STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017058	A. BUILDING: _____ B. WING _____	C 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING MARKET ST CBR	1870 MARKET ST CROSS PLAINS, WI 53528

(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 04/14/2026, the bureau of assisted living southern regional office conducted a complaint investigation at Milestone Senior Living Market Street a CBRF located in Cross Plains, WI. As a result of this survey, 2 violations of DHS Chapter 83 were identified. The complaint was substantiated. Census: 19	N 000		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were free from misappropriation of property. On 03/17/2026, Provider discovered resident medications had been misappropriated from their medication cart: -14 doses of Resident 1's Oxycodone 5 mg tablets had been opened/taped over, some of the taped over slots had been emptied, and the rest were replaced with Hydroxyzine 25 mg tablets. -9 doses of Resident 2's Morphine Sulfate 15 mg	N 348		

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
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N 348	Continued From page 1	N 348		

tablets had been replaced with Hydroxyzine 25 mg tablets.
-6 doses of Resident 3's Hydroxyzine 25 mg tablets had been removed without being documented in the MAR.
-14 doses of Resident 4's Hydroxyzine 25 mg tablets had been removed without being documented in the MAR.

FINDINGS INCLUDE:

On 04/03/2026, the Department received a complaint regarding misappropriation of schedule II narcotic medication.

On 04/14/2026, Surveyor reviewed a self-report submitted to the Department by Nurse C on 03/17/2026. The "Incident Description," documented the following, " [Caregiver D] went to administer PRN Oxycodone 5 mg to [Resident 1]. [S/he] discovered the bubble pack card was tampered with. Multiple bubbles had been opened and taped closed and the Oxycodone was replaced with Hydroxyzine tablets. The medication was not administered to the resident. Healthcare Coordinator notified. All narcotic cards were inspected. Additional cards were found to have been tampered with in the same manner with narcotic medications replaced with Hydroxyzine or Acetaminophen ...".

On 04/14/2026, Surveyor reviewed a self-report submitted to the Department by Nurse C on 04/03/2026. In the "Incident Description," documented the following, "One tablet of Oxycodone 5 mg was removed from [Resident 1's] bubble pack and replaced with hydroxyzine 25 mg tablet Discrepancy was not discovered at change of shift Narcotic Count at 11:00 PM on 4/2/26 by [Caregiver F] and [Caregiver H].

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N 348	Continued From page 2 Discrepancy was found when [Caregiver F] popped out a tablet of Oxycodone to medicate [Resident 1] at 2:00 AM. The resident did not receive the Hydroxyzine tablet. Resident received the correct medication. Health Care Coordinator notified by [Caregiver F]. All narcotic cards were audited/examined. No other medications were missing or tampered with. All narcotic cards were last audited at 3 PM on 4/2/26 by [Lead Caregiver G] and no issues were found. This is consistent with a prior diversion on 03/17/26 with the same medication and same resident ..." On 04/14/2026, Surveyor arrived at the facility for a complaint investigation. On 04/14/2026 at approximately 9:15 AM, Surveyor discussed the above self-reports with Administrator A and Director B. Director B reported that Caregiver F was the original staff to report that residents blister packs had been tampered with. Administrator A and Director B reported that the slots in the blister packs had slits cut at the bottom and then taped back over with scotch tape. Administrator A and Director B reported [Resident 1's] Oxycodone 5 mg blister pack had been refilled with hydroxyzine tablets, and they couldn't identify how many hydroxyzine tablets had been administered to Resident 1. Director B stated the local police have been investigating the theft of narcotics since 03/17/2026. Director B stated the individual who misappropriated Resident 1's narcotics had not been identified at this time. Administrator A and Director B described their own extensive internal investigation, and frustration with their own lack of findings. Administrator A and Director B reported that all staff were drug tested, and all staff results were negative.	N 348		

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N 348	Continued From page 3 On 04/14/2026, Surveyor reviewed the investigation into the misappropriation of medications identified on 03/17/2026. The following was documented, " ...call at 12:00 AM on 3/17/26 from [Caregiver D] who reported that when [s/he] popped out a tablet to administer PRN Oxycodone 5 mg to [Resident 1] it was harder than usual to pop the tablet out of the bubble pack. [S/He] turned over the card and noticed that there was tape over the bubble. [S/he] turned over the card and noticed that there was tape over the bubble. [S/he] looked up the pill online on the pill identifier site and the pill was Hydroxyzine not Oxycodone. [S/he] also noted that there were 14 bubbles on the same card with tape over the backs. Some of the bubbles were empty and some still had medication in them ...All interviewed deny knowledge of missing medication. All staff tested negative. All narcotic cards audited. Evidence of tampering found on other cards ...9 doses of Morphine for [Resident 2] were replaced with Hydroxyzine ...Two residents in the community have orders for Hydroxyzine PRN. The card of Hydroxyzine for [Resident 3] had 6 tablets missing. No Hydroxyzine was documented on the EMAR (electronic medication administration record) as given. The card of Hydroxyzine for [Resident 4] had 14 tablets missing. No Hydroxyzine was documented on the EMAR as given ...". EXAMPLE 1: Resident 1 On 04/14/2026, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 02/13/2026. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: low back pain, right knee pain, chronic pain, diverticulosis of large intestine without perforation of abscess	N 348		

