 4 often refused cares including oral hygiene, but acknowledged staff should be documenting this. The management team did not provide further comment on Resident 4's oral hygiene concern. Surveyor asked for clarification on Resident 4's fall on 7/6 and who assisted in the transfer. The management team acknowledged observing the video and identified Maintenance Person BB as the 2nd staff. The management team stated it was not standard of practice for maintenance staff to assist in transfers and did not know why another staff member was not available. The management team acknowledged an understanding of the concerns and verbally confirmed they would send Maintenance Person BB's employee record.

On 10/01/2026 at 3:08 PM, Surveyor interviewed Physical Therapist X via phone. Physical Therapist X reported they did not start seeing Resident 4 until the end of August 2026. Physical Therapist X reported s/he gave Regional Nurse L the recommendation for the EZ stand on 9/15 and noted the day before s/he eluded to Regional Nurse L that Resident 4 would require the lift. Physical Therapist X reported their company does not assist in obtaining the device for the patient.

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N 353	Continued From page 21 Cross Reference: N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan	N 353		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 4 was assessed when his/her needs, condition and abilities changed. Resident 4 had multiple falls with missing assessments completed after each incident. Resident 4's record included hand swelling pain on 08/02/2026, there was no assessment completed. Findings include: On 08/03/2026, the Department received a	N 381		

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complaint alleging concerns with a resident's care.

On 09/17/2026, Surveyor conducted a complaint investigation and identified the following:

Resident 4 was admitted to the provider on 05/28/2026 with a diagnosis of Parkinson's disease. Resident 4's record indicated s/he had a legal guardian (Guardian P).

Resident 4's individual service plan (ISP) dated 09/17/2026 documented: "Fall risk: [Resident 4] is a high fall risk with a history of recurrent falls, including falls associated with attempts at independent mobility or transfers. [Resident 4] primarily uses a manual wheelchair for mobility. Two care staff will assist [Resident 4] with transfers using the sit-to-stand. Staff will ensure the sit-to-stand is properly positioned and secured before beginning the transfer, explain the transfer to [Resident 4], provide simple directions, and allow [him/her] time to participate as able. Staff will ensure [Resident 4] is safely positioned before leaving [him/her] and will keep [his/her] wheelchair appropriately positioned with brakes locked during transfers. Staff will follow [Resident 4]'s individualized fall-prevention interventions and report significant changes in [his/her] mobility, transfer ability, strength, coordination, cognition, or tolerance of the sit-to-stand to the appropriate supervisor/clinical/provider contact. Interventions include: 09/04/26 - Staff will offer assistance getting up well before supper and offer toileting at that time. 09/03/26 - Staff will ensure [Resident 4] is safely seated before leaving for additional assistance. 08/23/26 - PT will be asked to evaluate [Resident 4]'s transfers, mobility, and fall risk and provide recommendations for safe mobility. 08/21/26 - [Resident 4] will be safely

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positioned away from the bathroom when additional assistance is needed. 08/18/26- Shower supplies will be gathered and within reach before shower care begins. 08/11/26 - Recliner will be positioned to reduce movement/tipping and allow safe wheelchair access. 07/24/26- If [Resident 4] becomes confused or agitated during mobility, staff will pause the activity and redirect before continuing. 07/20/26 - [Resident 4] will primarily use [his/her] wheelchair for mobility. Staff will offer assisted walking as appropriate. 07/12/26 - Staff will accompany [Resident 4] to [his/her] room when [s/he] leaves common areas to address mobility and transfer needs. 07/06/26 - [Resident 4] will be educated to request staff assistance before attempting independent mobility. 06/28/26 - [Resident 4]'s bed will be maintained at a safe transfer height and pathways kept clear of tripping hazards. 06/17/26 - Staff will position [Resident 4] away from the edge of the bed following care. Bed rails may be used for repositioning and bed mobility. 06/04/26 - [Resident 4]'s wheelchair will be kept in a consistent, accessible location and brakes locked before transfers. 06/01/26 - Frequently used personal items will be kept within [Resident 4]'s reach while in bed. 05/30/26 - Staff will offer incontinence care before [Resident 4] is left to rest in [his/her] room."

Resident 1's record included unwitnessed falls on the following dates:
-06/17/2026: writer observed resident on floor upon entering room. Resident was on the side of the bed.
-06/28/2026: resident was observed on the floor in [his/her] room when staff returned to check on [him/her] before putting away another resident's laundry. Staff immediately approached the

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resident and asked how [s/he] ended up on the floor. Resident stated that [s/he] did not know how [s/he] got there. No obvious injuries were observed at the time.
-07/06/2026: I was working in another unit at the time of the incident. A caregiver and another resident informed me that the resident was on the floor. I immediately went to the resident's room to assist. When I entered the room. I found the resident lying on the floor.
-07/12/2026: After breakfast resident took [him/herself] to [his/her] room and tried to get in bed. Co worker and I found [him/her] on floor shortly after when heard yelling for help. Resident was in between under the bed and out. [His/her] feet were under and torso out.
-07/24/2026: Pt notified staff that resident was on the floor. When staff entered the room resident was standing up and holding on electric wheelchair. Resident asked if [s/he] fell or lowered [him/herself] onto the floor, resident didn't answer and kept calling out for [his/her] grandchildren.
-08/23/2026: Resident was responsive, resident was ok. Resident was laying on the floor on resident left side, no bruises, no pain."

There was no evidence in Resident 4's record s/he was assessed after falls on 06/17, 06/28, 07/06, 07/12, 07/24, and 08/23.

Resident 4's progress notes documented: "-08/02/2026: [Resident 4] said [his/her] hand hurt. [S/he] can't lift self up on [his/her] bar. [His/her] hands are swollen and they hurt."

There was no evidence in Resident 4's record s/he was assessed after reporting hand swelling pain on 08/02.

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N 381	Continued From page 25 On 09/25/2026 at 12:37 PM, Surveyor sent the following email to Director A and Chief Operating Officer R: " ...-In [Resident 4's progress notes, there is injuries noted on 07/17 and 08/02, but no follow up or investigation in the record. ...07/06/2026 incident report indicates staff completed a set of vitals after a fall, but I cannot find this information in the record. ...After reviewing [his/her] incident reports and fall assessments, I did not see fall assessments completed after falls on the following dates: 06/17, 06/28, 07/06, 07/12, 07/24, 08/23." On 09/28/2026 at 10:02 AM, Regional Nurse L with Director A, Director of Operations B, and Chief Operating Officer R included sent the following email: "08/02 Hand Swelling/Pain This concern was documented by care staff on 8/2/2026 while I was not on site. When I returned on 8/3/2026, I was not aware that [Resident 4] had reported hand swelling or pain and therefore did not complete a follow-up assessment related to that concern. 07/06 Vitals The 7/6/2026 progress note indicates that vital signs were obtained following the incident; however, I have been unable to locate the actual documented vital sign values in the record. The note was entered by a former nurse who is no longer employed by the community, and I am therefore unable to confirm where those values may have been recorded. Missing Post-Fall Assessments I do not have additional information regarding the fall assessments identified as missing for	N 381		

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N 381	Continued From page 26 6/17/2026, 6/28/2026, 7/6/2026, 7/12/2026, 7/24/2026, and 8/23/2026. The community nurse at that time was responsible for completing these assessments. To date, I have not located completed fall assessments for those incidents." On 09/30/2026 at 10:00 AM, Surveyor conducted an exit conference and shared findings with Director A, Director of Operations B, Regional Nurse L, and Chief Operating Officer R. The management team acknowledged an understanding of the above concerns. The management team did not provide further comment.	N 381		
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 record review and interview, the provider did not ensure the individual service plan (ISP) of Resident 4 was followed. Resident 4 was transferred without the use of a gait belt, without 2 staff, and without the use of a sit to stand as indicated in his/her ISP. Resident 4 was not escorted to lunch on 07/04/2026 and 07/12/2026 as indicated in his/her ISP. Resident 4's food intake monitoring was not consistently recorded as indicated in his/her ISP. This is a repeat deficiency. See Statement of Deficiency (SOD) 3PSC11, dated 02/06/2024.	N 388		

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N 388	Continued From page 27 Findings include: On 08/03/2026, the Department received a complaint alleging concerns with a resident's care. On 09/17/2026, Surveyor conducted a complaint investigation and identified the following: Resident 4 was admitted to the provider on 05/28/2026 with a diagnosis of Parkinson's disease. Resident 4's record indicated s/he had a legal guardian (Guardian P). Example 1: Transfer concerns Resident 1's ISP dated 06/21/2026 documented: "Transferring: Care staff (2 persons) will assist [Resident 4] with all transfers using a gait belt at scheduled times and as needed. Staff will ensure proper positioning, secure application of the gait belt, and resident comfort during transfers. Staff will monitor [Resident 4's] tolerance, balance, and strength, and report any concerns or changes to the Community Nurse promptly." Resident 4's ISP dated (unknown date) documented: "Transferring: Transferring: Two staff will assist [Resident 4] with all transfers using the sit-to-stand. Do not use gait belt for transfers. Explain the transfer before beginning and allow [Resident 4] adequate time to participate as able. Two care staff will assist [Resident 4] with all transfers using the sit-to-stand. Staff will explain the transfer before beginning, ensure [Resident 4] and the equipment are properly positioned, and confirm the sit-to-stand is appropriately secured before initiating the transfer. Staff will provide simple	N 388		

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directions and allow [Resident 4] time to participate as able. Staff will monitor [Resident 4's] tolerance and safety throughout the transfer and ensure [s/he] is safely positioned at the completion of the transfer. Significant changes in [Resident 4's] strength, coordination, ability to participate, or tolerance of the sit-to-stand will be reported to the appropriate supervisor/clinical/provider contact. Ambulation/Mobility: care staff will support [Resident 4's] mobility according to [his/her] assessed abilities and safety needs. [Resident 4] uses [his/her] manual wheelchair as [his/her] primary mobility device. Two care staff will assist with transfers using the sit-to-stand. Staff will ensure the wheelchair and sit-to-stand are appropriately positioned and secured before transfers."

On 09/17/2026 at 12:00 PM, Surveyor observed Assistant Director G, Caregiver U, and Caregiver V perform a transfer on Resident 4 from his/her wheelchair to bed. The three staff used a gait belt and confirmed this was Resident 4's method of transferring. During the transfer, Resident 4 appeared unsteady during the pivot phase, required multiple cues, and the 3 staff used the gait belt to complete the transfer.

On 09/17/2026, Surveyor reviewed Resident 4's physical therapy discharge report dated 08/06/2026. The following was documented: "At discharge, patient continues to require assistance for bed mobility and transfers, with performance varying from min assist to max assist depending on Parkinson symptoms, fatigue, cognition, initiation, and environmental setup. At this time, patient benefits from staff assistance during functional transfers and power wheelchair mobility to support sequencing, positioning,

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environmental awareness, and safe controlled mobility. Patient has achieved maximum functional potential within the home health (HH) setting. Patient is transitioning to facility-based outpatient/Med B therapy through [different therapy provider] for continued maintenance, wheelchair coordination training, transfer practice, staff carryover, and long-term mobility support. HHPT discharge completed at this time due to max potential achieved in home health, transition to in-house therapy services, and ongoing need for facility-based safety management and staff-supported mobility plan."

On 09/17/2026, Surveyor reviewed Resident 4's occupation therapy discharge report dated 08/06/2026: "Pt has made modest progress this plan of care (POC), reaching maximum rehab potential for the HH setting at this time. PT and [Guardian P] present for session. Pt presented with improved mobility and initiation of movement during session today, however d/t Parkinson's this is not [his/her] consistent level of mobility. Pt demonstrated toilet transfer from motorized w/c to toilet at MinA with gait belt. Pt recently had access to motorized w/c limited d/t pt inconsistent ability to control movement, resulting in pt injuring two other residents. Pt presents with impulsivity and will leave meals when [s/he] is done, despite care plan requiring escort back to room for motorized w/c safety."

On 09/24/2026 at 3:00 PM, Surveyor interviewed Guardian P via phone. Guardian P reported ongoing concerns with Resident 4's transfers at the facility. Guardian P reported Resident 4 started with 1-assist, then the gait belt was added, then gait belt with 2-assist, and most recently as of 09/15, s/he was changed to a sit-to-stand. Guardian P reported there have been

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several therapists trying to get a consistent routine of how to transfer Resident 4 and an attempt to set up very specific things. Guardian P reported Physical Therapist X thought the sit-to-stand would help since it limits the number of options. Guardian P reported even with the sit-to-stand there is still no consistency. Guardian P confirmed there was a camera in Resident 4's room and s/he had observed staff regularly not using a gait belt, using Resident 4's arms, wrists, pants, etc to move him/her, and not using the sit-to-stand. Guardian P reported 1 staff often completes the transfers due to the facility being short staffed and staff verbally comment this on the videos. Guardian P reported s/he was unable to save footage of all the dates but would review videos and provide a summary of his/her observations.

On 09/28/2026 at 4:56 PM, Surveyor received the following email from Guardian P regarding staff not following Resident 4's ISP in regard to transfers:
"Here are a few notes from the last week:
9/27 1231 no gaitbelt back to bed."

"Additional dates of concerns were submitted:
07/02 1702
There were a lot of issues with this interaction and lack of communication, clarity, or precise directions. Overall, no gait belt....repeating the same basic command for [him/her] to transfer [him/herself]. Continued to use [his/her] arm and bare skin (with a shirt draped over [his/her] hand) after causing pain. Very unsafe for both of them, including the chair being on, moving as [s/he] was holding onto it, and driving it with [him/her] halfway in it.

