STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(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 09/08/2025, Surveyor conducted a complaint investigation at Sage Meadows Lake Geneva. Four deficiencies were identified. The complaint was substantiated. Censuss: 42	N 000		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Resident 1's health information was confidential. Taped to the outside of Resident 1's bedroom door, there was a yellow sign that identified his/her first and last name, that they are on hospice, the hospice agency, his/her date of admission to hospice, and his/her hospice	N 346		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(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 346	Continued From page 1 diagnoses. Findings include: On 09/08/2025, at 10:14 a.m., Surveyor toured the facility. Surveyor observed a yellow sign taped to the door of room #18. The sign identified Resident 1's first and last name, that s/he is on hospice, the name of the hospice agency, his/her date of admission to hospice, his/her hospice nurse, his/her hospice social worker, hospice chaplain, and his/her hospice diagnoses. The door was closed and faced a common hallway just outside of the facility's dining room. This information is visible to any individual that visits the facility. At 11:20 a.m., Surveyor interviewed Resident 1. Surveyor asked if Resident 1 was aware that there was a sign on his/her door that identified his/her first and last name, that they are on hospice, and his/her hospice diagnoses. Surveyor showed Resident 1 the sign on the outside of his/her door and Resident 1 stated s/he was not aware and that the information should be private. At 12:55 p.m., Surveyor shared the above concerns with Executive Director A, Service Coord B, and Corporate HR C. Corporate HR C agreed the sign should not be on the outside of the door.	N 346		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 2	N 352		

prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.

This Rule is not met as evidenced by:
Based on record review and interview, the CBRF did not provide medication administration appropriate to meet the needs of 37 of 37 residents on 08/19/2025 and 08/20/2025.

On 08/19/2025, around 12:00 p.m., the provider's Wi-Fi internet went out and caregivers were unable to access resident's electronic medication administration records (MAR). Without having access to resident's MARs, caregivers did not administer any resident's medications until the Wi-Fi was restored at around 12:00 p.m. on 08/20/2025.

Findings include:

On 08/20/2025, the department received a complaint alleging that all residents had not received their prescribed medication for about 24 hours from 08/19/2025-08/20/2025.

At 9:37 a.m., Surveyor interviewed Service Coord B about the Wi-Fi going out on 08/19/2025-08/20/2025. Service Coord B stated that the provider's Wi-Fi went out after caregivers had administered resident's noon meds on 08/19/2025. Service Coord B stated that s/he had been the service coordinator for 2 weeks when the incident happened and there were no paper MARs so there was no way to document medication administration. Service Coord B stated that the Wi-Fi did not come back on until about noon on 08/20/2025, so the caregivers were unable to pass medications for the time in between, approximately 24 hours. Service Coord

