STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014886	A. BUILDING: _____ B. WING _____	R 05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURDY OAKS	926 CAMPFIRE DRIVE SUN PRAIRIE, WI 53590

(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
{M 000}	INITIAL COMMENTS From 05/07/2026 to 05/13/2026, Surveyor conducted a verification visit and complaint investigation at Sturdy Oaks, an AFH in Sun Prairie. One deficiency was identified. Statement of Deficiency (SOD) 5V2513, dated 11/24/2025, was corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 2	{M 000}		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed had changes in their health documented. Resident 2's record did not include documentation related to his/her left humeral fracture, right humerus fracture, and pneumonia diagnosis, hospice discussions and hospitalization resulting in death. Resident 2's physician was not immediately notified of changes in his/her health. Findings include:	M 448		

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

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From 05/07/2026 to 05/13/2026, Surveyor conducted a complaint investigation alleging care concerns at the provider's facility.

On 05/07/2026 at approximately 10:15 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's home in August 2017 and discharged from the home on 04/25/2026. Resident 2 had a legal guardian. The following concerns with documentation of health changes were noted:

Left Humeral Fracture:

Resident 2's record included an After Visit Summary that indicated Resident 2 was seen 01/07/2026 for a left humeral fracture. Resident 2's record did not include further documentation regarding Resident 2's fracture.

On 05/07/2026, while reviewing Resident 2's record, Surveyor asked Licensee A and Caregiver C for documentation regarding Resident 2's left humeral fracture. Licensee A reported s/he didn't have documentation to provide. Licensee A and Caregiver C stated Resident 2 was favoring the arm and showing signs of pain, so they took Resident 2 to be evaluated. Licensee A stated there was not a witnessed event resulting in the fracture, but that Resident 2 ambulated throughout the home and would frequently run into things. Licensee A stated Resident 2 would have been able to get up from the ground if s/he had sustained a fall.

Right Humerus Fracture and Pneumonia:

Resident 2's record included an After Visit Summary that indicated Resident 2 was seen 03/24/2026 for a right humerus fracture

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M 448	Continued From page 2 secondary to fall and pneumonia. On 05/07/2026, while reviewing Resident 2's record, Surveyor asked Licensee A and Caregiver C for documentation regarding Resident 2's fall and pneumonia diagnosis. Caregiver C stated Resident 2 did not sustain a fall that the provider was aware of. Caregiver C stated Resident 2 was resisting movement of his/her arm as s/he assisted him/her getting dressed one morning, so the provider took him/her to be evaluated, and the fracture was diagnosed. Caregiver C stated Resident 2 did not have a witnessed event resulting in the fracture, but that Resident 2 would have been able to get up on his/her own had s/he sustained an unwitnessed fall. The provider did not have documentation regarding signs or symptoms of the pneumonia. Licensee A stated Resident 2 was chronically "phlegmy." Hospice Care: Resident 2's record included an in-home physician visit, dated 04/08/2026, that documented hospice was discussed and that Licensee A would get back to the physician. On 05/07/2026, while reviewing Resident 2's record, Surveyor asked Licensee A for documentation related to hospice arrangements. Licensee A stated s/he attempted to reach Resident 2's legal guardian twice after the 04/08/2026 physician visit but was unsuccessful. Licensee A provided Surveyor with an email correspondence between Licensee A and Resident 2's physician group, dated 04/13/2026, which indicated consent for hospice services had been obtained by the physician group and Licensee A would expect to hear from hospice within the next day or two. Surveyor asked	M 448		

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Licensee A if s/he had documentation regarding the attempts to obtain consent for hospice or follow up regarding hospice services. Licensee A stated s/he had no additional documentation to provide.

Change in Condition:

On 05/07/2026, while reviewing Resident 2's record, Surveyor interviewed Licensee A and Caregiver C regarding Resident 2's final days at the home. Caregiver C stated s/he noticed a change in Resident 2's appetite beginning February 2026 and hospice arrangements were in the works. Licensee A verbally summarized Resident 2's final days at home as follows:

- 04/22/2026: Speech appeared different at dinner time. Resident 2 was up multiple times during the night and was found on the floor at one point during the night. Resident 2 reported s/he was comfortable on the floor and remained sleeping there until moving him/herself back to his/her chair.
- 04/23/2026: Similar to 04/22/2026 except not found on floor. Licensee A called physician group to report change noted and Resident 2 being "phlegmy," which s/he had a history of.
- 04/24/2026: Slept all day, which was not unusual for Resident 2. Found to be heavily incontinent at approximately 5:00 p.m. during cares. Refused dinner and fluids during the night. Stayed in recliner overnight.
- 04/25/2026: Refused fluids. Licensee A stated s/he checked Resident 2 throughout the night and did not observe incontinence. In the morning, Licensee A was unable to obtain a blood pressure due to 1 upper extremity being in a sling and Resident 2 not holding his/her other upper extremity out for Licensee A. Resident 2 would

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not open his/her eyes for Licensee A or Caregiver C. Licensee A stated Resident 2 had a history of "playing possum;" therefore s/he did not immediately notify Resident 2's physician of Resident 2 not responding. Licensee A stated s/he did contact Resident 2's physician group at 2:34 p.m. to voice concern that Resident 2 was not responding to Licensee A or Caregiver C. Licensee A stated s/he had not been able to complete cares due to Resident 2 not responding. Upon call to the physician group, Licensee A stated the physician group updated Licensee A that hospice had not been ordered yet and instructed that Resident 2 be sent out for evaluation. Licensee A stated Resident 2 was sent to the hospital where s/he passed away. Licensee A stated Resident 2's code status was "Do Not Resuscitate." After Licensee A's summary of Resident 2's final days, Surveyor requested documentation of the health changes. Licensee A provided Surveyor with a notepad that documented sporadic intakes, blood pressure readings, continence/incontinence, and transfer status from 04/21/2026 to 04/23/2026. Documentation did not include Resident 2's changes in health from 04/24/2026 to 04/25/2026, correspondence with Resident 2's physician group or Resident 2's ultimate discharge to the hospital where s/he passed away.

On 05/27/2026 at approximately 12:30 p.m., Surveyor discussed concern with Licensee A that changes in Resident 2's health were not documented, and his/her physician was not notified until 2:34 p.m. Licensee A acknowledged Surveyor's concern and stated s/he had recognized documentation was an area that needed to improve. Licensee A stated s/he used to document everything but changed to charting by exception and would now go back to charting

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M 448	Continued From page 5 everything. Licensee A stated s/he didn't update Resident 2's physician group until 2:34 p.m. because of the history of playing possum." On 05/12/2026 at approximately 7:00 a.m., Surveyor reviewed hospital records for Resident 2, obtained by Surveyor. Records documented that Resident 2 was found to be bradycardic in the 20's with EMS and presented to the hospital being bagged. The record indicated Resident 2 presented unresponsive, pale, cool and with no pulse. Records documented that Resident 2 presented wearing a DNR bracelet and all resuscitative efforts were ceased once testing showed no cardiac activity, indicating a [pulseless electrical activity] arrest. On 05/12/2026 at 8:40 a.m., Surveyor interviewed Case Manager D. Case Manager D stated s/he had spoken with Licensee A on 04/24/2026 and was not informed of any new concerns other than pending hospice arrangements. Case Manager D stated improved documentation and timely notifications of health changes were a frequent discussion with Licensee A during Resident 2's time at Licensee A's home.	M 448		