STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015326	A. BUILDING: _____ B. WING _____	C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF HASMER LAKE	N168 W22026 MAIN ST JACKSON, WI 53037

(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
U 000	INITIAL COMMENTS On 12/09/2025 with information gathered through 12/16/2025, Surveyor conducted a complaint investigation at Charter Senior Living of Hasmer Lake, a Residential Care Apartment Complex (RCAC) in Jackson, WI. Three deficiencies identified. Complaint substantiated. Census: 31	U 000		
U 114	89.23(1) SERVICES GENERAL REQUIREMENT. A residential care apartment complex shall provide or contract for services that are sufficient and qualified to meet the care needs identified in the tenant service agreements, to meet unscheduled care needs of its tenants and to make emergency assistance available 24 hours a day. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure services were provided to meet the unscheduled care needs of tenants. Tenant 1 was not assisted after sustaining a fall.	U 114		

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

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U 114	Continued From page 1 Findings include: On 12/15/2025, the Department received a complaint alleging staff were not assisting tenants when they needed help and not answering call lights. On 12/11/2025, Surveyor reviewed Tenant 1's record. On 12/11/2025 at approximately 3:45 PM, Surveyor received an incident report from Fire Chief B. The incident report was dated 11/07/2025 and stated the following: "Around 0500 hours on the morning of November 7,2025, the Jackson Fire Department was dispatched to Charter Senior Living for the report of a resident who slid out of bed. Myself and partner responded with the ambulance to assist with lifting the patient. Upon arrival at Charter, we were met in the main hallway by an elderly [tenant] who was polite, cooperative and very apologetic for calling 911 for assistance. The [tenant] explained that [his/her spouse] had slid from [his/her] recliner and was unable to get up on [his/her] own. [Tenant] stated they had been attempting to get assistance through their call alert system for approximately an hour before deciding to contact emergency services. We followed the resident back to their apartment, which was located in the main hallways on the first floor. Upon entering, we found an elderly [tenant] seated on the floor directly in front of [his/her] recliner chair. The patient was alert and oriented, calm and not in any apparent distress. [S/he] stated [s/he] attempted to shift positions in the chair when [s/he] slid forward and was unable to regain [his/her] footing. [S/he] denied hitting [his/her] head, loss of consciousness, or any pain or discomfort. After confirming [s/he] was not	U 114		

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U 114	Continued From page 2	U 114		

injured, the patient requested only assistance getting back into [his/her] chair. With a standard two-person lift, the patient was assisted into a standing position and then guided backward until [s/he] was seated comfortably in [his/her] recliner. The patient was re-assessed once seated, and all findings remained unremarkable. [S/he] maintained full range of motion in all extremities and denied any new or worsening symptoms. The patient declined transport to the hospital and expressed appreciation for how quickly the department arrived and for the care provided. Both the patient and [his/her spouse] stated this was not the first time they have experienced long delays when attempting to summon help from staff, especially during the third shift hours. The [spouse] expressed frustration, stating that they often feel ignored during nighttime hours. During the duration of our interaction and lift assist, no Charter Senior Living staff members entered the apartment or made any effort to check on the patient. Given this lack of response, our crew took the initiative to ensure that staff were notified of the incident before we left the facility. We searched the main floor and common areas before proceeding to the second floor, where two staff members were located in the lounge area. One staff member was lying on a couch with headphones in, appearing to be using their phone. The second staff member was lying under a blanket and appeared to be sleeping. Neither individual initially acknowledged our presence despite our clear visibility and radio traffic. After verbally addressing them, one staff member responded and was informed a resident had fallen and EMS had been called to assist. The staff reaction was notably indifferent and lacked urgency. While in the building, a very strong odor of marijuana was noted in multiple areas, including both the first-floor hallway near

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U 114	Continued From page 3 the patient's apartment and the second-floor lounge where the staff were located. This odor was consistent and noticeable upon entry and throughout time on scene." On 12/11/2025, Surveyor reviewed Tenant 1's record and identified the following: -Tenant 1 was admitted to the provider on 10/25/2024 with diagnoses including diabetes, arthritis, fibromyalgia, and history of falls. There was no staff documentation of Tenant 1 having a fall on 11/07/2025. On 12/15/2025 at approximately 3:00 PM, Surveyor interviewed Tenant 2. Tenant 2 stated s/he had to call 911 to have someone come and assist his/her spouse because s/he had waited about an hour with no response from any staff on duty on 11/07/2025. On 12/16/2025 at approximately 10:45 AM, Surveyor discussed concern with Regional Director of Operations A that Tenant 1 had sustained a fall and was not attended to by caregivers. Executive Director B and Regional Director of Operations A stated they both had no idea this incident had occurred because nobody notified them and there was no documentation of the incident. Regional Director of Operations A stated both caregivers would be suspended immediately pending an investigation of what happened on 11/07/2025.	U 114		
U 129	89.23(4)(a)2. SERVICES PROVIDER QUALIFICATIONS. Service Providers.	U 129		