09/21 0817

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N 388	Continued From page 31 [Caregiver Z] and [Caregiver V] had a gait belt on [him/her]. [Caregiver Z] on [his/her] left and holding gaitbelt at [his/her] back. Told [him/her] to "grab this arm, grab it" and it appears trying to have [him/her] grab the bed side rail. [Caregiver V] was on [his/her] right and took [his/her] arm, rather than the belt. No communication was made with [Resident 4] about waiting or when and how to transfer. [S/he] is known to be extremely impulsive and to stand, or often start a transfer too early. So this is surprising. [S/he] prefers and it is usually easier and safer to let [him/her] crawl/step into bed forward. It seems like that is how they were set up. However, as soon as [Caregiver Z] told [him/her] to grab that arm, all in one combined and sudden motion, [s/he] did slightly, stood (which you can see they both followed a bit and [Caregiver Z] sorta assisted with) and step-lunged into the bed, as well as threw [his/her] torso over and to the left (head of the bed). [Caregiver V] barely had [him/her] and lost grip completely. The wheelchair also moved backwards during this because it wasn't locked into place. 09/26 1018 Off camera [staff] confirms [s/he] is done in the bathroom. [Caregiver V] gets gloves on and moves manual wheelchair into bathroom (Ez-stand in in the middle of [his/her] living quarters at this time). You can see [Caregiver V] reach over the back of the chair (the unlocked and very wobbly wheelchair) to assist. No directions or communication about the transfer is had. [S/he] reaches more again, but down lower in a way that looks like [s/he] helps position [him/her] back farther in the chair. Then [s/he] backs the chair out of the bathroom, as [staff] flushes the toilet. As they are all in the living area you can see [s/he] has no gait belt on ([s/he] is	N 388		

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N 388	Continued From page 32 also leaning a bit in the chair..and they proceed to take [him/her] out to the common area. 09/26 1207 [Caregiver V] enters and puts gloves on. [S/he] is brought back in from common area hall in [his/her] manual wheelchair afterwards.... [Caregiver V] puts the second foot rest away and then comes up next to [him/her] and helps push [him/her] forward and toward bathroom while saying "okay [Resident 4], let's go to the bathroom." [S/he] says, "no, I don't have to." [S/he] responds "it's best that we go, because you are going to be calling us that you have to go."...Still without gait belt on (& Ez-Stand set in the middle of the room and [him/her] with [his/her] visible lean), [s/he] is pushed with wheelchair into bathroom and then [staff] steps around past it into the bathroom. Again, the chair is not locked, and with no communication regarding the transfer at all, and [Caregiver V] standing directly behind the wheelchair. The chair moves a bit more and then [s/he] backs up with the empty chair. 09/26 1217 Sling slips down by butt and [s/he] has [him/her] sit back down and apologizes. [S/he] places pillow to help cushion and then leaves [him/her] partially in sling and wheelchair with drastic left lean. In the 1.25mins that [s/he] is gone [s/he]: drops the pillow on the floor, picks it up and puts it on the bed, tries to use the bed rail to keep [him/herself] up, and then starts to try to stand [him/herself]. [S/he] reenters just in time to stop the latter. [Caregiver V] following. [other staff] asks, "it no good." [Caregiver V] checks and says, "It's the wrong one" and leaves to the bathroom for the other sling (too large of a size came with it originally). [S/he] sets it aside and as they are trying to unhook the large sling, that is under	N 388		

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[his/her] butt and [other staff] lowers the EZ-Stand the rest of the way, [s/he] tries to stand on [his/her] own....While [s/he] is holding on standing, s[s/he] clears the apples and pillow off the area needed on the bed. Then tries to roll the stand and it gets caught because one of [his/her] feet had come off. So [other staff] has [him/her] sit down. [Caregiver V] goes around and helps adjust [his/her] Left foot and says, "keep your foot right there." [Other staff] also unclips the sling. Then [Caregiver V] tells [him/her] to stand up again and [other staff] holds around [his/her] back (no gait belt) as they move [him/her] and the EZ-Stand together. They got caught on [his/her] wheelchair slightly in the process, and as they had [him/her] sit down on the bed the (unlocked) stand rolled out a bit. Luckily neither was enough to ruin the extremely unsafe transfer. Lastly, wthout any communication warning or request for help from [him/her] or [other staff], in order to get [him/her] laying down and feet up, [Caregiver V] took it upon [him/herself] to put [his/her] arm around [his/her] back and right arm under [his/her] legs and swivel [him/her] over and back into bed alone.

09/28 1145
[Staff] enters and approaches [Resident 4]. Talks [him/her] into getting up. [Assistant Director G] leaves. [Staff] has [him/her] help 'swing [his/her] legs' around while [s/he] assists. Gait belt is still on [him/her] from prior and [s/he] uses that. Puts [his/her] shoes on. Repositions [his/her] wheelchair near the bed - rolls some and obvious that the left wheel is never locked. [S/he] grabs the front of the gait belt with one, while [s/he] is still leaning back/nearly laying and has one foot nearly on the bed versus the floor (also doesn't give any cues or ask for [him/her] to grab or hold onto anything), and then adds [his/her] second

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hand to the front of the gait belt and says, "come on, let's stand" and [s/he] pulls [him/her] up using [his/her] body weight leaning back against [his/her] to lift [him/her] completely, and swings [him/her] over ([his/her] L to R) onto, the edge, of the manual wheelchair. [S/he] braces a bit by grabbing the right chair arm and [s/he] says, "let's scoot back in the chair, [Resident 4]" as [s/he] lets go of the front of [his/her] gait belt with [his/her] right hand and grabs it or [his/her] left side (unable to visualize) and pushes [him/her] over into the chair farther while holding [him/her] up with [his/her] left. (Luckily [s/he] wasn't too afraid and stopped bracing on the right or [s/he] wouldn't have been able to be positioned into the chair fully at all.) [S/he] is then sitting in the chair leaning far to the left. [Assistant Director G] comes back into the room right at this point and says hi to [him/her] and asks how [s/he] is. Luckily [s/he] was mostly limp and very compliant and [other staff] was able to lift and counter with [his/her] body weight. In any other situation, even [his/her] weight countering, it could've been extremely detrimental to them both. I was also amazed that [Assistant Director G] would be in the room and then leave for exactly the one minute it took to do this transfer!?! Despite being well aware [other staff] was prepping and following through on this transfer, [s/he] left [him/her] alone to do it. Why wouldn't [s/he] advise [staff] on [his/her] technique or assist [him/her] in doing it, and/or stress that [s/he] is supposed to be a 2-assist and with the Ez-stand, which was also already available and just stored in his bathroom?!?"

Example 2: Meal concerns

Resident 4's ISP dated 06/21/2026 documented: "Meal Escort-1 Assist: care staff will provide 1

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assist to escort [Resident 4] to and from meals using [his/her] electric wheelchair as needed. Staff will monitor for safety, and report concerns to the community nurse. Resident is to eat in the dining room."

On 07/24/2026, Guardian P filed a grievance with the provider regarding Resident 4 not being offered meals. Director A submitted the following response on 07/29/2026: "Response:
I have investigated all of the concerns identified and have taken appropriate disciplinary action where needed. Moreover, the complete care plan has been provided to the care team again on 7/24/2026. Areas investigation include toileting times, personal hygiene related to toileting, wait times, privacy, meal refusals and all meals be offered."

Surveyor reviewed the provider's investigation into the above concerns dated 07/26/2026 completed by Director A: " ...Writer interviewed 11 different staff regarding the concerns from 7/4/26 through 7/25/2026.
7/4 - [Caregiver CC] - could not confirm if [s/he] was served lunch. Said [s/he] provided cares.

...7/12 - [Caregiver CC] and [Caregiver N] - staff confirmed they were working that day, could not confirm lunch was given. Careplan not followed.

... Concerns continue to be that [Resident 4] at times will eat snacks in room. Mornings [Resident 4] gets up after breakfast and will eat later in the morning. This did not occur on 7/4 and 7/12."

Example 3: Meal intake monitoring

Resident 4's ISP dated 06/21/2026, 07/14/2026,

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N 388	Continued From page 36 08/12/2026 and 09/17/2026 indicated "Eating: staff will monitor and document intake." Surveyor reviewed Resident 4's record including medication administration records (MARs), progress notes, and task administration records dated June to September 2026. The provider did not consistently document intake and the Surveyor observed only the following dates as being completed: 06/25/2026 (1 meal), 08/11/2026 (1 meal), 08/13/2026, (1 meal), 08/16/2026 (1 meal), 08/17/2026 (1 meal), 08/24/2026 (1 meal), 09/16/2026 (2 meals). There was no other evidence in the record that intake was recorded from 06/21/2026 to 09/17/2026. Interviews: On 09/17/2026 at 1:30 PM, Surveyor interviewed Chief Operating Officer R. Surveyor asked for clarification regarding Resident 4's ISP directing staff to record food intake and this information not being available in the record. Chief Operating Officer R reported s/he did not know this information was on his/her ISP and management staff must have entered the information. Chief Operating Officer R stated s/he would remove it today because Resident 4 did not have a doctors order. Chief Operating Officer R acknowledged an understanding of the above concern. On 09/30/2026 at 10:00 AM, Surveyor conducted an exit conference and shared findings with Director A, Director of Operations B, Regional Nurse L, and Chief Operating Officer R. The management team acknowledged an understanding of the above concerns. Director of Operations B confirmed s/he had reviewed video footage provided by Guardian P of staff not	N 388		

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N 388	Continued From page 37 following Resident 4's ISP with transfers. The management team reported staff had been trained with each ISP update and had access to resident ISPs via the provider's electronic health record (EHR). Surveyor expressed concern for the repeated occurrences of not following Resident 4's ISP with transfers, still as of 09/28 with Assistant Director G in/out of the room. The management team reported they planned to develop summaries of resident ISPs for staff to reference during their shift, instead of relying on them to read the whole document. Cross Reference: N0352 DHS 83.32(3)(l) Rights Of Residents: Adequate Treatment	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	N 431		

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N 431	Continued From page 38 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 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 provide or arrange services adequate to meet the needs of Resident 4. The provider did not monitor Resident 4's Deep Brain Stimulation (DBS) device resulting in low recharging levels. Findings include: Resident 4 used a Medtronic Percept RC Neurostimulator and Wireless Recharger system. The wireless rechargeable model WR9230. "Your Rechargable DBS System: Implanted components: Your DBS system is comprised of leads and lead extensions, wires (leads) that carry electrical signals to precise areas of your brain as determined by the programming of your neurostimulator that can help to control some of the movement disorder symptoms associated with Parkinson 's Disease, Dystonia, or Essential Tremor. Check the battery frequently. Use your patient programmer to check your implant battery levels on a regular basis. The time before your battery gets low depends on the level of stimulation you are receiving. No matter your recharging schedule or your stimulation settings, your device will last for 15 years before it needs to be replaced." (Source: Medtronic Website, DBS Percept RC Recharger Patient Brochure,	N 431		

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N 431	Continued From page 39 2023, https://www.medtronic.com/content/dam/medtronic-wide/public/western-europe/products/neurological/dbs-percept-rc-recharger-patient-brochure.pdf (retrieval date - October 15, 2026).) On 08/03/2026, the Department received a complaint alleging concerns with a resident's care. On 09/17/2026, Surveyor conducted a complaint investigation and identified the following: Resident 4 was admitted to the provider on 05/28/2026 with a diagnosis of Parkinson's disease. Resident 4's record indicated s/he had a legal guardian (Guardian P). Resident 4's individual service plan (ISP) dated 06/21/2026 documented: "Other: Directions: [Resident 4] has a DBS device implanted in [his/her] chest, which is connected to [his/her] brain. [S/he] uses a DBS recharger to maintain the device. The recharger is a large white disc with a blue back that is placed over the charging port. [Resident 4] requires assistance with proper placement and use of the charging device. Method for delivering care/Who is responsible: Care staff will assist [Resident 4] with the DBS recharging process. The DBS recharger (white disc with blue back) will be placed correctly over the charging port to charge the internal device in [Resident 4's] chest. Staff will follow all instructions provided, which are located in [Resident 4's] room and in the medication room. Staff will ensure the device is charged per recommended schedule and monitor for any issues with the device or charging process. Any concerns, malfunctions, or changes in [Resident 4's] condition will be reported promptly to the Community Nurse."	N 431		

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Resident 4's ISP dated 08/31/2026 documented: "DBS Charging: care staff will assist [Resident 4] with the DBS recharging process. The DBS recharger (white disc with blue back) will be placed correctly over the charging port to charge the internal device in [Resident 4's] chest. Staff will follow all instructions provided, which are located in [Resident 4's] room and in the medication room. Staff will ensure the device is charged per recommended schedule and monitor for any issues with the device or charging process. Any concerns, malfunctions, or changes in [Resident 4's] condition will be reported promptly to the Community Nurse."

DBS recharging instructions in Resident 4's room and medication room indicted: "DBS supplies are in the top left cloth bin-under [his/her] radio. 1. A gait belt can help hold it in place. 2. Charging only takes 10-15 mins, if done daily and correctly. Put the large white disc (Recharger) in the blue sling with the target icon on the sling lining up with the target icon on the pouch. When [Resident 4's] device in [his/her] chest is fully charged, the white disc will make beeps and the lights will turn off. Beeps are two sets of three notes, going up in pitch. It can be removed any time after this. If it isn't after a few minutes , it will beep a couple times and the round power button light goes off. A few minutes later, it will beep again and the battery light will go off. This means the recharger has finished charging [Resident 4."

Surveyor reviewed Resident 4's task administration record (TAR) and progress notes dated May to August 2026 where staff recorded if daily DBS recharging was completed. The TARs did not consistently record the task as completed. The following dates were missing staff notations indicating the task had been completed:

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N 431	Continued From page 41 June: 6/19-6/20, 6/22, 6/24-6/30 July: 7/1, 7/3, 7/7, 7/11, 7/13, 7/17-7/23, 7/26 Surveyor reviewed Resident 4's DBS charging task report dated 08/13/2026 to 09/17/2026 where staff recorded DBS recharging percentage. The document did not consistently record the percentage and percentages below 90% were observed. The following dates had concerns: -08/16/2026: Deep Brain Stimulation (DBS) Device Charge Q. After charging, what is the charge percentage? A. 75 -08/24/2026: Deep Brain Stimulation (DBS) Device Charge Q. After charging, what is the charge percentage? A. 70 -09/02/2026: Deep Brain Stimulation (DBS) Device Charge Q. After charging, what is the charge percentage? A. 80 -09/03/2026: Deep Brain Stimulation (DBS) Device Charge Q. After charging, what is the charge percentage? A. 80 -8/18, 8/26, 9/7-no percentages were recorded in the record. Resident 4's progress notes documented: "-09/22/2026: 9:30 AM: Resident observed this morning in the dining room with continued	N 431		

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left-sided leaning. Staff had previously placed a pillow for positioning/support. Resident was pleasant and cooperative during observation. @ 11:15 AM: Received update from [Guardian P] regarding resident's 9/21/26 appointment with [Physician T]. Labs and urinalysis were obtained. Guardian reported no outward signs of acute illness or infection were identified. Resident demonstrated significant fatigue, weakness, left-sided leaning, and decreased coordination during the visit. Guardian reported resident was in a good mood, with some hallucinations noted. Provider documentation and test results are expected to be faxed to the community.

-09/21/2026 1:45 PM: Resident scheduled for medical evaluation today following behavioral changes noted last evening to assess for a possible underlying medical cause. Today, resident was observed leaning significantly to [his/her] left while seated. Per guardian request, resident will use [his/her] electric wheelchair for transportation to the appointment. Electric wheelchair is equipped with a seatbelt and will provide safer positioning and support during transportation given the significant left-sided leaning observed today.

