STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017777	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 03/23/2026, Surveyor conducted a complaint investigation and standard survey at Charter Senior Living - Madison, a RCAC in Madison. Three deficiencies were identified. One deficiency is a repeat deficiency - See Statement of Deficiency (SOD) B33911, dated 08/13/2024, SOD B33912, dated 04/09/2025, and SOD B33913, dated 08/20/2025. The complaint was substantiated. Census: 53	U 000		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure nursing services were	U 118		

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
	0017777	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 118	Continued From page 1	U 118		

provided for 3 of 3 tenants reviewed.

Tenant 1's blood sugar monitoring and insulin administration were not documented in his/her record. Tenant 1 did not receive his/her Carbidopa Levodopa as prescribed.
Tenant 2's record did not include the monitoring and treatment of his/her left shin wound.
Tenant 3's record did not include the monitoring and treatment of his/her left lower extremity wound.

This is a repeat deficiency - See Statement of Deficiency (SOD) B33911, dated 08/13/2024, SOD B33912, dated 04/09/2025, and SOD B33913, dated 08/20/2025.

Findings include:

On 03/23/2026, Surveyor conducted a complaint investigation alleging care concerns at the provider's complex.
On 03/23/2026 at approximately 10:00 a.m., Surveyor conducted interviews and reviewed records. The following concerns were identified:

TENANT 1

Tenant 1 was admitted to the provider's complex on 07/01/2025 with diagnoses including diabetes and Parkinson's disease. Tenant 1's service plan, dated 12/10/2025, indicated the provider's staff were responsible for Tenant 1's medication administration.

Blood Sugars & Insulin Administration

Tenant 1's physician orders included the following:
- Check blood sugar readings 4 times daily (Start

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017777	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 118	Continued From page 2 Date: 12/25/2025). - Humalog 100 unit/ml (Start Date: 12/25/2025) - Inject 15 units with each meal plus correction <150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. - Humalog 100 unit/ml (Start Date: 12/25/2025) - Inject 15 units at bedtime plus correction <200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units. Tenant 1's Medication Administration Record (MAR), dated 03/01/2026 to 03/23/2026, did not document Tenant 1's blood sugar readings or the number of insulin units administered. On 03/23/2026 at 10:43 a.m., Surveyor interviewed RN B and asked if s/he had documentation of Tenant 1's blood sugar readings and insulin administration. RN B reviewed Tenant 1's MAR and stated s/he did not realize the electronic charting program was not set to prompt the med passer to document blood sugar readings and insulin administration. RN B stated s/he would follow up with the provider's pharmacy to make the change in the electronic charting program. RN B stated s/he was responsible for Tenant 1's medication administration that morning and had not documented the blood sugar reading or insulin administration. Carbidopa Levodopa On 03/23/2026 at 9:44 a.m., Surveyor interviewed Tenant 1 and Tenant 4. Tenant 1 stated the provider was responsible for his/her medication administration and voiced concern that s/he did not always receive his/her Carbidopa Levodopa as prescribed because the provider did not always staff a caregiver with the ability to pass	U 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017777	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 118	Continued From page 3	U 118		

medications. Tenant 1 stated the missed doses caused his/her body to be out of sync, shuffling his/her feet more and caused lethargy. Tenant 4 stated s/he noted increased Parkinson's dementia symptoms when Tenant 1 did not receive his/her Carbidopa Levodopa as prescribed. Tenant 1 stated s/he had missed a dose of Carbidopa Levodopa over the weekend and was still feeling the effects.

Tenant 1's physician orders included the following:
- Carbidopa Levodopa (Start Date: 12/25/2025) 25-100 mg - Take 3.5 tablets at 6:00 a.m., 10:00 a.m., 2:00 p.m. and 6:00 p.m.
- Carbidopa Levodopa (Start Date: 12/24/2025) 25-100 mg - Take 5 tablets at 10:00 p.m.

Tenant 1's MAR, dated 03/01/2026 to 03/23/2026, documented the following occurrences when Tenant 1 did not receive his/her Carbidopa Levodopa as prescribed: 03/04/2026 10:00 a.m., 03/05/2026 10:00 p.m., 03/07/2026 2:00 p.m., 03/10/2026 6:00 a.m., 03/11/2026 10:00 p.m., 03/14/2026 10:00 a.m., 03/15/2026 10:00 a.m., and 03/21/2026 at 6:00 a.m. The MAR did not document a reason why the doses were missed.

On 03/23/2026 at 10:43 a.m., Surveyor interviewed RN B and discussed concern that Tenant 1 had missed doses of Carbidopa Levodopa, allegedly due to lack of staff available that were able to administer medications. RN B reviewed Tenant 1's MAR and confirmed missed doses of Carbidopa Levodopa. RN B stated s/he was unable to confirm staffing was the reason for each missed dose but did confirm the provider's complex was not always staffed, particularly at night, with staff capable of administering medications. RN B stated s/he should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017777	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 118	Continued From page 4	U 118		

contacted if medication administration was needed and s/he would have been able to get to the provider's complex within 30 minutes.

On 03/23/2026 at 11:00 a.m., Surveyor reviewed the employee roster with RN B to clarify who was delegated to administer medications. Surveyor then reviewed the provider's schedule, dated 03/01/2026 to 03/23/2026. Surveyor noted the following dates when 3rd shift was not staffed with a staff member delegated to administer medications: 03/06/2026, 03/09/2026, 03/14/2026, 03/15/2026 and 03/20/2026. RN B stated s/he planned to delegate the 2 3rd shift employees that were not delegated to pass medications on 03/25/2026.

TENANT 2

On 03/23/2026 at approximately 8:50 a.m., Surveyor reviewed the tenant roster and discussed tenant needs with RN B. RN B identified Tenant 2 as an individual that required wound care.