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U 129	Continued From page 4 Nursing services and supervision of delegated nursing services shall be provided consistent with the standards contained in the Wisconsin nurse practice act. Medication administration and medication management shall be performed by or, as a delegated task, under the supervision of a nurse or pharmacist. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medication administration and management performed by 2 of 2 caregivers reviewed was delegated under the supervision of a nurse or pharmacist. Caregiver C and Caregiver D administered tenant medications without delegation from a nurse or pharmacist. Findings include: On 12/11/2025 at approximately 3:13 PM, Surveyor reviewed Caregiver C and Caregiver D's records and identified the following: - Caregiver C was hired on 01/07/2025. Caregiver C's record indicated s/he had received training in medications but did not include delegation for medication administration from an RN or pharmacist. - Caregiver D was hired on 08/13/2025. Caregiver D's record indicated s/he had received training in medications but did not include delegation for medication administration from an RN or pharmacist.	U 129		

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U 129	Continued From page 5 On 12/16/2025 at approximately 10:30 AM, Surveyor interviewed Regional Director of Operations A. Regional Director of Operations A stated all the information on Caregiver C and Caregiver D was sent to Surveyor and if it was not in the documentation, then Caregiver C and Caregiver D did not have nurse delegation. CROSS REFERENCE N0267 DHS 89.34(16) TENANT RIGHTS	U 129		
U 267	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order. This Rule is not met as evidenced by:	U 267		

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Based on record review and interview, the provider did not ensure 3 of 3 tenants reviewed received all medications as prescribed. Tenant 3, Tenant 4 and Tenant 5 missed their 8:00 PM medications on 11/08/2025.

Findings include:

On 11/10/2025, the Department received a complaint regarding tenants not receiving their medications as prescribed.

On 12/09/2025 with information gathered through 12/16/2025, Surveyor reviewed Tenant 3, Tenant 4 and Tenant 5's record. Surveyor identified the following:

Tenant 3
Tenant 3 was admitted on 08/29/2025. Tenant 3's November 2025 Medication Administration Record identified the following:
-Acetaminophen 325 MG caplet, take two tablet by mouth twice daily for pain at 8:00 AM and 8:00 PM.
-Atorvasatin 80 MG tab, take 1/2 tablet by mouth once a day at 8:00 PM.
-Carboxymethylcellulose 0.5% OP, instill one drop in both eyes twice daily at 8:00 AM and 8:00 PM.
-Eliquis 5 MG tab, take 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM.
-Entresto 49/51 MG tab, take 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM.
-Hydralazine 50 MG tab, take 1 tablet by mouth three times daily at 8:00 AM, 4:00 PM and 8:00 PM.
-Melatonin 3MG tab, take 3 tablets by mouth once daily at bedtime at 10:00 PM.
-Pregabalin 75 MG cap, take 1 capsule by mouth twice daily at 8:00 AM and 8:00 PM.

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-Simethicone Chew 80 MG tab, take 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM.
-Tenant 3's November 2025 MAR stated Tenant 3 did not receive his/her 8:00 PM medications on 11/08/2025. Tenant 3 missed 9 doses of his/her medication. The exception reason stated outside of parameters.

Tenant 4
Tenant 4 was admitted on 01/21/2025. Tenant 4's November 2025 Medication Administration Record identified the following:
-Eliquis 2.5 MG tab, take 1 tablet by mouth twice a day at 8:00 AM and 8:00 PM
-Tenant 4's November 2025 MAR stated Tenant 4 did not receive his/her 8:00 PM medications on 11/08/2025. Tenant 4 missed 1 dose of his/her medication. The exception reason stated outside of parameters.

Tenant 5
Tenant 5 was admitted on 03/16/2023. Tenant 5's November 2025 Medication Administration Record identified the following:
-Lantus Solostar 100Unit/ML pen, inject 39 units subcutaneously once daily at bedtime at 8:00 PM for type 2 Diabetes.
-Tenant 5's November 2025 MAR stated Tenant 5 did not receive his/her 8:00 PM medications on 11/08/2025. Tenant 5 missed 1 dose of his/her insulin. The exception reason stated medication not available.

On 12/16/2025, Surveyor interviewed Executive Director E. Executive Director E stated the facility did not have a medication passer from 5:00 PM until almost midnight on 11/08/2025 and stated tenants did not receive their 8:00 PM medications on 11/08/2025. Executive Director E stated the certified medication passer did not show up for

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U 267	Continued From page 8 his/her shift so s/he had to try and call other staff to come in and the earliest someone could come in to pass the medications was after the 8:00 PM medication pass. All tenants who had 8:00 PM medications did not receive their medications.	U 267		