-07/12/2026: writer checked resident and resident was dry. Also writer checked resident heart monitor and resident was at 70% so writer put [his/her] DPS [sic] monitor on so [s/he] can be at 90-100%.Will be letting NOC shift know to check to see if [his/her] DPS [sic] monitor is at 90-100%."

Resident 4's neurology appointment dated 06/17/2026 documented: "Assessment & Plan: ... [Resident 4's age] with progressive Parkinson's disease complicated by motor fluctuations s/p

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N 431	Continued From page 43 DBS and Parkinson's disease dementia with psychosis, with recent functional decline prompting transition to memory care where [s/he] appears safer and is beginning to regain strength. Disability is driven predominantly by Parkinsonian motor dysfunction with impaired coordination/proprioception and left-predominant postural/mobility impairment rather than pure weakness. Hallucinations are improved though intermittently persistent. History of Present Illness: .... DBS planning and treatment discussion: -DBS interrogation performed today because of concerns about battery function, gait freezing, and left arm symptoms. -Rechargeable DBS is intended to be charged daily around 10 AM at the facility, though recent charging history showed inconsistent charging." Resident 4's palliative care notes dated 06/24/2026 documented: "History of present illness: ...[Resident 4] is a [age] [fe/male] with progressive Parkinson's disease complicated by motor fluctuations, bradykinesia, dystonia, left arm weakness, reduced proprioception, s/p Deep Brain Stimulator and Parkinson's disease dementia with psychosis, recurrent falls, hearing loss, with recent functional decline prompting transition to memory care ....GI-appetite stable, needs reminders to eat. Needing assistance for feeding due to inability to get food to mouth. Often has intermittent looser stools, intermittent incontinence. Denies dysphagia but tends to eat quickly and can cough. If DBS has not been charged will also experience episodes of choking." Surveyor reviewed Guardian P's grievance dated 09/02/2026. The following was documented: "	N 431		

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N 431	Continued From page 44 ...Issue/Concern/Complaint: DBS scheduling was messed up in medication administration record (MAR)/care plan again, despite detailing it with [Regional Nurse L] 8/12 and via email & care team meeting multiple times prior back to 7/26. Is to be charged ONCE per day, fully & documented %. The latter shows in the MAR that 8/16 & 8/24 [staff] only charged it to 75% & 70%, respectively. Please retrain [him/her] on this & need for 90%+ goal. As well as verbally and clearly inform all aides of the desire for it to be charged in the evenings only." Director A responded to the above grievance on 09/18/2026 at 6:11 PM: "The first Grievance is attached regarding the DBS scheduling. Prior to 8/13/2026, low percentages being identified on the DBS, so we had increased the charging to twice a daily; this was disruptive for the resident. Care Plan was updated on 8/13/2026 to be once a day at 8 pm with the percentage of charge being documented. Since 8/13, we added the data with a goal of 90%; the lowest number has been 70%. I am attaching the data. I believe these adjustments have met [Resident 4's] needs. The grievance is concerned with the 70% numbers. Staff member in question has been retrained and verbalizes the understanding that the goal is 90%. 70% is too low." On 09/18/2026 at 6:19 PM, Director A sent the following email to the Surveyor: "Here is the first response to the grievance #1 - DBS charging. Please note that the DBS issues have been addressed prior and have been discussed almost weekly. The percentage documentation and only 1x per day was added on 8/13. The target charge is 90%. The device has not at any time ever been at 0% since admission. We never want that to occur."	N 431		

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N 431	Continued From page 45 Email exchanges: On 10/06/2026, Surveyor reviewed email exchanges between Guardian P, and at least Director A, Director of Operations B, Assistant Director G, Regional Nurse L, Case Manager Q, Chief Operating Officer R, and RN Case Manager W. The following emails showed repeated concerns reported to the provider regarding Resident 4's DBS recharging: Guardian P sent the following email on 06/17/2026 at 2:26 PM: "Well the neurologist just brought to my attention that [his/her] DBS is at 10%!?!? It has not been full since the 9th. Was charged okay on the 10th, to 90%, but took lot longer than it could've and over two sessions because of one having mediocre connection. Then NOT CHARGED UNTIL 14th and only for 3 mins and only to 50%!?!?! And NOT CHARGED SINCE!?!" Guardian P sent the following email on 07/08/2026 at 1:38 PM: "Well there has been a TON this week, unfortunately. Key issues:..14) DBS found at 50% ~1700 7/6. (Print sheet I sent?)." Director A sent the following email on 07/29/2026 at 1:52 PM responding to a grievance filed by Guardian P on 07/24/2026: " ...7) Notes from 7/8-7/15: Toileting concern, hygiene (wiping with toileting), Window curtain open, DBS put on incorrectly, wait times for care, care staff in direct care when requested not to be, meal refusals, and not being asked to meals: Response: I have investigated all of the concerns identified and have taken appropriate disciplinary action where needed. Moreover, the complete care plan has	N 431		

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been provided to the care team again on 7/24/2026. Areas investigation include toileting times, personal hygiene related to toileting, wait times, privacy, meal refusals and all meals be offered ...DBS training has been provided to staff. We will be retraining staff again this week. The timing as agreed upon is in the mornings."

Guardian P sent the following email on 09/22/2026 at 6:54 PM: "[His/her] DBS was at 30% today as of 16:20. Observed by myself and [Functional Screener]. [Caregiver DD] was informed in person and we both came to the conclusion that "they must not have done it" (& likely for at least two days, or correctly for many). Luckily I was spending time with [him/her] enough time even and am sending [him/her] back fully charged. Unacceptable. I am not spending time scouring video for who and when the issues arose unless requested. I am going to see if [his/her] Movement Disorders appt 10/23 can be in person and to check adjustment of [his/her] programming. In hopes to help [his/her] leg function, especially left side. Since that seems to be dragging quite a bit more than [his/her] right even. We will see if they can tweak anything. They can pull the records of the last 30days of charging and quality. So from here until then we will have exacts. Hopefully it can be remedied now rather than using that for further correction."

Interviews:

On 09/17/2026 at 9:45 AM, Surveyor toured Resident 4's room. Surveyor observed Resident 4's DBS recharging instructions were displayed for staff to reference.

On 09/17/2026 at 2:35 PM, Surveyor interviewed Resident 4. Resident 4 reported concerns that

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N 431	Continued From page 47 staff did not always recharge his/her DBS device. On 09/24/2026 at 3:00 PM, Surveyor interviewed Guardian P via phone. Guardian P reported ongoing concerns related to Resident 4's DBS device not being charged enough by staff. Guardian P reported in June 2026 at Resident 4's neurology appointment the percentage was down to 10% and s/he never had seen it get so low. Guardian P stated s/he reported this concern to the provider. Guardian P reported Resident 4 knows it is his/her lifeline and is very syn with how charged it is or if it has been charged that day. Guardian P reported the charging times had changed a few times since admission due to low percentages being identified. Guardian P stated if done correctly charging takes 10-15 minutes. Guardian P stated s/he placed recharging instructions in Resident 4's room and had provided a copy to the provider. Guardian P reported s/he had requested Resident 4's MARs from July and August 2026 and had observed staff recording low percentages. Guardian P stated on 08/13/2026, the provider agreed to a goal of 90% of recharging 1x/day. Guardian P stated after that ISP update, concerns continued and on 9/22 when Resident 4 had a functional screen assessment scheduled, the DBS was read at 30%, witnessed by the screener. Guardian P reported s/he had filed a grievance on 9/2 with Director A regarding the DBS concerns and s/he did not get a response until the Department was involved. Guardian P confirmed s/he had a camera in Resident 4's room and had observed many occurrences of staff not recharging Resident 4's DBS correctly. Guardian P reported s/he had provided video footage to the provider of staff not using Resident 4's DBS charger correctly, often observing it backwards. Guardian P reported s/he offered to	N 431		

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train staff on this task, but was never asked by the provider. Guardian P stated s/he would review footage and provide a summary of his/her observations regarding recharging the DBS.

On 09/28/2026 at 4:14 PM, Guardian P sent the following email to the Surveyor summarizing concerns with recharging Resident 4's DBS: "In addition to the huge issue 9/22 of it only being at 30% (attached to the overall email) here are some notes from the last couple weeks that I just happened to noticed. I am not combing through each day at all.
...Recent notes:
9/17 1756 DBS [Caregiver DD] had it in the sling wrong, [s/he] called to me about [him/her] needing snacks and I heard it beeping and explained how to put it in
9/22 22:44 DBS [Caregiver DD] in backwards again; just to take pic for [Director A] (but had to flip it around a few times)
9/25 2223 DBS [Caregiver DD] charged and voiced on camera 100%
No entries noted 9/27-9/28 @11:40am!!!"

On 09/30/2026 at 10:00 AM, Surveyor conducted an exit conference and shared findings with Director A, Director of Operations B, Regional Nurse L, and Chief Operating Officer R. The management team acknowledged an understanding of the above concerns. No further comment was provided.

On 10/06/2026 at 11:00 AM, Surveyor interviewed Guardian P via phone. Guardian P reported Resident 4 was supposed to be seen by neurology on 9/21 but due to a behavioral incident at the facility and needing an evaluation, the appointment was cancelled. Guardian P reported the neurology clinic can pull records of

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N 431	Continued From page 49 the last 30 days of charging and quality. Guardian P stated that information could only be obtained in the clinic. Guardian P reported Resident 4 has a rescheduled appointment later in the month. Guardian P reported s/he was concerned with the 9/22 incident and observing Resident 4's DBS device at 30%. Guardian P reported s/he was concerned with staff falsifying records because staff record the percentage is at 100% most of the time. Guardian P stated if the device was charged daily as indicated on the ISP, the percentage should never get to 30%. Surveyor questioned if Resident 4 often removes the charger. Guardian P stated Resident 4 knows it is his/her lifeline and will only remove if staff leave the device on for an extended period of time and do not come back to assist.	N 431		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange medication administration services adequate to meet	N 432		

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N 432	Continued From page 50 Resident 4's needs. Resident 4's Acetaminophen, Certavite, Tab-A-Vite with Iron, and Quetiapine were not administered as prescribed due to unavailability. Resident 4's Buspirone continued to be administered despite taper/discontinued orders sent on 07/31/2026 and 09/04/2026 to the pharmacy. Resident 4's as needed (PRN) and scheduled Nystatin were not administered despite ongoing skin concerns. Findings include: On 08/03/2026, the Department received a complaint alleging concerns with a resident's care. On 09/17/2026, Surveyor conducted a complaint investigation and identified the following: Resident 4 was admitted to the provider on 05/28/2026 with a diagnosis of Parkinson's disease. Resident 4's record indicated s/he had a legal guardian (Guardian P). Resident 4's individual service plan (ISP) dated 09/17/2026 indicated staff administer his/her medications. Example 1: Unavailability of medications Resident 4's physician order included: "-Certavite Senior with instructions to take 1 tablet by mouth daily with a start date of 05/28/2026 and end date of 08/11/2026. -Tab-A-Vite with Iron with instructions to take 1 tablet by mouth daily with a start date of 08/11/2026.	N 432		

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N 432	Continued From page 51 -Acetaminophen 500 mg tab with instructions to take 2 tablets (1000mg) by mouth 2 times daily for pain, with a start date of 06/10/2026 and end date of 08/02/2026. -Acetaminophen 500 mg tab with instructions to take 2 tablets (1000mg) by mouth 2 times daily as needed for pain, with a start date of 06/09/2026 and end date of 08/01/2026. -Quetiapine 25 mg with instructions to take 1 tablet by mouth daily at 7pm for Parkinson disease related psychosis, with a start date of 06/29/2026." Resident 4's medication administration record (MAR), dated 07/01/2026 to 09/30/2026, documented the following occurrences of medications being unavailable for administration: -Quetiapine 25 mg: No Pass Reason: "Waiting on pharmacy." 07/03, 07/04, 07/05, 07/08, 07/11, 07/12, 07/13, 07/15 - Certavite: No Pass Reason: "Waiting on pharmacy." 07/04, 07/09, 07/22, 07/24, 07/26, 07/28, 07/30, 08/02, 08/04, 08/06, 08/07, 08/08, 08/11 - Acetaminophen 500 mg (scheduled): No Pass Reason: "Waiting on pharmacy." 08/01, 08/02, 08/08, 08/09, 08/13, 08/14, 08/15, 08/17, 08/20, 08/22, 08/23, 08/24, 08/25, 09/08, 09/11 -Tab-A-Vite with Iron: No Pass Reason: "Wait on pharmacy." 08/12, 08/15, 08/18, 08/19, 08/20, 08/21, 08/22, 08/23 Example 2: Buspirone Resident 4's physician orders noted on the MAR included:	N 432		

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"-Buspirone 10 mg with instructions to take 0.5 tablet (5 mg) by mouth in the morning, with a start date of 06/11/2026 and end date of 08/11/2026.
-Buspirone 5 mg with instructions to take 1 tablet by mouth in the morning, with a start date of 08/10/2026.
-Buspirone 10 mg with instructions to take 1 tablet by mouth at bedtime, with a start date of 06/11/2026."

Resident 4's palliative care notes dated 07/27/2026 documented:
"Assessment & Plan:
-Consider taper/discontinue of buspirone as question whether current dosing is not at the therapeutic dose and question whether providing benefit. Goal is to simplify medication list. [Guardian P] agrees. Will communicate to PCP.
Provider Narrative: Fax note to:
1) [Physician T]
2) [Providers name]
Recommendations for primary provider: called clinic on 7/28/26
.....4) Consider taper or discontinuation of buspirone as question whether providing benefit at current dose and goal of simplifying."

Resident 4's palliative care notes dated 09/03/2026 documented:
"History of present illness: ....Since last visit palliative care visit about 6 weeks ago, [Resident 4] established care with psychiatry on 8/12/2026 without changes made and schedule follow up on 9/16/2026. Medication administration times were simplified to 2x daily and verified per review of med list today. Plan was to taper [his/her] buspirone starting 7/31/2026, but continues on med list today at prior dosing of 5 MG AM and 10 MG HS.
Assessment & Plan:

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N 432	Continued From page 53 -1) .....-Per review of med list today taper and discontinuation of buspirone per discussion at last palliative care visit has not occurred despite orders from PCP. Discussed with [Regional Nurse L] and [Assistant Director G] who confirm [Resident 4] has still been receiving the buspirone. Will contact PCP to resend orders to [pharmacy]. Provider Narrative: Fax note to: 3) [Physician T] 4) [Providers name] Recommendations for primary provider: per chart review [Guardian P] discussed with PCP and orders have been entered in Epic. 1) Recommend taper/discontinuation of buspirone as per plan following last palliative care visit. 2) Recommend increase in nystatin from PRN to scheduled 2x daily." Resident 4's psychiatric visit notes dated 08/12/2026 documented the following current medications: "Buspirone 5 mg, take 1 tab at 7pm for 7 days then discontinue." Resident 4's August and September 2026 MARs documented the following: -Buspirone 5 mg tab (morning) documented as administered 08/01/2026 to 09/17/2026 (day of survey). -Buspirone 10 mg tab (bedtime) documented as administered 08/01/2026 to 09/17/2026 (day of survey). Resident 4's telehealth visit with Physician T dated 09/04/2026 documented: "Clinical notes: ...Had been still taking buspirone as it didn't get taken off the MAR. The pharmacies switched and the timing got screwed up. [Resident 4] thinks [s/he's] getting twice a day but the timing is	N 432		

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wrong. [Resident 4] desires to minimize [his/her] medications where able."