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 3 B stated that s/he reported the Wi-Fi outage to Executive Director A, Nurse D and Corporate. Executive Director A stated that s/he was in a training on 08/19/2025 and had contacted the provider's internet provider to try to get the problem resolved but that the internet provider could only give them 2-hour windows of when they thought the Wi-Fi would be back on. Executive Director A stated s/he did not have access to resident MARs and that someone at corporate emailed them to him/her the next day, on 08/20/2025, and then s/he went to the library to print out the MARs and made binders. Executive Director A stated that Ombudsman E came out after the incident and informed him/her that s/he could have called the pharmacy to have them print the MARs as well. Surveyor reviewed the provider's resident MARs for August 2025 and documented the following: Example 1 - Resident 1 Resident 1 was admitted to the provider on 01/02/2019 with diagnoses including dementia, hypertension, and atrial fibrillation. Resident 1 is on hospice care. From 08/19/2025-08/20/2025, Resident 1 did not receive the following medications: -Acetaminophen 325 mg, twice -Vitamin B-complex -Cran-max 500mg -Probiotic 250mg, twice -Garlic 1000mg -Hydrochlorot 12.5mg -Lisinopril 10mg, twice -Omeprazole 20mg -Xarelto 20mg -Ferrous Sulf 325mg -Vitamin D-3 5,000unit -Hydroco/apap 5-325mg, twice	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 4 Example 2 - Resident 2 Resident 2 was admitted to the provider on 06/17/2025 with diagnoses including vascular dementia. From 08/19/2025-08/20/2025, Resident 2 did not receive the following medications: -Tramadol HCL 50mg, three times -Lorazepam 0.5mg, twice -Sertraline 100mg -Stool softening/lax 8.6-50mg, twice -Mirtazapine 30mg -Olanzapine 10mg Example 3 - Resident 3 Resident 3 was admitted to the provider on 06/30/2025 with diagnoses including depression, anxiety disorder, psychophysiological insomnia, and chronic pain. From 08/19/2025-08/20/2025, Resident 3 did not receive the following medications: -Baclofen 20mg -Baclofen 40mg -Vitamin B-12 1000mcg -Gabapentin 300mg, twice -Gabapentin 600mg -Fluoxetine 20mg -Folic Acid 1mg -Pot Chloride 20MEQ ER, twice -Lisinopril 10mg, twice -Omeprazole 20mg -Ropinirole 0.25mg, three times -Trazodone 150mg -Vitamin D-3 25mcg -Simvastatin 20mg -Cetirizine 5mg -Polyeth Glyc 3350 -Fluticasone 50MCG SPR -Bupropion 150mg -Flutic/Salme 250/50AER	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 5 -Fentanyl 12MCG Example 4 - Resident 4 Resident 4 was admitted to the provider on 02/16/2016 with diagnoses including dementia, hypertension, and diabetes. Resident 4 is on hospice care. From 08/19/2025-08/20/2025, Resident 4 did not receive the following medications: -Trazodone 50mg -Vitamin D-3 50mcg -Sertraline 25mg -Aspirin low 81mg -Atorvastatin 20mg -Metoprolol Suc 25MG ER -Glucerna -Lantus Solosar 100U/ML -Humalog Kwik 100/ml inj sliding scale insulin, three times -Anti-diarrhea 2mg Example 5 - Resident 5 Resident 5 was admitted to the provider on 08/19/2024 with diagnoses including dementia, diabetes, bipolar disorder, anxiety disorder and failure to thrive. From 08/19/2025-08/20/2025, Resident 5 did not receive the following medications: -Depakote SPR 125mg -Quetiapine 100mg -Quetiapine 50mg -Exelon 9.5mg/24 dis -Pregabalin 50mg -Furosemide 20mg -Pot Chloride 10MEQ ER -Loratadine 10mg Example 6 - Resident 6 Resident 6 was admitted to the provider on 04/17/2023 with diagnoses including diabetes,	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 6 major depressive disorder, anxiety disorder, cardiac arrest, diastolic heart failure, and paroxysmal atrial fibrillation. From 08/19/2025-08/20/2025, Resident 6 did not receive the following medications: -Atorvastatin 80mg -Carvedilol 3.125mg, three times -Fluoxetine 20mg -Furosemide 20mg -Vescepa 1gm, twice -Invokana 100mg -Levothyroxine 88mcg -Mag oxide 400mg, twice -Mucus Relief 600mg, twice -Aspirin Low 81mg -Probenecid 500mg, twice -Ferrous Sulf 325mg -Insulin Asp Flexpen 100u/ml sliding scale insulin, three times -Degludec Fle 100unit inj, twice Example 7 - Resident 7 Resident 7 was admitted to the provider on 04/03/2023 with no diagnoses listed. Resident 7 is on hospice care. From 08/19/2025-08/20/2025, Resident 7 did not receive the following medications: -Calcium/D3 600-10 tab, twice -Losartan Pot 100mg -Montelukast 10mg -Vitamin C 500mg -Buspirone 5mg -Melatonin 10mg -Haloperidol 2mg -Nitrofurantn Mono/MC 100mg On 09/10/2025, at 8:55 a.m., Surveyor interviewed Nurse D, who works at another facility owned by the licensee. Nurse D stated s/he was notified of the Wi-Fi being down and the facility	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 7 not administering medications on 08/20/2025 at around 10:00 a.m., Nurse D stated that s/he uploaded eMARs for Executive Director A once s/he was made aware that the facility did not have them. Nurse D stated that the facility did not have a nurse at that time, but s/he has no idea why no one notified him/her sooner and added that the facility will have a new nurse starting soon. Nurse D stated that s/he would not have instructed staff not to administer medication. If s/he had been notified of the staff not having access to the eMAR sooner, s/he could have provided MARs and would have instructed staff to administer medications. Nurse D stated that s/he told Executive Director A and Service Coord B that they should not have been making medication decisions and should have contacted corporate. Nurse D stated that the nurse is to make those decisions for the medical safety and wellbeing of residents, noting that Executive Director A and Service Coord B were not nurses.	N 352		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the	N 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(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 406	Continued From page 8	N 406		

pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.

This Rule is not met as evidenced by:
Based on record review and interview, the CBRF did not develop and implement a policy for disposing unused, medications in compliance with federal, state and local standards or laws.