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N 348	Continued From page 4 without bleeding, depression, bipolar disorder and anxiety. On 04/14/2026, Surveyor reviewed Resident 1's March 2026 MAR (medication administration record). A total of 22 administrations of PRN Oxycodone were documented by staff during March. Surveyor reviewed 2 orders for Oxycodone 5 mg tablets: 1.) OXYCODONE 5 MG TABLET - TAKE 1 TABLET BY MOUTH THREE TIMES DAILY AS NEEDED - Start Date: 02/13/2026 - End Date: 03/17/2026 2.) OXYCODONE 5 MG TABLET - TAKE 1 TABLET BY MOUTH THREE TIMES DAILY AS NEEDED - Start Date: 03/18/2026 On 04/14/2026, Surveyor reviewed Resident 1's Progress Notes from 02/01/2026 to 04/14/2026. On 03/27/2026 at 10:00 AM, Nurse C documented the incident on 03/17/2026 when 14 slots on Resident 1's Oxycodone 5 mg blister pack were identified as tampered/replaced. Example 2: Resident 2 On 04/14/2026, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted to the facility on 08/13/2025. Resident 2 had an activated power of attorney. Resident 2 received hospice services at facility. On 04/14/2026, Surveyor reviewed Resident 2's March 2026 MAR. Surveyor reviewed the following order, "MORPHINE SUL TAB 15MG ...TAKE ONE-HALF TABLET (7.5MG) BY MOUTH EVERY 4 HOURS AS NEEDED ...Start Date: 08/15/2025 ...). Zero, administrations of PRN Morphine were documented as administered on the MAR.	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 348	Continued From page 5 Example 3: Resident 3 On 04/14/2026, Surveyor reviewed Resident 3's facility record. Resident 3 was admitted to the facility on 03/13/2025. Resident 3 had an activated power of attorney. Resident 3 was diagnosed with but not limited to: psoriasis, insomnia and dementia. On 04/14/2026, Surveyor reviewed Resident 3's March 2026 MAR. Surveyor reviewed the following order, "HYDROXYZ HCL TAB 25MG ...TAKE 1 TABLET BY MOUTH EVERY 4 HOURS AS NEEDED FOR ITCHING ...Start Date: 08/22/2025 ..." Zero, administrations of PRN Hydroxyzine were documented as administered on the MAR. Example 4: Resident 4 On 04/14/2026, Surveyor reviewed Resident 4's facility record. Resident 4's was admitted to the facility on 03/07/2025. Resident 4 had an activated power of attorney. Resident 4 was diagnosed with but not limited to: chronic rhinitis, dry eye syndrome of the lacrimal glands and dementia. On 04/14/2026, Surveyor reviewed Resident 4's March 2026 MAR. Surveyor reviewed the following order, "HYDROXYZ HCL TAB 25MG ...TAKE 1 TABLET BY MOUTH EVERY 8 HOURS AS NEEDED ...Start Date: 03/17/2026 ..." Zero, administrations of PRN Hydroxyzine were documented on the MAR. EXIT INTERVIEW: On 04/17/2026 at 12:00 PM, Surveyor discussed	N 348		

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N 348	Continued From page 6 the above concerns with Administrator A, Director B, Nurse C and Director L. Administrator A, Director B, Nurse C and Director L acknowledged Resident 1, Resident 2, Resident 3 and Resident 4 had medications misappropriated from the facility medication cart. Director L stated when medication cart outside of medication room, there will be a 2 staff policy for administration of narcotics. Administrator A stated facility would continue to work with local police to identify the individual(s) responsible for misappropriation of resident medications. CROSS REFERENCE: N0415 DHS Chapter 83.37(2)(d) Documentation Of Medication Administration	N 348		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the staff administering the medication documented in the resident record the	N 415		

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name, dosage, date and time of the medication taken and initialed the medication administration record (MAR).

In March 2026, Caregiver J did not document 5 administrations of Oxycodone 5 mg tablet in Resident 1's MAR.

This is a repeat of statement of deficiency (SOD) 1NLQ11 dated 03/15/2022, SOD I52G11 dated 10/27/2023 and SOD I52G12 dated 05/03/2024.

FINDINGS INCLUDE:

On 04/03/2026, the Department received a complaint regarding misappropriation of schedule II narcotic medication.

On 04/14/2026, Surveyor arrived at the facility for a complaint investigation.

RECORD REVIEW:

On 04/14/2026, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 02/13/2026. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: low back pain, right knee pain, chronic pain, diverticulosis of large intestine without perforation of abscess without bleeding, depression, bipolar disorder and anxiety.