Resident 4's progress notes did not provide details 07/31/2026 to 09/17/2026 regarding Resident 4's buspirone.

Example 3: Nystatin

Resident 4's physician orders included:
"-Nystatin with instructions to apply 3 times daily as needed (for fungal infection), with a start date of 08/03/2026 and end date of 09/13/2026.
-Nystatin with instructions to apply powder topically twice daily, with a start date of 09/13/2026."

Resident 4's palliative care notes dated 07/27/2026 documented:
"-History of present illness: Today, [Resident 4], [Guardian P] both share multiple concerns regarding care at the facility, which is what the majority of our visit today was spent on ... [Guardian P] shares concerns related to infrequency of toileting at ALF, with caregivers often not toileting [Resident 4] for up to 8 hours during the day and up to 11.5 hours overnight. [Resident 4] is incontinent of both urine and stool at times ....[Guardian P] has shared these concerns with [Director A] and [MCO team]. [S/he] continues to meet weekly with ALF Director.
Assessment & Plan:
- ...Communicated concerns to [Director A]. Continue weekly meetings with ALF, guardian, and MCO, and ombudsman to promote collaboration and communication of care concerns.
-Recommend simplifying med regimen to meds 2x daily at 7 AM and 7 PM. To [pharmacy] to

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decrease refusal of medications and paranoia surrounding meds. [Guardian P] agrees. Will communicate to PCP.
- ...3) Urinary incontinence, Bowel incontinence: guardian noting limited frequency of toileting occurring at ALF with risk for skin breakdown.
-Full skin completed at visit today without evidence of skin breakdown, bruising, rashes.
-Recommend order for nystatin cream PRN daily to groin. Will communicate to PCP.
Provider Narrative: Fax note to:
5) [Physician T]
6) [Providers name]
Recommendations for primary provider: called clinic on 7/28/26
1) In effort to decrease med refusals and paranoia, recommend simplifying medication administration times to 2x daily 7 AM and 7 PM.
...3) Order for PRN nystatin cream daily PRN to groin folds."

Resident 4's palliative care notes dated 09/03/2026 documented:
"History of present illness: ...[Guardian P] is concerned about a new rash in [his/her] groin area. [His/her] nystatin was recently changed to PRN to scheduled daily, but according to med list today remains ordered as PRN. [Resident 4] continues to experience urinary incontinence and often sits in wet incontinence briefs.
Physical Exam: Skin: rash was indicated, additional details skin: wet pink rash to bilateral groin, without warmth or scaling.
Assessment & Plan:
..3) Urinary Incontinence, Bowl Incontinence, Intertrigo: with light pink rash to bilateral groin area on exam today. No evidence of erythema or discharge. -Per review of ALF medication list, nystatin remains ordered PRN rather than scheduled daily per PCP orders 8/26/2026.

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Discussed with [Regional Nurse L] and [Assistant Director G] who note they have received the updated order and will make changes starting today."

Resident 4's telehealth visit with Physician T dated 09/04/2026 documented: "Clinical notes: they were wondering if they can schedule the nystatin powder twice daily. This skin has been red. This way in case [s/he] refuses, they'll offer once more."

Resident 4's progress notes documented:
"-08/11/2026 completed by Director A: Writer, regional nurses, [Chief Operating Officer R], ombudsman, [Guardian P], [MCO case team], and resident met .....Group did review that [s/he] was having some yeast issues.
-08/26/2026 completed by Regional Nurse L: message left with resident's PCP requesting nystatin PRN order to be scheduled."

Resident 4's August and September 2026 MARs documented the following:
-Nystatin powder PRN (start date 08/03/2026)-no dates recorded as administered.
-Nystatin powder scheduled (start date 09/13/2026), documented as administered 09/14/2026 to 09/16/2026.

Interviews and email reviews:

On 08/20/2026 at 2:16 AM, Guardian P sent the following email to at least Director A, Regional Nurse L, and Chief Operating Officer R: "[His/her] groin redness and yeast infection is not being dried or cared for as ordered, including yesterday when [s/he] showered with [Director A] (& it had a super strong odor and no evidence of any cream having been applied). As well as [staff] having no

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idea about it needing to be dried last night nor what to use to do so (we eventually used one of [his/her] hand towels per my suggestion)."

On 09/20/2026 at 10:48 PM Director A sent the following email to the Surveyor and Guardian P regarding his/her grievance filed on 09/02 regarding groin issues. " ...The current Nystatin powder order on 9/13/2026 has the medication ordered twice daily. The medication was ordered PRN on 8/13/2026, then daily on 9/3/2026. As stated in grievance, PRN medication usage was not consistent, so the order was moved to scheduled.
There have been multiple refusals by the resident for administration. Based on the times the resident is getting up in the morning, a 9 or 10 am order may be more in line with the resident getting up for the day (rather than when still in bed and not wanting to get up). And then again after dinner. This can be reviewed with guardian as to time of administration. Please let me know if you have any questions. I would like to further discuss the administration times that would better meet [Resident 4's] needs. The current refusals may be due to timing."

On 09/24/2026 at 3:00 PM, Surveyor interviewed Guardian P via phone. Guardian P stated s/he had ongoing concerns related to Resident 4's medications. Guardian P stated s/he was not aware Resident 4 did not receive his/her Quetiapine in July until concern discussed with the Surveyor. Guardian P noted the dates Quetiapine was not available coincides with some of the first major behavior incidents. Guardian P stated s/he was not aware Resident 4 was continuing to receive his/her buspirone until the palliative care nurse practitioner (NP) had told him/her on 9/3 that facility staff was still

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administering, despite d/c orders sent by the PCP on 7/31. Guardian P shared the facility had switched pharmacies over the summer and had ongoing concerns with medication orders. Guardian P reported s/he told Regional Nurse L at the end of July about the nystatin order and infrequency of incontinence changes. Guardian P reported after Resident 4's palliative care visit on 9/3, skin concerns were noted and facility staff continued to not use the PRN nystatin.

On 09/25/2026 at 12:37 PM, Surveyor sent the following email to Director A and Chief Operating Officer R: " ...Med concerns: Seroquel and Acetaminophen unavailability Nystatin, and Buspirone supposed to taper then d/c dated 7/31. [Palliative care] notes show as of 9/3 Buspirone still being given, despite orders sent from PCP. Aug and September MAR show administrations of this med."

On 09/28/2026 at 10:02 AM, Regional Nurse L with Director A, Director of Operations B, and Chief Operating Officer R responded " ...Nystatin / Buspirone
After the palliative care provider identified that the medication changes had not been reflected in the record, I followed up regarding both the Nystatin scheduling and Buspirone discontinuation.

On 8/26/2026, I documented contacting [Physician T's] clinic and requesting that the PRN Nystatin order be changed to a scheduled order. In the interim, medication staff were instructed to continue administering the existing PRN Nystatin order as indicated.

On 9/8/2026, because I was still not seeing either the scheduled Nystatin order or the Buspirone taper/discontinuation order reflected by the

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pharmacy, I contacted the [palliative care] and requested clarification. The NP advised that these orders needed to come directly from [Resident 4's] PCP and indicated that [Physician T] had transmitted orders to [pharmacy] on 9/4/2026 for scheduled Nystatin twice daily and discontinuation of Buspirone. My recollection is that I subsequently followed up with the PCP clinic directly regarding implementation of those orders." Additional note: There is no evidence in the record of Regional Nurse L following up with Physician T or the pharmacy after the above interaction with palliative care.

" ...Medication availability / staff education: Review of the MAR shows multiple instances where medications were documented as "waiting on pharmacy." In some cases, an active PRN or alternate available supply of the same medication was present. Additional education is indicated for medication passers on checking all active orders and available medication supplies before documenting a medication as unavailable."

On 09/30/2026 at 10:00 AM, Surveyor conducted an exit conference and shared findings with Director A, Director of Operations B, Regional Nurse L, and Chief Operating Officer R. The management team acknowledged an understanding of the above concerns. The management team reported concerns with not seeing medication orders transcribed from the pharmacy into their electronic health record, despite orders being sent from Resident 4's physician multiple times. The management team did not provide further comment.

On 09/30/2026 at 2:28 PM, Surveyor interviewed Physician T's office via phone. Surveyor spoke to Nurse Y who reported the clinic had resent orders

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N 432	Continued From page 60 to the provider's pharmacy on 9/4 regarding the nystatin scheduled and buspirone taper/discontinuation.	N 432		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure services were provided to manage residents' behaviors. Resident 4 exhibited behaviors of verbal and physical aggression towards others. Additionally, Resident 4 exhibited sexually inappropriate behavior towards staff. The provider did not assess behavioral needs and did not add behavioral interventions until 08/12/2026, even though staff recorded at least 11 incidents of the above behaviors from 06/08/2026 to 08/08/2026. Resident 4 had PRN Quetiapine available since 06/29/2026 and his/her individual service plan (ISP) dated 8/31 & 9/17 directed staff to utilize for behaviors. From 08/31/2026 to 09/30/2026, staff documented 6 behavioral incidents. There was no administration of Resident 4's PRN Quetiapine. Resident 4 was a high fall risk with a history of	N 433		

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reoccurring falls due to self-transferring attempts and lowering him/herself to the floor. Resident 4's ISP was not updated until August 2026 with new fall interventions, even though staff recorded at least 22 incidents from 05/30/2026 to 08/11/2026 of the above behaviors. Additionally, Resident 4 had 7 more incidents from 08/13/2026 to 09/17/2026.

The provider did not ensure an effective behavior management plan was implemented.

Findings include:

On 08/03/2026, the Department received a complaint alleging concerns with a resident's care.

On 09/17/2026, Surveyor conducted a complaint investigation and identified the following:

Resident 4 was admitted to the provider on 05/28/2026 with diagnoses of Parkinson's disease, depression, and psychosis. Resident 4's record indicated s/he had a legal guardian (Guardian P).

Example 1: Aggression & sexually inappropriate behavior

Resident 4's ISP dated 05/29/2026 did not identify behaviors. The following was documented for mental illness: "[Resident 4] has a diagnosis of depression and psychosis. [S/he] may experience changes in mood, thought process, or behavior and benefits from routine, reassurance, and supportive interactions. Care staff will provide support, redirection, and reassurance as needed. Staff will monitor [Resident 4] for changes in mood, behavior, or signs of increased symptoms

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SAGE MEADOWS OF MIDDLETON - 5330	5330 CENTURY AVE MIDDLETON, WI 53562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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and report concerns to the community nurse."

Resident 4's progress notes documented the following verbal/physical aggression and/or sexually inappropriate behaviors towards staff from 05/28/2026 to 06/21/2026:

"-06/08/2026: 8:45 AM: Writer went into residents' room this morning to get [him/her] up for breakfast. I lifted resident sitting up right on [his/her] bed. As I was sitting [him/her] in position on the bed [s/he] grabbed my right breast inappropriately. Writer told resident keep your hands to yourself. Resident responded "Okay." 2:45 PM: Writer went into resident's room to assist co worker with toileting resident. Resident had assistance standing up and we were able to get [his/her] depend on and pull [his/her] pants up. As Resident was getting pivoted to [his/her] wheelchair. Resident stood and was turning. Resident was told by co worker to reach to [his/her] wheelchair handle and instead resident inappropriately grabbed my right breast and then lowered [his/her] hand and grabbed my left butt cheek. Co worker immediately told resident "no no don't grab [him/her], reach for the chair handle."

Resident 4's ISP dated 06/21/2026 did not identify behaviors. The same above information remained unchanged regarding mental illness.

Resident 4's progress notes documented the following verbal/physical aggression and/or sexually inappropriate behaviors towards staff from 06/22/2026 to 07/14/2026:

"-06/28/2026: @ 1:30 PM: while I was in the resident's room providing [him/her] with a snack [s/he] had requested, I was standing in front of

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[him/her] when [s/he] extended [his/her] hand toward my genital area and made brief physical contact. I immediately told the resident, "NO" stepped away, and existed the room to ensure my safety. The contact was minimal and lasted only a moment. I reported the incident to my supervisor according to facility policy. @ 5:15 PM: Resident spit out one prescribed medication during medication administration despite encouragement to take it as ordered. Throughout the shift, resident displayed verbally rude and uncooperative behavior toward staff while staff attempted to provide care and assistance. Staff calmly redirected the resident and explained that they were only trying to help and that respectful communication was expected. Resident responded by stating that [s/he] was "going to be rude" and that [s/he] "did not care." No physical aggression was observed. Resident continued to refuse to communicate appropriately with staff. Resident's responsible party was notified of the resident's behavior. Staff will continue to monitor the resident, encourage medication compliance, and provide care using a calm and respectful approach. Also POA has been contacted about the situation as well.