Findings include:

On 08/20/2025, the department received a complaint alleging that all residents had not received their prescribed medication for about 24 hours from 08/19/2025-08/20/2025.

At 9:37 a.m., Surveyor interviewed Service Coord B about the Wi-Fi going out on 08/19/2025-08/20/2025. Service Coord B stated that the provider's Wi-Fi went out after caregivers had administered resident's noon meds on 08/19/2025. Service Coord B stated that s/he had been the service coordinator for 2 weeks when the incident happened and there were no paper MARs so there was no way to document medication administration. Service Coord B stated that the Wi-Fi did not come back on until about noon on 08/20/2025, so the caregivers were unable to pass medications for the time in between, approximately 24 hours.

At 10:38 a.m., Surveyor asked Service Coord B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(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 406	Continued From page 9 what happened to 37 of 37 resident's medications that were not administered from 08/19/2025-08/20/2025. Service Coord B stated that the medications were not passed and then s/he believes destroyed. At approximately 10:40 a.m., Surveyor asked Executive Director A for the disposition of medications record. Executive Director A stated that would be a Service Coord B question. At 12:55 p.m., Surveyor shared the above concerns with Executive Director A, Service Coord B, and Corporate HR C. Corporate HR C agreed the sign should not be on the outside of the door. Service Coord B stated that there was no medication destruction record due to the previous service coordinator but that Nurse D is coming to the facility tomorrow to show Service Coord B how to do one.	N 406		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s.	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(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 454	Continued From page 10 DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(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 454	Continued From page 11	N 454		

the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not document blood glucose checks for 2 of 2 residents reviewed that had an order for it.

Resident 4's and Resident 6's had an order to check blood glucose levels four times daily. Neither resident's blood glucose was not documented on 08/19/2025 at 4:00 p.m. and 8:00 p.m., and was not documented on 08/20/2025 at 8:00 a.m. and 12:00 p.m.

Findings include:

On 08/20/2025, the department received a complaint alleging that all resident had not received their prescribed medication for about 24 hours from 08/19/2025-08/20/2025.

Surveyor reviewed the provider's resident MARs and progress notes for August 2025 and documented the following:

Example 1 - Resident 4
Resident 4 was admitted to the provider on 02/16/2016 with diagnoses including dementia, hypertension, and diabetes. Resident 4 had a physician orders for:
- Lantus Solosar 100U/ML *prime 2 units before each dose then inject 18 units subcutaneously

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(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 454	Continued From page 12	N 454		

every night at bedtime *hold if blood sugar is less than 100
-Humalog Kwik 100/ml inj to inject three times a day per sliding scale check blood sugar before meals, if 61-150 give no units, if 151-200 give 3 units, 201-250 give 5 units, 251-300 give 8 units, 301-350 give 12 units, 351-400 give 15 units, if greater than 400 give 15 units, and if greater than 450 then update provider.
-Blood glucose check, staff to take and record resident's blood glucose at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.

Resident 4's blood sugar was not documented on 08/19/2025 at 4:00 p.m. and 8:00 p.m., and was not documented on 08/20/2025 at 8:00 a.m. and 12:00 p.m.

Example 2 - Resident 6
Resident 6 was admitted to the provider on 04/17/2023 with diagnoses including diabetes, major depressive disorder, anxiety disorder, cardiac arrest, diastolic heart failure, and paroxysmal atrial fibrillation. Resident 6 had physician orders for:
- Insulin Asp Flexpen 100u/ml *prime 2 units before each dose then inject 6 units subcutaneously three times a day with meals plus sliding scale: 99-149=3 units, 150-199=6 units, 200-249=9 units, 250-299=12 units, 300-349=15 units, 350 and above = 18 units.
- Degludec Fle 100unit inj *prime 2 units before each dose then inject 50 units subcutaneously twice a day.
- Blood glucose check, staff to take and record resident's blood glucose at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Please let MD know if BS is greater than 450.

Resident 4's blood sugar was not documented on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(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 454	Continued From page 13 08/19/2025 at 4:00 p.m. and 8:00 p.m., and was not documented on 08/20/2025 at 8:00 a.m. and 12:00 p.m. At 12:55 p.m., Surveyor shared the above concerns with Executive Director A, Service Coord B, and Corporate HR C. Surveyor asked how resident's blood sugars were monitored and if there was any concerns since insulin was not administered. Service Coord B stated that s/he did check every diabetic resident's blood sugars every two hours and wrote it on a piece of paper. Surveyor asked to review the documentation and Service Coord B stated s/he was unsure of where it was and was unable to provide documentation of Resident 4 and Resident 6's blood glucose levels.	N 454		