On 03/23/2026 at approximately 10:30 a.m., Surveyor reviewed Tenant 2's record. Tenant 2 was admitted to the provider's complex on 04/12/2024 with diagnoses including diabetes and congestive heart failure. Tenant 2's record did not include documentation of skin concerns or wound care.

On 03/23/2026 at approximately 10:43 a.m., Surveyor requested documentation regarding Tenant 2's wound from RN B. RN B stated s/he didn't have any documentation to provide. RN B stated s/he observed the wound on 03/13/2026 and described the wound as an open blister with an approximate size of 6 cm by 4 cm on his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017777	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 118	Continued From page 5	U 118		

left shin. RN B stated s/he and/or Tenant 2 had been caring for the wound every other day with saline, antibiotic ointment and wrapping. RN B stated s/he had requested wound care from Tenant 2's primary care physician 03/13/2026; however, they did not visit Tenant 2 until 03/19/2026. RN stated when Tenant 2's physician completed the visit, the physician documented the wound as resolved when it wasn't so the provider worked to have Tenant 2 establish care with a new physician. RN B stated Tenant 2 had an assessment completed with a new physician group on 03/20/2026 and s/he was waiting for wound care orders. RN B did not have documentation to provide regarding the monitoring and treatment of Tenant 2's wound.

TENANT 3

Tenant 3 was admitted to the provider's complex on 08/31/2022. Tenant 3's physician orders included silver sulfadiazine 1% cream (Start Date: 02/27/2026) - Apply topically to burned area as directed once daily. Tenant 3's MAR, dated 03/01/2026 to 03/15/2026, documented administration of the medication on 03/09/2026 and 03/14/2026. Tenant 3 was hospitalized on 03/16/2026 for an unrelated concern.

On 03/23/2026 at 11:00 a.m., Surveyor interviewed RN B regarding Tenant 3's medications and discussed Tenant 3's order for silver sulfadiazine 1% cream. RN B stated Tenant 3's silver sulfadiazine 1% cream was for a wound on Tenant 3's calf. RN B stated the wound was approximately 3 cm by 2 cm and not measurably deep. RN B stated s/he had been completing wound care daily and applying silver sulfadiazine cream 1% up until Tenant 3's hospitalization. RN B stated s/he did not document the monitoring or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017777	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 118	Continued From page 6 treatment to Tenant 3's wound on his/her calf.	U 118		
U 127	89.23(3)(f) SERVICES SERVICE QUALITY. Meals and snacks served to tenants shall be prepared, stored and served in a safe and sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure meals and snacks served to tenants were prepared and stored in a safe and sanitary manner. Findings include: On 03/23/2026 at 11:28 a.m., Surveyor toured the provider's kitchen and observed the following concerns: Appliances: - The provider's oven had a thick layer of grease built up in the front left corner. - Refrigerator and freezer shelves had food crumbs scattered throughout the shelves. Food: - 2 chocolate cream pies were stored in the provider's freezer without the packaging being secured. - 2 boxes of juice concentrate were stored on the floor in the provider's refrigerator. - A rolling cart had a plastic covering with a tear greater than 12 inches in length and 4 inches in width, exposing the food. The cart contained individual cups of yogurt parfaits that did not have	U 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017777	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 127	Continued From page 7 any sort of covering over them, raw chicken in a bag that was left open to air and unidentified meat that was wrapped in tinfoil sitting on a tray covered with pink liquid. - A dry food storage shelf that stored ice cream toppings had an unlabeled container that appeared to have chocolate syrup in it. The syrup had 13 white dots scattered on the surface. - A refrigerated prep table contained plastic containers of sliced ham, shredded cheese, onions, tomatoes, lettuce and pickles. The containers were not dated. "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) On 03/23/2026 at 11:30 a.m., Cook C stated the white dots on the ice cream topping appeared to be mold. Cook C stated s/he would dispose of the topping. On 03/23/2026 at 11:32 a.m., Cook D stated the provider's appliances were cleaned weekly. Cook D stated the deli ingredients had been prepared 3 days prior to Surveyor's visit. On 03/23/2026 at approximately 12:00 p.m., Surveyor reviewed food storage concerns with Executive Director A and RN B. Executive Director A made note of Surveyor's concerns.	U 127		
U 134	89.23(4)(d)1. SERVICES	U 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017777	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 134	Continued From page 8 PROVIDER QUALIFICATIONS. Staff training. All facility staff shall have training in safety procedures, including fire safety, first aid, universal precautions and the facility's emergency plan, and in the facility's policies and procedures relating to tenant rights. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 caregivers reviewed were trained in safety procedures, including first aid. Findings include: On 03/23/2026, Surveyor conducted a complaint investigation alleging concerns with employee training. On 03/23/2026 at approximately 10:00 a.m., Surveyor reviewed employee records provided by Executive Director A. The record of Caregiver E documented s/he was hired on 02/23/2026. Caregiver E's record did not include documentation of first aid training. On 03/23/2026 at 10:40 a.m., Surveyor interviewed Executive Director A and asked if Caregiver E had received training in first aid. Executive Director A showed documentation indicating Caregiver E had completed a review of tenant rights and the employee handbook but stated the provider's orientation had not occurred	U 134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017777	A. BUILDING: _____ B. WING _____	C 03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING-MADISON	5601 BURKE RD MADISON, WI 53718

(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 134	Continued From page 9 yet. Executive Director A stated orientation was scheduled for 03/25/2026. On 03/23/2026 at 1:00 p.m., Surveyor reviewed the provider's schedule, dated 03/01/2026 to 03/23/2026. The schedule documented Caregiver E had worked 7 shifts from 03/01/2026 to 03/23/2026.	U 134		