-07/02/2026: Writer went with co worker to resident room to get [him/her] toileted and changed for the day. Writer went up to resident and said Good morning and noticed water was on floor. Co worker cleaned up water and after I asked resident if [s/he] could help me remove [his/her] shirt so we can get a fresh one on. Resident immediately swung at writer and writer backed up and said "hey don't hit me. I am just trying to help you" [s/he] said " you stood in front of my camera. I then attempted to grab [his/her] fresh white shift from the bed and [s/he] was able to swing and hit my arm twice. My co worker then

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N 433	Continued From page 64 backed me up and said "hey, why are you hitting [him/her]. [s/he] said [s/he]'s a [expletive] [expletive]" then my co worker went to go get supervisor and director who were already on unit. I stayed in resident room and waited and let [him/her] know I was just trying to help there was no need to hit me and [s/he] said " smile for the camera you [expletive] [expletive]" I walked out of resident room. -07/07/2026: being very rude hitting writer and other staff. -07/08/2026: Writer went into resident room to get [him/her] dressed and toileted for the day. Resident was cooperating with writer. Resident let me change [his/her] socks then moved on to [his/her] shirt. As writer was helping get shirt on writer noticed that [his/her] right hand was making a gesture that if I was to lean a little more forward towards resident [his/her] hand would be closer to my private area. I immediately step back and let resident fix [his/her] own shirt. [Guardian P] logged into the camera, and [s/he] was asking if I could see why [his/her] phone isn't working and why [s/he] hasn't been able to call. I quickly checked for [his/her] but it said "not in service" Writer simply told the [Guardian P] what it said, and [s/he] said Ok thank you. Writer got resident all dressed and I asked [him/her] to help me pivot onto [his/her] chair. Resident did a good job getting into [his/her] chair but once [s/he] was in it I felt residents right hand grab the back of my thigh all the way up my Butt and squeezed it. I quickly jumped up and [s/he] said "I'm sorry" I said [Resident 4] that was not okay. I'm here to help you not to get touched inappropriately. Resident said "it's just that you're so beautiful. I said thank you but that was not okay. [S/he] said I'm sorry. Writer was touching [his/her] chair	N 433		

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N 433	Continued From page 65 remote to try and get remote chair in position to leave outdoor. Writer looked up and resident had both [his/her] index finger and middle finger in [his/her] mouth doing inappropriate things It made me feel very uncomfortable. Writer informed (Assistant Executive Director (AED)) of the situation. -07/09/2026: Resident seems to be having an OK morning. [S/he] stated [s/he] was not hungry over and over but was screaming for 30 minutes wanting to leave the building stating [s/he] wants to go home staff and writer were trying to redirect resident but nothing was working. AED came in to try to assist and get resident up as well and resident was refusing to get up for breakfast so resident has not eaten breakfast, but [his/her] breakfast is in the microwave if [s/he] does decide to get up before lunch. -07/13/2026: The writer was notified by care staff that the resident was being aggressive during breakfast and threw [his/her] plate of food at another resident. When the writer went to the dining room to assess the situation, the writer observed the resident's plate and cup on the floor next to [his/her] peer, Writer asked the resident did [s/he] throw the plate at [his/her] peer, the resident stated "yes" writer asked why, the resident responded "because [s/he]'s not listing to me" writer informed the resident that was not ok, and [s/he] should not be throwing things at other people. The writer cleaned the resident up, and the care staff walked the resident back to [his/her] room. The resident's POA was notified." Note: Resident 4's record included 7 entries of the above behaviors from 6/8-7/13 and his/her ISP did not include behavioral interventions for staff to use.	N 433		

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Resident 4's ISP dated 07/14/2026 documented: "Behavior & Mood: Chart all difficult behaviors that inhibit resident care process: any issues including combativeness, hitting, throwing items, aggressive verbal behavior, refusals of care, any sexual behaviors towards staff when providing cares." The same above information remained unchanged regarding mental illness.

Note: No interventions included, only to chart behaviors.

Resident 4's progress notes documented the following verbal/physical aggression and/or sexually inappropriate behaviors towards staff from 07/15/2026 to 08/12/2026:

"-07/18/2026: Resident was threatening me and calling me names. Resident attempted to throw water on me and forced me to leave [his/her] room. Resident was combative and refused to get changed and dressed.

-07/23/2026: resident was very aggressive yesterday toward me, and a co-worker we had took [him/her] to the bathroom and [s/he] was being very disrespectful and saying no to, me and so we were trying to assist to get off the toilet I was holding the back of [his/her] pants from keeping [him/her] from falling so another staff walked by the door [s/he] just started going in on [him/her] [s/he] wasn't even in the room [s/he] was by the door then [s/he] came in with assisting us with [him/her] [s/he] tried to hit me while I was holding Still, I was holding [him/her] to keep from falling [s/he] continued resisting to sit in the wheelchair so staff assisted [him/her] down to the floor I was calling [Guardian P] voice control., it wasn't working so I asked co-worker to call

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N 433	Continued From page 67 [him/her], on the phone, another care staff walked in while [s/he] was sitting on the floor [s/he] tried to hit [him/her] and [him/her] private area I left out the room after that because how [s/he] was treating us. Once the [Guardian P] was on the phone, [s/he] began saying everything we were saying to [him/her], the same way. So [s/he] could understand the electric chair would not go into the bathroom; [s/he] needed to use the other wheelchair. The resident wasn't listening to anything [s/he] had to say, so we were finally able to assist [him/her] into the Electric chair. resident kept stating we were going to steal [his/her] electric chair; care staff continued to assist [him/her], and we left the room. -07/25/2026: Previous observation 07/24/2026,Med passer and I went to residents room, Med passer went in to give resident [his/her] medications and I stayed outside the room door, When med passer went into resident room med passer notified resident [s/he] had [his/her] medications and asked resident if [s/he] would like to come out to dinner, resident would not take the medications, and continued to tell the med passer to get the "[expletive]" out of [his/her] room [boy/girl], resident was trying to get up from [his/her] bed to try to [his/her] the med passer, after med passer asked resident again could [s/he] take [his/her] medications resident still refused. So med passer and I walked away from residents room. -08/08/2026: Staff x2 went in to help resident get ready for bed. Resident was bent over and eating crushed crackers on the floor. Staff went back to the kitchen to grab the broom to clean up the mess. As staff went to reenter room resident said no get that [expletive] out of my room talking about writer. Writer stated [Resident 4] I am just	N 433		

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trying to help clean up your room and help you get ready for bed. Resident persisted to keep saying that writer was a [expletive] and to get [him/her] out of [his/her] room. Resident was trying to hit writer and grab the broom. Resident ended up grabbing [his/her] shoes off of the floor and threw both shoes at the staff one shoe was thrown at each staff member. Writer left room and stood by door so other staff member wasn't the only staff in the room. The other staff member was trying to calm resident down with no success. Resident was trying to stand up and hit staff. Resident stated if that [expletive] comes into my room ill kill and attack [him/her]. Resident laughed after that statement was made. The other staff member said [Resident 4] that is not nice we are just trying to do our job and help you. Resident was not having anything and did not want help at all so staff exited room and called management to see how to proceed going further."

Note: Resident 4's record included 4 entries of the above behaviors from 7/18-8/8 and his/her ISP did not include behavioral interventions for staff to use.

Resident 4's ISP dated 08/12/2026 documented: "Behavior & Mood: [Resident 4] occasionally becomes frustrated and acts out. [Resident 4] becomes frustrated and respond aggressively. This is observed by [Resident 4] throwing items at staff and other residents, using inappropriate language with staff, refusing cares from staff. When [Resident 4] is aggressively frustrated, staff will ensure [Resident 4's] safety and leave [him/her] alone. They will return later and offer care again." The same above information remained unchanged regarding mental illness.

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N 433	Continued From page 69 Note: the 8/12 ISP is the first time interventions were included to mitigate above behaviors. Resident 4's progress notes documented the following verbal/physical aggression and/or sexually inappropriate behaviors towards staff from 08/13/2026 to 08/31/2026: "-08/16/2026: When [staff] finally became available, the two of us went to help the resident, who was wet in [his/her] bed. We asked [him/her] to please get up so we could take [him/her] to the bathroom and change [him/her]; however, upon seeing that we were using the manual wheelchair, the resident became agitated and tried to walk, pushing [him/herself] forward. [s/he] was very agitated. [S/he] was informed that the small chair would be used to take [him/her] to the bathroom, since it is impossible for two people, the chair, and [him/her] to fit inside the bathroom when the space is too small. But [s/he] didn't understand that and physically assaulted [staff]; at the same time, [s/he] headbutted the caregiver in the forehead and started calling us lazy [expletives], saying [s/he] would fire us "that we should consider ourselves dismissed. As [s/he] kept hurling insults, I called [his/her] [Guardian P], [s/he] sounded annoyed and told us to leave [him/her] alone, saying [s/he] wouldn't understand and was too angry at the moment. I handed the phone to the resident, and we walked out of the room so [s/he] could calm down. Upon returning, we continued interacting with [him/her]; when we asked [him/her] to please sit in the chair, he refused, instead, [s/he] rode the electric wheelchair as far as the bathroom, and then we used the manual wheelchair to get [him/her] inside. All the while, [s/he] was laughing, gesturing with [his/her] hands and sticking out [his/her] tongue. The resident finally allowed us to	N 433		

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help [him/her], but while in the bathroom, [s/he] wouldn't let Caregiver assist [him/her]; [s/he] would only let [staff] change [him/her]. However, while [s/he] was standing facing the bathroom wall, [s/he] struck my face with [his/her] elbow. I asked [him/her] why [s/he] did that and told [him/her] not to hit me, explaining that I only wanted to help. [S/he] then started shouting loudly, "I didn't hit you! You're lying you're lying!"

-08/18/2026: 08/17/2026 Resident was eating lunch after [s/he] was done [s/he] was ready to go back to [his/her] room caregiver ask if [s/he] can give [him/her] a few minutes ([s/he] was assisting another resident) [s/he] then start yelling saying [s/he] was ready to go to [his/her] room NOW pushing another resident chair which made them upset so both caregivers assist resident back to [his/her] room. When caregivers and resident got to [his/her] room resident tried to get [him/herself] in the bed by lifting [his/her] leg over the bedrail. Caregivers then told [him/her] that was not safe or the right way to get into bed. [S/he] was then ask if [s/he] would let both caregivers assist [him/her] the right way that's when [s/he] pushes [his/her] wheelchair back into caregiver stomach in proceed to put [him/herself] in bed."

Resident 4's ISP dated 08/31/2026 documented: "Behavior & Mood: [Resident 4] occasionally becomes frustrated and acts out related to confusion, frightened, night terrors, and hallucinations. Especially if woken up. Care staff will knock, introduce themselves, explain care before beginning, allow extra response time, and offer two simple choices whenever possible. Maintain routines and promote adequate sleep, food, fluids, comfort, and orientation. Use humor when [Resident 4] is receptive. If upset, ask what is bothering [him/her] and consider confusion,

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hallucinations, fear, hunger, thirst, fatigue, or pain. Remain calm, give physical space, and offer music, a snack/drink, or a call to [his/her] [daughter/son]/sister-in-law (SIL). Avoid arguing, threatening, demeaning language, or forceful directives. If [Resident 4] refuses care or becomes increasingly upset and is safe, stop, give [him/her] time alone, and reapproach later without emphasizing that the care "has to" be completed. If behavior escalates, prioritize safety and disengage when safe to do so. Administer PRN medication only as ordered when indicated. Document significant behaviors/refusals and report concerning changes to the Community Nurse." The same above information remained unchanged regarding mental illness.

Resident 4's progress notes documented the following verbal/physical aggression and/or sexually inappropriate behaviors towards staff from 08/31/2026 to 09/17/2026:

"-09/06/2026: Resident was disrespectful to pm staff calling out [his/her] name and was picking with other resident doing dinner telling them to shut up. Rushing me to hurry up to take [him/her] back to [his/her] room. I told resident that I would take [him/her] back once I was done folding laundry. Then [s/he] said that [his/her] [Guardian P] control everybody [s/he] was just been mean and how physical therapy goes by what [s/he] say and how the resident say [s/he] already going to get people fired.

-09/07/2026: @ 7:00 AM: Resident hitting and kicking staff and called [him/her] a [expletive] while we was trying to change resident caregiver and I reapproach resident a hour later and was able to get [him/her] into [his/her] wheelchair (WC). @ 8:30 PM: Resident was calling my name

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told another staff to tell me to hurry my [expletive] in the room cause [s/he] needed me to change [him/her]. I told Resident that [s/he] [s/he's] not the only resident that I have to attend to. [S/he] cursed at me and the staff that's on with me. [S/he] grab the wheel chair and had a crazy angry look like [s/he] was going to throw the chair so I called [his/her] [Guardian P] and [s/he] say [s/he] have Dementia and I told [him/her] [s/he] not the only resident with dementia. [S/he] talking give [him/her] the phone so [s/he] can talk to [him/her] so I gave [him/her] the phone and left out the room. We was coming to change [him/her] but we don't have to be disrespected or put in harm to help a resident saying [his/her] [Guardian P] can get us fired I have worked with dementia resident.

-09/10/2026: at 7:10am Staff entered residents' room with noc shift worker to do rounds and in a kind voice. Staff let resident know that we'd be back at around 8:30 for breakfast, reason to be is that when resident is around others, [s/he] can get a little bit angry towards them. So, for [his/her] safety and the others we make sure [s/he] gets up last. That way staff can sit with [him/her] and monitor [him/her] and [his/her] behavior. Staff did provide resident with a snack while [s/he] waited. When we came at 8:30 [staff] was putting on shoe on left foot, when resident intentionally tried to kick [him/her], caregiver told resident, "Don't kick me or I won't be able to help you." Resident stated that "it was an accident." Resident then got taken to dining room for breakfast. Staff tried to put on a clothing protector and resident angrily said no, when staff tried to encourage it so white shirt wouldn't get dirty resident said that [s/he] could care less about getting dirty and that [s/he] did not want it. You could tell resident was getting more angry so staff stopped trying and continued to get residents breakfast. After resident was

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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
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done with breakfast staff asked resident is [s/he] could get [his/her] vitals done. [s/he] said no. Staff encouraged [him/her] and told [him/her] that [s/he] should at least get [his/her] "weight done since it would be better to get it done now then later." Resident thought about it and put [his/her] feet up and staff tried taking [him/her]. When resident and staff were passing med passer, resident took [his/her] hand and touched med passer on bottom inappropriately. When staff told resident not to do that and [s/he] shouldn't be touching other people resident got upset with the staff taking [him/her] to get [his/her] weight done and proceeded to try and hit [him/her]. Staff then stopped helping resident, so resident had time to cool down. Staff talked to supervisor and were told to call POA and make a report/observation. While staff was on phone with POA, Med passer and maintenance were passing by Resident. Resident was making inappropriate gestures to the maintenance [staff] "putting [his/her] arms out like if resident was trying to fight [him/her] them mumbling inappropriate things under [his/her] breath. Resident then continued to decline care and was not letting staff take [him/her] to [his/her] room. Resident was trying to get there on [his/her] own when a pt offered to help. PT then distracted resident and calmed [him/her] down. After an Hour resident had calmed down and let us get [his/her] weight done. still refused to get vitals done.

-09/12/2026: Resident was hitting another resident at dinner when [s/he] tried to take [his/her] food I moved resident to another table and issue was resolved."