On 04/14/2026, Surveyor reviewed Resident 1's March 2026 MAR (medication administration record). Surveyor reviewed 2 orders for Oxycodone 5 mg tablets:
1.) OXYCODONE 5 MG TABLET - TAKE 1 TABLET BY MOUTH THREE TIMES DAILY AS NEEDED - Start Date: 02/13/2026 - End Date:

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N 415	Continued From page 8 03/17/2026 - The following intervals were documented as administered: -03/01/2026 at 3:39 AM, Caregiver F -03/04/2026 at 4:00 PM, Caregiver I -03/05/2026 at 3:32 PM, Caregiver H -03/07/2026 at 5:15 AM, Caregiver D -03/08/2026 at 12:03 AM, Caregiver D -03/09/2026 at 12:41 AM, Caregiver D -03/09/2026 at 10:05 PM, Caregiver J -03/11/2026 at 6:09 AM, Caregiver F -03/11/2026 at 7:41PM, Caregiver J -03/12/2026 at 3:45 PM, Caregiver I -03/13/2026 at 1:55 AM, Caregiver F -03/17/2026 at 11:45 PM, Caregiver D 2.) OXYCODONE 5 MG TABLET - TAKE 1 TABLET BY MOUTH THREE TIMES DAILY AS NEEDED - Start Date: 03/18/2026 - The following intervals were documented as administered: -03/20/2026 at 1:05 AM, Caregiver F -03/22/2026 at 10:03 PM, Caregiver I -03/23/2026 at 7:26 PM, Caregiver J -03/24/2026 at 3:38 AM, Caregiver F -03/24/2026 at 11:37 PM, Caregiver F -03/25/2026 at 11:16 PM, Caregiver F -03/26/2026 at 11:28 PM, Caregiver F -03/28/2026 at 4:40 PM, Caregiver J -03/29/2026 at 11:30 PM, Caregiver K -03/30/2026 at 11:30 PM, Caregiver F On 04/14/2026, Surveyor reviewed Resident 1's Oxycodone 5 mg tablet, "INDIVIDUAL PATIENT'S NARCOTICS RECORD," and cross referenced it to Resident 1's March 2026 MAR. Surveyor reviewed the following documented administrations present on the narcotic count, that were not present on the MAR: -03/01/2026 at 3:33 PM, Caregiver J -03/01/2026 at 7:15 PM, Caregiver J -03/28/2026 at 7:00 PM, Caregiver J	N 415		

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N 415	Continued From page 9 -03/31/2026 at 4:00 PM, Caregiver J -03/31/2026 at 7:00 PM, Caregiver J On 04/14/2026 at 12:00 PM, Surveyor discussed the documentation discrepancy with Administrator A, Director B and Nurse C. Administrator A, Director B and Nurse C, acknowledged they had been aware of Caregiver J's documentation error on 03/28/2026. Nurse C stated s/he had been made aware Caregiver J didn't document the Oxycodone 5 mg tablet a second time on 03/28/2026. Nurse C had reported s/he had spoken with Caregiver J and Caregiver J stated the computer wouldn't allow him/her to document the second administration on 03/28/2026. Nurse C stated s/he hadn't been aware of Caregiver J failing to document 2 doses on the MAR on 03/01/2026 and then on 03/31/2026. Nurse C verified s/he had spoken to Caregiver J about the documentation concern on 04/03/2026, and Caregiver J had correctly documented administration of Oxycodone 5 mg tablets since that meeting. Nurse C reported facility computer system doesn't always save staff documentation. Nurse C reported facility will be switching to a new electronic health record (EHR) in the future. On 04/14/2026 at 3:50 PM, Surveyor, Administrator A and Director B interviewed Caregiver J. Caregiver J acknowledged Nurse C had previously spoken to him/her about failing to document the second dose of Oxycodone 5 mg tablet on 03/28/2026. Caregiver J stated the computer system had blocked him/her from documenting the second dose on 03/28/2026. Surveyor showed Caregiver J Resident 1's narcotic count sheets for the Oxycodone 5 mg tablets and Resident 1's March 2026 MAR. Surveyor asked Caregiver J why s/he failed to document 2 administrations of Oxycodone 5 mg	N 415		

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N 415	Continued From page 10 tablets on 03/01/2026. Caregiver J stated s/he must have forgotten to document those 2 administrations on the MAR. Surveyor asked Caregiver J why s/he failed to document 2 administrations of Oxycodone 5 mg tablets on 03/31/2026. Caregiver J stated s/he was too distracted during medication pass and must have forgotten to document the 2 doses of narcotic on the MAR. Surveyor asked Caregiver J how long s/he had been passing medications. Caregiver J stated s/he has passed medications for 10 years. CROSS REFERENCE: N0348 DHS Chapter 83.32(3)(d) Rights Of Residents: Free From Mistreatment	N 415		