Resident 4's ISP dated 09/17/2026 documented: "Behavior & Mood: Care staff will approach [Resident 4] calmly, identify themselves, explain

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care before beginning, use simple one-step directions, provide limited choices when appropriate, and allow adequate time for [Resident 4] to process information. Staff will tell [Resident 4] what they are doing before initiating hands-on personal care, transfers, dressing, toileting, or other close-contact assistance. Because inappropriate touching has occurred during hands-on care, staff will maintain awareness of [Resident 4's] hand placement and positioning during close-contact care and position themselves in a manner that promotes the safety of both [Resident 4] and staff whenever reasonably possible. If [Resident 4] makes a sexually inappropriate comment, staff will remain professional and provide a brief, clear boundary and redirection, such as informing [Resident 4] that the comment is inappropriate and redirecting the conversation or activity. If [Resident 4] reaches for, grabs, or attempts to touch a staff member's breasts, buttocks, genital area, or other intimate area, staff will immediately move out of reach when safely possible, clearly tell [Resident 4] that the touching is not appropriate, redirect [his/her] hands, and re-establish personal space. Staff will not ridicule, shame, threaten, argue with, or retaliate against [Resident 4]. If the behavior continues during non-emergent care, staff may stop the care attempt, ensure [Resident 4] is safe, provide time and space for [him/her] to calm, and re-approach later using an alternative approach. When indicated by [Resident 4's] established care plan, additional staff assistance should be utilized during hands-on care for safety and support. Any sexually inappropriate behavior directed toward another resident, attempted unwanted sexual contact, significant escalation in sexual behavior, physical aggression resulting in injury, or other immediate safety concern will be promptly reported to the community

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N 433	Continued From page 75 RN/management and addressed according to the community's resident-protection, incident-reporting, and provider-notification procedures. Mental Illness: Medication-trained staff will administer [Resident 4's] scheduled and PRN medications according to the current provider orders and MAR. Staff will monitor [Resident 4] for changes in mood, anxiety, paranoia, hallucinations, confusion, agitation, sleep patterns, verbal or physical behaviors, participation in usual activities, and other significant changes from [his/her] established baseline. When [Resident 4] demonstrates increased confusion, fear, hallucinations, paranoia, or behavioral symptoms, staff will first assess for possible contributing factors or unmet needs when appropriate, including pain, toileting needs, hunger/thirst, fatigue, illness, sleep disruption, environmental overstimulation, fear, or discomfort. Staff will utilize [Resident 4's] established non-pharmacological interventions, including calm reassurance, simple explanations, redirection, reduced stimulation, familiar routines, personal space, and adequate processing time. PRN Quetiapine 12.5 mg will be administered only according to the current provider order/MAR for the ordered indication of Parkinson disease-related psychosis. Staff will document the specific symptoms present prior to administration and monitor and document [Resident 4's] response and effectiveness following administration. Staff will monitor for potential medication-related concerns, including excessive sedation, dizziness, weakness, increased confusion, changes in gait or balance, abnormal movements, or other significant adverse effects, with particular attention to	N 433		

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N 433	Continued From page 76 [Resident 4's] existing fall risk." Resident 4's progress notes documented the following verbal/physical aggression and/or sexually inappropriate behaviors towards staff from 09/17/2026 to 09/22/2026: -09/20/2026: @ 7:45 PM: Caregiver's went to take resident back to [his/her] room after dinner when caregivers went to cancel [his/her] pendent, [s/he] starts yelling. Caregiver told [him/her] that [s/he] had to cancel [his/her] pendent. Caregivers got [him/her] into the bathroom ...Caregiver's continue to help get [him/her] changed [staff] went to put [his/her] depend on. Resident took [his/her] hand to touch on the caregiver inappropriate [s/he] laugh both caregivers told [him/her] that [s/he] can't do that and to not touch on the caregiver. After that caregiver went to put [his/her] depend on [s/he] lift [his/her] foot to try in kick caregiver in the face. Caregivers got [him/her] dress went to help [him/her] in bed [s/he] throws [him/her] self in bed even after caregivers asking [him/her] to let us help. [S/he] went knee first trying to pull caregiver down with [him/her]. As caregivers went to leave out, [s/he] yells to tell us [his/her] [Guardian P] will be here. Caregiver left out went to contact executive director (ED) to let [him/her] know what was going on caregivers also contacted ED this morning to let [him/her] know about what resident did. @ 11:45 pm resident was very disrespectful to staff [s/he] tried to kick pm staff in the face while we were changing [him/her] and [s/he] kept saying they be here tmro [sic]. [S/he] tried to hit me [s/he] called us pigs and we asked [him/her]to stand up [s/he] refused we use the gate [sic] belt [s/he] tried to pull me down in the bed as we was in [his/her] room. Resident tried to touch staff breast and when [s/he] told that's not ok to touch	N 433		

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N 433	Continued From page 77 [him/her.] [S/he] laugh like [s/he] canndo [sic] what [s/he] want. [S/he] tried to hit me and told [him/her] we was in [his/her] room trying to help [him/her]. Tonight was trying to do my rounds with shift change [s/he] was on the floor. [S/he] grabed [sic] the weight and dint [sic] want nobody in [his/her] room so me and another staff was entering to help [him/her]. [S/he] got really aggressive, had the staff go get the other staff so [s/he] can help me but [s/he] was saying [s/he] did not want us in [his/her] room. Called [his/her] [Guardian P], [s/he] telling us to back off [him/her] so that's what we did. [S/he] was yelling saying get out [his/her] room. [His/her] [Guardian P] is giving feed back about whats going on I went in to see if [s/he] was ok, [s/he] threat to bash my skull with weight. -09/22/2026: Received update from guardian regarding resident's 9/21/26 appointment with [Physician T]. Labs and urinalysis were obtained. Guardian reported no outward signs of acute illness or infection were identified. Resident demonstrated significant fatigue, weakness, left-sided leaning, and decreased coordination during the visit. Guardian reported resident was in a good mood, with some hallucinations noted. Provider documentation and test results are expected to be faxed to the community." Resident 4's record did not include any behavioral assessments. Resident 4's physician orders included: "-Quetiapine 25 mg with instructions to take 0.5 (12.5 mg) tablet by mouth daily as needed for Parkinson disease related psychosis, with a start date of 06/29/2026." Note: Resident 4's 8/31 and 9/17 ISP's directed	N 433		

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staff to utilize PRN Quetiapine for behaviors. From 08/31/2026 to 09/30/2026, staff documented 6 behavioral incidents. There was no administration of Resident 4's PRN Quetiapine. In addition, Surveyor reviewed Resident 4's 06/01/2026 to 09/17/2026 medication administration records (MARs). The records showed PRN Quetiapine only being administered on 7/2 and 7/20.

Example 2: Fall risk

Resident 4's ISP dated 05/29/2026 documented: "Resident is a fall risk due to impaired mobility related to Parkinson's. Care staff will provide 1 assist with ambulation and transfers, ensure proper use of walker and wheelchair, maintain a safe environment, and monitor for changes in mobility. Staff will report any falls or concerns to the community Nurse."

Resident 4's progress notes documented the following falls, self-transfer attempts, and lowering self to the floor (some additional aggression noted) from 05/28/2026 to 06/21/2026:

"-05/30/2026: Resident was found lying on the floor between [his/her] bed, dresser, couch and wheelchair in [his/her] room during rounds. Earlier, another resident had entered [his/her] room and believed [s/he] was sleeping. To avoid disturbing [him/her], the writer had shut resident's door back so [s/he] can sleep. When staff later conducted rounds and entered the room, the resident was observed on the floor. Staff asked the resident what had happened, and [s/he] stated that [s/he] don't remember what happened. Upon assessment, staff observed that the front of the resident's pants was wet and that [s/he] was

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N 433	Continued From page 79 not wearing a shirt. Based on these observations, it appeared that the resident may have attempted to get up a to change [his/her] clothing after being incontinent and accidentally fell during the process. Resident let staff know that [s/he] couldn't stand up independently and should request assistance when needing to transfer or retrieve [his/her] wheelchair. The resident was cooperative with care and allowed staff to assist [him/her] with cleaning up and returning safely to bed without an incident. -06/01/2026: The resident was in [his/her] room when caregiver and help [him/her] get up [Resident 4] was on the floor next to [his/her] bed. There were no witnesses other than the videos from the cameras in [his/her] room. [His/her] vital signs were taken and the on-call doctor was called. BP 126/68, pulse 78, R17, O2 98. -06/04/2026: When caregivers walk into resident [s/he] was sitting on [his/her] butt on the floor. -06/10/2026: Resident refused to eat lunch was upset because [s/he] couldn't eat in [his/her] room. [Guardian P] and AED did talk to [him/her]. When caregivers went to get AED both caregivers came back to [his/her] room, [s/he] was room putting [him/her]self in [his/her] bed [s/he] was told that was not safe [s/he] laughs in said ([s/he] got it watch this) then jump into [his/her] bed. -06/17/2026: Staff went into resident room to change [him/her] and check on [him/her]. Resident was on the floor, staff asked [him/her] was [s/he] hurt? [S/he] said no staff asked did [s/he] fall [s/he] said no so staff pick the resident up and got [him/her] back into bed and changed. Staff round on [him/her] around 2:05am."	N 433		

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N 433	Continued From page 80 Note: Resident 4's record included 5 entries of the above behaviors from 5/30-6/17 and his/her ISP was not updated with new fall interventions. Resident 4's ISP dated 06/21/2026 included the same above information unchanged regarding fall risk. Resident 4's progress notes documented the following falls, self-transfer attempts, and lowering self to the floor (some additional aggression noted) from 06/22/2026 to 07/14/2026: "-07/06/2026: I was working in another unit at the time of the incident. A caregiver informed me that the resident was on the floor. I immediately went to the resident's room to assist; resident had already been gotten up by other staff placed in [his/her] chair. Writer did go back and ask care staff to obtain vitals and document them, when writer did so resident was in the restroom. -07/07/2026: Upon entry to room resident was trying to self transfer onto electric wheelchair. Resident agreed to have assistance with transferring to regular wheelchair to assist resident with morning cares. Resident was dressed, toileted, and received quick wash up. Resident was brought to dinning room to receive medications and have breakfast. Resident in overall pleasant mood and cooperated with cares. -07/09/2026: Resident was up in [his/her] chair but [s/he] got back in bed on [his/her] own and writer asked if [s/he] wanted lunch [s/he] refused to get up at all and refused when AED went in to ask if [s/he] wanted food.	N 433		

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-07/12/2026: After breakfast resident took [him/her]self to [his/her] room and tried to get in bed. Co worker and I found [him/her] on floor shortly after when heard yelling for help. Resident was in between under the bed and out. [his/her] feet were under and torso was out. Co worker and I asked if resident felt any pain or hit [his/her] head. Resident replied no. just wanted to get in bed. Co worker and I slid [his/her] upper body more from out the bed so we can stand [him/her] up together and that's what we did. It was a smooth transition. POA and supervisor notified."

Note: Resident 4's record included 4 entries of the above behaviors from 7/6-7/12 and his/her ISP was not updated with new fall interventions.

Resident 4's ISP dated 07/14/2026 included the same above information unchanged regarding fall risk.

Resident 4's progress notes documented the following falls, self-transfer attempts, and lowering self to the floor (some additional aggression noted) from 07/15/2026 to 08/12/2026:

"-07/15/2026: Resident slept through the night-rolled off bed around 4:30am did incident report. @ 1:30 PM: Resident refused breakfast and lunch, Resident was asked if [s/he] was sure and [s/he] replied yes. Resident since then has been in bed. Writer was bringing laundry to resident room when I visually saw [him/her] crawling from bed trying to get on floor. I hurried and ran in there and said let's not get on the floor. Resident sat up in [his/her] bed and I helped [him/her] adjust in [his/her] bed. After lunch resident pressed [his/her] call light. Writer and co worker went into resident room and helped [him/her] up

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from the floor back to bed. Not even 15 minutes later Writer goes back in room to turn call light off since I forgot and [s/he]'s back on the floor. Resident is toileted and laundry is done and put away. Resident room is tidy and new liner in bin.

-07/17/2026: ...Caregiver was assisting residents when caregiver called [s/he] over; [s/he] noticed the resident lying on the floor near [his/her] bed. [Staff] asked if [s/he] was alright and if [s/he] had fallen, but [s/he] said no; [s/he] explained that [s/he] was trying to walk, as [s/he] hadn't walked since moving into the unit. The resident was sitting calmly on the edge of [his/her] bed, eating an apple. [Staff] assisted the resident by taking [him/her] to lunch and to the restroom; upon [his/her] return to bed, [s/he] was instructed to press the call button if [s/he] needed anything, as no prior call for assistance had been detected. The resident stated that [s/he] had called for over 20 minutes, yet no call was recorded in the system. The resident is currently resting in bed with no visible signs of injury. @ 7:00 PM: I asked the resident what had happened. [s/he] stated that [s/he] had hit [his/her] left eyebrow on the bed support and that the same thing had happened to [him/her] several times before.

-07/19/2026: The resident was assisted in getting ready to eat; [s/he] tried a couple of bites but then threw the plate food and all onto the floor, saying [s/he] didn't like it. [S/he] then headed to [his/her] room, where [s/he] transferred [him/herself] onto [his/her] bed because [s/he] did not want to wait for us to help [him/her].

-07/20/2026: Staff was doing rounds, when going to resident's room staff found resident on the floor. Staff asked if resident was in any pain resident told staff that [s/he] was not in pain and

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N 433	Continued From page 83 [s/he] just wanted to go for a walk. Staff then helped resident to the bathroom. Now resident is in [his/her] room with snacks. -07/21/2026: Resident resistant to getting changed. Did not cooperate to stand up and transfer. Once resident was transferred to wheelchair and taken to bathroom resident did not want to stand up and when [s/he] did resident tried to walk back to bed while holding onto furniture after multiple attempts, resident was able to sit on wheelchair. Peer and writer changed resident at bedside. Resident threw [him/her]self onto bed, writer tried to reposition resident into a more comfortable position, resident refused. Offered snack and water, snack accepted, water declined. -07/24/2026: PT notified staff that resident was on the floor. When staff entered the room resident was standing up and holding on into electric wheelchair. Resident asked if [s/he] fell or lowered [him/herself] onto the floor, resident didn't answer and kept calling out for [his/her] grandchildren. [Guardian P] called [s/he] talked to resident and was able to get [him/her] to calm down. Resident didn't want to sit on couch and kept standing up. Resident kept swatting at peer like if [s/he] was trying to hit them. Resident lowered [him/her]self onto the floor and began to crawl towards bed. Offered helped and accepted, resident assisted by two caregivers off the floor and onto bed. Resident repositioned, vitals taken. @ 1:15 PM: A caregiver went to assist a coworker with a resident. As the caregiver was entering the resident's room, both caregivers observed the resident standing while holding onto the back of [his/her] electric wheelchair and attempting to walk. The caregiver immediately positioned [his/herself] on the resident's left side to support	N 433		

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N 433	Continued From page 84 [him/her] and prevent a fall. While placing a gait belt around [his/her] waist and attempting to assist [him/her], the resident struck caregiver forcefully on the left side of [his/her] ribs with [his/her] left hand and elbow. The caregiver stated, Please do not hit me. The resident then began asking who [s/he] was and stated that [s/he] wanted to see [his/her] grandchildren, repeatedly mentioning two children by name. The caregiver explained that [s/he] appeared to be confused. The resident responded in an aggressive tone, I am not confused. Bring me my grandchildren immediately. Who are you? The caregiver identified [him/herself] by saying, I am [staff], and I am here to help you. Immediately afterward, the resident attempted to strike the caregiver in the face with [his/her] left hand. The caregiver told [him/her] not to hit [him/her]. The resident attempted to strike the caregiver in the face on two separate occasions. When the caregiver asked the resident to sit down, [s/he] became increasingly agitated and demanded to speak with [his/her] [Guardian P]. The [Guardian P] was contacted by phone in an attempt to help calm the resident. The situation was explained to [him/her]. [s/he] stated that the resident may have had a bad dream and might have been thinking about [his/her] grandchildren. [S/he] asked staff to explain to [him/her] that [his/her] grandchildren were safe at [his/her] home and that [s/he] was unable to bring them to [him/her]. The caregiver relayed this information to the resident; however, [s/he] continued displaying aggressive behavior. The resident then lowered [him/her]self to the floor and began crawling toward the bed without waiting for assistance. Two caregivers remained beside [him/her], but [s/he] initially refused their help. Staff explained that they needed to assist [him/her], and [s/he] eventually agreed. The caregivers assisted the resident into bed.	N 433		

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N 433	Continued From page 85 -07/25/2026: writer was in the building, care staff came to the other unit to ask writer for assistance, because resident was intestinally scooting [him/her]self out of [his/her] electric chair, Writer and care staff assisted [him/her] up right into [his/her] chair, writer took resident to the dining room table to eat lunch. Writer went back to Tuscan to assist care staff came back and asked for assistance again, when writer went to the common area writer observed resident on the floor. The electric chair was next to [him/her], writer asked resident if [s/he] fell, resident stated no, writer and care staff assisted resident back into [his/her] electric chair and care staff took [him/her] back to [his/her] room to toilet [him/her]. Writer contacted the POA Via Email. -07/27/2026: Resident ate all [his/her] breakfast and took [his/her] meds. Resident went to [his/her] room after breakfast. Writer was finishing up [his/her] laundry and went to [his/her] room to put it away. Writer found resident on the floor. Resident put [him/her]self on the floor [s/he] said. Writer helped resident get up. Writer toileted resident, [s/he] had a medium size bm. Resident was changed and put back into bed. Resident is resting and will bring resident for lunch. -07/31/2026: resident was in resident chair wen [sic] staff and another staff member walk into resident room resident stated resident had went to use the restroom staff helped resident back into bed there was no concerns. -08/03/2026: [Resident 4] sat on the floor waiting on [his/her] [Guardian P] to come get [him/her]. [S/he] said [his/her] back was hurting sitting and the chair but once [s/he] saw [Guardian P] [s/he] was feeling better.	N 433		

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N 433	Continued From page 86 -08/06/2026: Resident seemed to be in a good mood morning. Resident came to breakfast and lunch with no concerns. When staff encourages resident to put on glasses resident puts them on to take them off than after doesn't want to put them back on. When taking resident back to [his/her] room from lunch resident tried climbing in bed than jumped back up to stand but could not hold [his/her] balance. Staff assisted resident to the floor to ensure resident would not fall. After resident was assisted to [his/her] bed and is now in bed resting. -08/11/2026: A loud thud was heard. Resident was laying on [his/her] right side on the floor and recliner chair was also on the floor. Resident stated [s/he] was okay, stated [s/he] did not hit [his/her] head. Visible rug burn was noted on the right side of [his/her] nose and a little bit on [his/her] right cheekbone. Resident was initially on the recliner to [his/her] right but [s/he] self transferred to recliner [s/he] fell with. Resident was safely assisted off the floor with a 2 person assist with gait belt and transferred back to wheelchair. POA and AED notified." Note: Resident 4's record included 13 entries of the above behaviors from 7/15-8/11 and his/her ISP was not updated with new fall interventions. Resident 4's ISP dated 08/12/2026 documented: "Fall Risk: resident is identified as a fall risk due to impaired mobility related to Parkinson's and requires 2 assist with ambulation and transfers. Care staff will provide 2 assist with ambulation and transfers, ensure proper use of walker and wheelchair, maintain a safe environment, and monitor for changes in mobility. Staff will report any falls or concerns to the community Nurse."	N 433		

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N 433	Continued From page 87 Resident 4's progress notes documented the following falls, self-transfer attempts, and lowering self to the floor (some additional aggression noted) from 08/13/2026 to 08/31/2026: "-08/13/2026: resident was screaming and yelling stating that [s/he] wanted to go to [his/her] room right now. When staff was preoccupied with other residents. Staff told resident to please be patient and that staff will take [him/her] back to [his/her] room in just a little bit. Resident did not like that answer and was rocking back and forth and threw [him/herself] on the floor and then proceeded to lay on the floor screaming for [Guardian P] and then grabbed the railing in the hallway and pulled [him/her]self up into a standing position. -08/17/2026: The resident was escorted back to [his/her] room after finishing 100% of [his/her] meal. On the way back, [s/he] was asked to wait and not try to get up, as [s/he] had repeatedly attempted to rise from [his/her] chair; [s/he] had been rude to the staff in the dining room and was shouting "[Guardian P], [Guardian P]." Upon arriving at [his/her] room, we waited for assistance while [s/he] tried to get up, grabbing onto the bed and attempting to climb onto it by jumping. I went to get help because [s/he] urgently needed to use the bathroom. When help arrived, I tried to assist [him/her], but [s/he] said, "I don't want to go anymore; the urge has passed." [S/he] kept holding onto the bed rails and repeatedly tried to move on [his/her] own without assistance. My colleague and I helped [him/her] get onto the bed; however, when [s/he] stood up forcefully nearly falling in the process [s/he] shoved the wheelchair so hard that the handle slammed into my stomach with great	N 433		

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force. The pain was so severe that I could no longer assist my colleague; I had to leave the room to catch my breath, as the pain was intense and I could barely stay on my feet.

-08/18/2026: Resident was receiving assistance with shower in community shower. Resident kept trying to stand up by pulling [him/her]self up with the railing. Staff kept asking resident to stay seated on bench and wait until writer could assist [him/her] up. Writer reached to sink to get more body wash and resident stood up and slipped, resident kept holding on to railing until [s/he] was assisted onto the floor. Called for assistance, resident was assisted off the floor and moved to wheelchair with the assistance of two staff and gait belt. Resident was then dressed, resident did not complain of pain and stated [s/he] did not get hurt. POA notified when [s/he] came to pick [him/her] up for [his/her] appointment.

-08/21/2026: When writer arrived in resident room resident was on the floor and got to crawling to [his/her] toilet. Writer had told resident that [s/he] will be back, [s/he] needs to get another staff member to help her get [him/her] up. By the time writer arrived back to resident's room resident had already helped [him/her]self up on the toilet.

-08/23/2026: resident was found on the bathroom floor during my 4:00 round. Resident said [s/he] forgot [s/he] couldn't walk that well. Resident was not in pain and said [s/he] was only on the floor not longer than 10 mins. Resident was respectful and we got through it. I explained to resident that I'm watching the computer for pendants and ring for anything."

Note: Resident 4's record included 5 entries of the above behaviors from 8/13-8/23 and his/her

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N 433	Continued From page 89 ISP was not updated with new fall interventions. Resident 4's ISP dated 08/31/2026 included the same above information unchanged regarding fall risk. Resident 4's progress notes documented the following falls, self-transfer attempts, and lowering self to the floor (some additional aggression noted) from 08/31/2026 to 09/17/2026: "-09/03/2026: staff came in the room Resident was on the floor had told [him/her] I would be back had to have another staff to come help get [him/her] off the floor. -09/14/2026: Med passer noticed resident dropped [his/her] snack, medpasser went in kitchen after given all residents snacks, medpasser heard a thump and went into common area where Med passer witnessed resident on [his/her] knees looking towards the kitchen trying to get the food off the floor." Resident 4's ISP dated 09/17/2026 documented: "Fall Risk-High: [Resident 4] is a high fall risk with a history of recurrent falls, including falls associated with attempts at independent mobility or transfers. [Resident 4] primarily uses a manual wheelchair for mobility. Two care staff will assist [Resident 4] with transfers using the sit-to-stand. Staff will ensure the sit-to-stand is properly positioned and secured before beginning the transfer, explain the transfer to [Resident 4], provide simple directions, and allow [him/her] time to participate as able. Staff will ensure [Resident 4] is safely positioned before leaving [him/her] and will keep [his/her] wheelchair appropriately positioned with brakes locked	N 433		

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during transfers. Staff will follow [Resident 4's] individualized fall-prevention interventions and report significant changes in [his/her] mobility, transfer ability, strength, coordination, cognition, or tolerance of the sit-to-stand to the appropriate supervisor/clinical/provider contact. Interventions include: 09/04/26 - Staff will offer assistance getting up well before supper and offer toileting at that time. 09/03/26 - Staff will ensure [Resident 4] is safely seated before leaving for additional assistance. 08/23/26 - PT will be asked to evaluate [Resident 4's] transfers, mobility, and fall risk and provide recommendations for safe mobility. 08/21/26 - [Resident 4] will be safely positioned away from the bathroom when additional assistance is needed. 08/18/26- Shower supplies will be gathered and within reach before shower care begins. 08/11/26 - Recliner will be positioned to reduce movement/tipping and allow safe wheelchair access. 07/24/26- If [Resident 4] becomes confused or agitated during mobility, staff will pause the activity and redirect before continuing. 07/20/26 - [Resident 4] will primarily use [his/her] wheelchair for mobility. Staff will offer assisted walking as appropriate. 07/12/26 - Staff will accompany [Resident 4] to [his/her] room when [s/he] leaves common areas to address mobility and transfer needs. 07/06/26 - [Resident 4] will be educated to request staff assistance before attempting independent mobility. 06/28/26 - [Resident 4's] bed will be maintained at a safe transfer height and pathways kept clear of tripping hazards. 06/17/26 - Staff will position [Resident 4] away from the edge of the bed following care. Bed rails may be used for repositioning and bed mobility. 06/04/26 - [Resident 4's] wheelchair will be kept in a consistent, accessible location and brakes locked before transfers. 06/01/26 - Frequently used

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personal items will be kept within [Resident 4's] reach while in bed. 05/30/26 - Staff will offer incontinence care before [Resident 4] is left to rest in [his/her] room."

Note: the above fall interventions noted after each fall did not get updated on any of the previous ISP updates 06/21, 7/14, 8/12, and 8/31.

Resident 4's progress notes documented the following falls, self-transfer attempts, and lowering self to the floor (some additional aggression noted) from 09/17/2026 to 09/30/2026:

"-09/20/2026: Caregiver's went to take resident back to [his/her] room resident start yelling and hitting at caregiver resident then said [s/he] wanted caregiver to take [him/her] to [his/her] room. As we start pushing [his/her] back to [his/her] room, [s/he] wouldn't lift [his/her] feet laughing saying no [s/he] don't want to so the caregiver's had to wait till [s/he] was ready. We got to the room [s/he] then told caregiver (I just want to slap you for fun) caregiver said to [him/her] that's not nice you shouldn't say that. [S/he] laughed and said "yes, [s/he] can." Both caregivers then went to help [him/her] in bed resident hop up in [sic] put [him/herself] in bed. Caregiver told [him/her] no lets us help you. Resident put [his/her] self in bed knee first standing in the middle of the bed. Still trying to hit caregiver. [S/he] was in front of the camera.

-09/23/2026: resident sat on the floor trying to get snacks after we put [him/her] in bed, [s/he] also was being very disrespectful to staff so we called [Guardian P] and [s/he] said [s/he] likes to sit on the floor so we left out [his/her] room and [s/he] started screaming."

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N 433	Continued From page 92 Additional records: On 09/23/2026, Resident 4 was given a 30-day notice due to "Due to care that is required is beyond the CBRF's license , care is require that is inconsistent with the CBRF's program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter, and there is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident's record." Surveyor reviewed Resident 4's clinic visit notes with Physician T dated 09/21/2026: Assessment & Plan: [Resident 4] presents following an episode overnight in which [s/he] appeared altered and threatened staff with a dumbbell. Upon discussion with [Guardian P] and [Resident 4], [s/he] has good recollection of the event but is unable to explain [his/her] actions fully. It does not seem as [Resident 4] was truly hallucinating ([s/he] appears to have good recollection and insight into these historically). Differential for behavioral disturbance in the setting of known Parkinson's and history of psychosis includes organic etiologies such as UTI (less likely with no symptoms), electrolyte derangement, kidney dysfunction versus natural course of [his/her] known neuropsychiatric conditions. No clear localizing signs of infection with benign abdominal, skin, cardiac and pulmonary exam. Will complete workup with BMP, UA and CBC to rule out possible organic etiology." Surveyor reviewed Guardian P's grievance dated 09/02/2026. The following was documented: " ...Issue/Concern/Complaint: "Continued	N 433		

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demonstration & lack of knowledge/skill/guidance with de-escalation and patient centered (let alone dementia informed) care and communication. The care plan should illustrate some good tips as of 8/31 for methods to interact respectfully as well as tools working with [Resident 4] to prevent/deescalate agitation (e.g. Do not say [s/he] "has to do" "or that [his/her] [daughter/son] says [s/he] has to or will be upset." Do not bring [him/her] into public/shared area when [s/he] is already agitated. Do call [Guardian P] on phone whenever [s/he] is asking for [daughter/son] or grandkids or to leave, etc. Communicate slowly, clearly & without being condescending. Do not talk negatively about [Resident 4] or rehash events again in front/ in room with [him/her] especially if already aggravated."

Director A responded to the above grievance on 09/21/2026 at 6:19 PM: " Grievance #8 - Lack of skill/knowledge/training follow through (specifically working with [Resident 4] to de-escalate situations. All staff are provided training with orientation, including Challenging Behaviors. [Provider's name] complies with all DHS training requirements and has provided multiple additional trainings to meet the minimum requirement of 15 hours of training per year. In efforts to increase opportunities for education for all team members, [Provider's name] is implementing a software called Relias which has an even larger library of trainings to be provided to all team members. Dane County is providing training to all team members on 9/23 on Dementia."

Interviews:

On 09/17/2026 at 11:15 AM, Surveyor interviewed Caregiver EE. Caregiver EE reported s/he started

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working at the facility in November 2025. Caregiver EE provided a care summary of Resident 4. Caregiver EE reported Resident 4 can be verbally and physically aggressive towards staff/residents. Caregiver EE stated interventions were to remove him/her or ourselves from the environment and give Resident 4 time to calm down.

On 09/17/2026 at 11:40 AM, Surveyor interviewed Caregiver U. Caregiver U reported s/he started working at the facility 2 months ago after transferring from another sister community. Caregiver U provided a care summary of Resident 4. Caregiver U reported Resident 4 can be verbally/physically aggressive towards staff/residents and s/he will throw things. Caregiver U stated s/he personally did not have concerns with Resident 4's behaviors and noted it was all about the approach. Caregiver U stated s/he never had issues but other staff report them.

On 09/17/2026 at 12:55 PM, Surveyor interviewed Caregiver V. Caregiver V reported s/he had only worked 4-5 shifts at the facility and felt training could have been better regarding resident cares and behaviors. Caregiver V reported his/her trainer kept leaving him/her during orientation. Caregiver V stated "now I have been assigned to areas and I'm supposed to just figure it out." Caregiver V acknowledged Resident 4 had behaviors.

On 09/24/2026 at 3:00 PM, Surveyor interviewed Guardian P via phone. Guardian P stated s/he had ongoing concerns related to Resident 4's behaviors and staff not following through with calling me to help deescalate or following his/her ISP. Guardian P stated s/he was not aware Resident 4 did not receive his/her Quetiapine in

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July until concern discussed with the Surveyor. Guardian P noted the dates Quetiapine was not available coincides with some of the first major behavior incidents. Guardian P questioned why PRN Quetiapine was not used. Guardian P confirmed s/he had a camera in Resident 4's room. Guardian P reported s/he had observed behavioral incidents via the camera where staff will not provide clear communication or follow through and will often leave the room as soon as Resident 4 shows any agitation. Guardian P acknowledged Resident 4 was not an easy person to care for some days due to his/her diagnoses, however, if staff followed the ISP and had the time and support from management, s/he would be much more happy and easier to deal with.

On 09/25/2026 at 12:37 PM, Surveyor sent the following email to Director A and Chief Operating Officer R:
" ...Please send [Resident 4's] behavioral assessments from time of admission to present - ...After review of [his/her] record I can count 17 incidents where [s/he] fell or lowered self to the floor, was [Resident 4's] supervision ever assessed regarding his fall risk or behaviors? I could not find this type of assessment in his record. Was the MCO ever contacted regarding [Resident 4's] level of supervision?-If so, please provide what you have.
.... [Resident 4's] guardian asked about a behavioral plan for him on 08/19, was this created?"

On 09/28/2026 at 10:02 AM, Regional Nurse L with Director A, Director of Operations B, and Chief Operating Officer R responded:
" ...Behavioral Assessments / Behavioral Plan [Resident 4's] behavioral needs, interventions,

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N 433	Continued From page 96	N 433		

and supervision requirements were incorporated into [his/her] care plan rather than maintained as a separate behavioral plan. The care plan was updated as [his/her] behaviors, mobility, and care needs changed over time. The current care plan also includes 24-hour supervision and ongoing care coordination related to falls, behavioral concerns, mobility, and changes in condition.
Supervision / Fall Risk / MCO Involvement
[Resident 4's] supervision needs were addressed through [his/her] care plan rather than through a separate supervision assessment. The care plan included high-fall-risk interventions and individualized safety measures based on [his/her] clinical needs. These needs were also regularly reviewed during care-planning discussions involving the guardian and [MCO] case management.
Please send [Resident 4's] behavioral assessments from time of admission to present. These are in the care plans
-[Resident 4's] guardian asked about a behavioral plan for [him/her] on 08/19, was this created? [Resident 4's] care plan includes the behavioral plan which has been updated many times. We include our behavioral plans in the ISP/Care plan
- After review of [his/her] record I can count 17 incidents where [s/he] fell or lowered self to the floor, was [Resident 4's] supervision ever assessed regarding [his/her] fall risk or behaviors? I could not find this type of assessment in [his/her] record. Was the MCO ever contacted regarding [Resident 4's] level of supervision?-If so, please provide what you have. We meet with [Guardian P], and the MCO every week. MCO contacts include [Case Manager Q] and [RN Case Manager W]. The MCO was made aware weekly."

On 09/29/2026 at 3:23 PM, Surveyor interviewed

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N 433	Continued From page 97 Ombudsman GG. Ombudsman GG reported s/he was involved with Resident 4 starting in July when Guardian P requested assistance regarding electronic video recording. Ombudsman GG reported s/he attended a care conference with the provider in August regarding concerns of Resident 4's ability to use his/her electric wheelchair safely. Ombudsman GG reported s/he had been involved with the provider for several residents and the ongoing concern that keeps being reported was staff not following resident care plans. On 09/30/2026 at 10:00 AM, Surveyor conducted an exit conference and shared findings with Director A, Director of Operations B, Regional Nurse L, and Chief Operating Officer R. Surveyor shared concern for Resident 4's behaviors not being assessed. Surveyor noted Resident 4's record included many entries from staff with increasing behaviors and ISP's were not updated with new interventions until August 2026 (aggression/sexually inappropriate) and (fall risk). The management team reiterated that Resident 4's behaviors were discussed weekly and disagreed with the Surveyor's findings.	N 433		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that all rooms were kept clean and free from odors. This is a repeat deficiency. See Statement of	N 489		

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N 489	Continued From page 98 Deficiency (SOD) Y2BI12, dated 05/12/2026. Findings include: On 08/03/2026, the Department received a complaint alleging concerns with a resident's care. On 09/17/2026 at 9:38 AM, Surveyor toured the facility and observed the following: -Resident 5's carpet had 2 large circular stains in the carpet near his/her bed and recliner chair. The same conditions were observed at 3:04 PM. -Resident 6's room had many stains in the carpet throughout the entire floor space. There was a large area of food crumbs near Resident 6's bed. The same conditions were observed at 3:05 PM. -Resident 4's bathroom had no paper towels or means to dry your hands. There was a rotten banana peel left in a bowl near Resident 4's bulletin board. There were used food wrappers near the bowl. The toilet had dried bowel movement stuck to it. There was a yellow urinelike substance inside the toilet. Around Resident 4's bed, observed food crumbs on the floor. In the walkway to Resident 4's room, Surveyor observed food crumbs and debris on the floor. The same conditions were observed at 2:55 PM. -Resident 7's room had a pungent musty odor once entering. The carpet had many stains throughout the bedroom. Surveyor observed unsealed bags of chips and food crumbs inside cardboard boxes that were placed on a table inside the room. The same conditions were observed at 3:06 PM.	N 489		

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N 489	Continued From page 99 -Resident 8's room had a pungent odor of urine. The same conditions were observed at 3:06 PM. -Resident 9's room had a pungent musty odor once entering. The same conditions were observed at 3:06 PM. Resident 4's palliative cares notes dated 06/24/2026 documented: " The move to ALF has been challenging ....Today, [his/her] room smells like urine. [APS Social Worker] has been involved and addressing concerns. Will be having weekly meetings with ALF staff, APS, and [MCO] team." On 09/21/2026 at 6:19 PM, Director A sent the following email to Guardian P responding to his/her grievance filed on behalf of Resident 4 with concerns of housekeeping: " ...#9 - Housekeeping and laundry - All residents receive at minimum weekly whole room housekeeping and touch up in between. Resident laundry is to be done twice weekly and as needed. Laundry is often pulled later in the evening as most laundry is done by the overnight shift. [Resident 4] often eats snacks in [his/her] room which do create crumbs and additional issues. The team does sweep and mop up what is needed. We will increase [Resident 4's] frequency of a full room clean to at minimum twice a week. More as needed." On 09/22/2026 at 11:47 PM, Guardian P sent the following email to at least Director A, Regional Nurse L, and Chief Operating Officer R: "I am glad you are upping the frequency. My note was about quality and again you assuming/trusting that it is done or done well.	N 489		

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N 489	Continued From page 100 This is not even a big concern of mine, it is a moderate one of [his/her] but [s/he] isn't aware of most of the issues. I bring them to your attention because you have tried to act like things are done so well, and so frequent, but it just isn't the case... This week's examples: -banana peel rotting on [his/her] entrance table in bowl for over a week -sticky piece of red food substance, I believe, stuck to top of entry table -crumbs in [his/her] under bed drawer that are from weeks ago and got "cleaned" (after two weeks when I pointed them out and asked) but only the larger ones and the rest never actually fully removed from the drawer -clothes put away extremely hap hazardly - not in labeled areas, often inside out, often not folded at all but balled up and crammed (pic attached from *after* I removed two towels that were folded and all the sheets and pillow cases that were balled and crammed into the bottom right corner, as well as a pink chuck from the bottom left) -[his/her] shoes have had the same food matter and stains for several weeks plus more egg yolk, I believe, from yesterday [& photos of these were provided last week with the bathroom situation] -the three boxes of incontinence supplies were open but not unpacked or put away in any of [his/her] drawers -things were disheveled in [his/her] bathroom again -no paper towels present in the bathroom or dispenser *still since move in* -wheelchair had clump of dried food in the seat (seemingly from dinner 22hrs prior) -window sill had crumbs and debris but not from anything today and floor had been cleaned (so whoever cleaned the floor could have wiped them off the windowsill).	N 489		

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N 489	Continued From page 101 -two partially full cups of liquid were sitting around (one on [his/her] clothes cabinet and one by window - neither are the type [s/he] uses on [his/her] own, nor likes at all but the med passers keep using instead of [his/her] container with a straw. The timing means at least one was from the day prior and this was after 4pm.) -dirty dish containers in his bathroom as well as spit basin that badly needed to be washed." On 09/30/2026 at 10:00 AM, Surveyor conducted an exit conference and shared findings with Director A, Director of Operations B, Regional Nurse L, and Chief Operating Officer R. The management team acknowledged an understanding of the concerns. Director A asked for the expectation on carpet stains when they have been machine washed several times. Surveyor shared expectation. No further comment provided.	N 489		
Y3235	50.09(1)(f) Privacy (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: (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to:	Y3235		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 4's right to privacy in his/her living arrangement.

From July to September 2026, Resident 4 had incontinent cares and dressing completed in front of 2 windows in his/her room compromising his/her privacy. Resident 4's room was on the 2nd floor, and his/her windows are in direct view of the provider's main entrance and a busy 4 lane road next to the facility.

Findings include:

The facility can serve up to 52 residents in the following client groups: irreversible dementia & Alzheimer's, advanced age, developmentally disabled, and physically disabled.

On 08/03/2026, the Department received a complaint alleging concerns with a resident's care.

On 09/17/2026, Surveyor conducted a complaint investigation and identified the following:

On 09/17/2026 at 9:45 AM, Surveyor toured Resident 4's room. Surveyor observed Resident 4 had 2 large windows next to his/her bed. Surveyor observed directly outside the windows was the provider's main entrance and a small parking lot. Additionally, a busy 4 lane road was

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Y3235	Continued From page 103 next to the facility. On 09/24/2026 at 3:00 PM, Surveyor interviewed Guardian P via phone. Guardian P confirmed there was a camera in Resident 4's room. Guardian P reported the camera's view was placed to see the whole room including 2 large windows that looked out to the provider's main entrance and a busy 4 lane road next to the facility. Guardian P noted Resident 4's bed was placed against the windows. Guardian P reported s/he had observed many videos of staff performing incontinence changes to Resident 4 without covering the windows. Guardian P confirmed Resident 4 had window drapes available. Guardian P reported during overnight hours when completing incontinence changes, staff will have the lights on, and vehicle headlights can be seen going by in the footage. Guardian P reported changing Resident 4 in front of the windows has been a long-standing issue and repeatedly reported to the provider. Guardian P reported Resident 4 prefers to have his/her drapes closed at night due to how easy it is to see the street at night, let alone the parking lot. Guardian P reported s/he had placed two signs by Resident 4's windows asking staff to close the drapes at night and open during the day, this was also written in detail on his/her care plan. Guardian P reported s/he stopped looking or reporting in August and September because s/he was dealing with bigger issues, but noted the concern had continued into September. Guardian P reported s/he was unable to save footage of all the dates but would review videos and provide a summary with videos saved and other observations. On 09/28/2026 at 4:18 AM, Surveyor received the following email from Guardian P summarizing	Y3235		

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what s/he had observed with staff changing Resident 4 in front of his/her windows: "9/21 @0735 the new aide came in as normal and alone ...[Caregiver Z] joined [him/her] and they got [him/her] changed and dressed in clothes, there on [his/her] bed in front of the open window. (Even during the day, this window and position is very evident from the parking lot..Because [his/her] drapes were left open it may have attributed to [him/her] not being able to rest as well and [s/he] was also in total view of the window partially, to mostly, naked all night.) I also see no pericare performed, and definitely not [his/her] groin being dried and nystatin being applied (& I believe [Caregiver Z] is the med passer). They did run warm water, and took [him/her] to the bathroom but that was after clothing [him/her] in new, clean clothes; while changing [his/her] bed linens. To me, depending on how "soaking wet" [s/he] was, I would expect them to wipe his mid section to some extent as well.

....The following are other instances that I had already reported changing in front of the open window:
7/2 1216
7/5 1554
7/10 0511 dark out, light on, & not wiped
7/11 0149-0203 dark out light on
7/11 0558-0614 dark out light on
7/11 0735
7/14 0429 dark out light on, doesn't appear to have been wiped but briefly obscured
7/25 0215 dark out with light on

These are instances in the last weekend of [him/her] being changed in front of the open window:
9/26 1644 light outside [Caregiver AA] and

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Y3235	Continued From page 105 [Caregiver Z] - also don't believe [s/he] was wiped and definitely no in-depth peri-care, despite them both being med passers and able to do nystatin 9/26 2131 dark out with light on (new aide and [Caregiver Z])." Review of email correspondence: On 09/28/2026 at 10:02 AM, Regional Nurse L with Director A, Director of Operations B, and Chief Operating Officer R responded " .... Pulling the shades down had been inconsistent. In late July/early August the location of the bed was changed due to the difficulty of the caregiver having had to climb over [Resident 4] or move the bed to get to the blinds which was not practical. It was agreed upon with the guardian to rearrange the room." Interview: On 09/30/2026 at 10:00 AM, Surveyor conducted an exit conference and shared findings with Director A, Director of Operations B, Regional Nurse L, and Chief Operating Officer R. Director of Operations B confirmed s/he had reviewed video footage of staff performing incontinence changes and dressing in front of Resident 4's windows without privacy. The management team acknowledged an understanding of the concerns and stated staff would be retrained.	Y3235		