STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019869	A. BUILDING: _____ B. WING _____	R-C 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SONNET AT TENNYSON (THE)	1936 TENNYSON LN MADISON, WI 53704

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{N 000}	Initial Comments On 01/15/2026, the bureau of assisted living southern regional office conducted 2 complaint investigations and 2 verification visits at The Sonnet At Tennyson a CBRF located in Madison, WI. As a result of this survey, 3 violations of DHS Chapter 83 were identified. One violation from previous statement of deficiency (SOD) RFTY11 dated 07/21/2025 was corrected. One complaint was substantiated. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 58	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the community based residential facility (CBRF) and its operation complied with all laws governing the CBRF. From 02/13/2024 to 01/15/2026, the provider did not comply with all the laws governing the CBRF	N 196		

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

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N 196	Continued From page 1 as evidenced by 29 deficiencies identified, 9 repeat violations, and 11 complaints substantiated. This is a repeat of statement of deficiency (SOD) MXVF13 dated 09/18/2024 and SOD MXVF14 dated 12/10/2024. FINDINGS INCLUDE: RECORD REVIEW: On 01/11/2024, the provider was issued a probationary license. On 01/11/2025, the provider was issued a license as a Class CNA (non-ambulatory) facility with the ability to care for up to 60 residents with diagnoses including emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, physically disabled and advanced age. Example 1: Obtain and maintain compliance with laws governing the CBRF: On 02/13/2024, the bureau of assisted living Southern regional office conducted an on-site survey. As a result of the survey 2 complaints were substantiated and 1 deficiency was identified in SOD CJWV11: 9.) 83.32(3)(i) Rights of Residents: Adequate Treatment On 04/11/2024, the bureau of assisted living Southern regional office conducted an on-site survey. As a result of the survey 1 complaint was substantiated and 1 deficiency was identified in SOD MXVF11: 1.) 83.29(2) Admission Agreement Include	N 196		

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N 196	Continued From page 2 Services, Charges On 06/17/2024, the bureau of assisted living Southern regional office conducted an on-site survey. As a result of the survey 2 complaints were substantiated and 17 deficiencies were identified in SOD MXVF12: 1.) 83.12(2)(a) Caregiver: Investigating Abuse & Neglect 2.) 83.12(4)(b) Reporting When Law Enforcement Is Called 3.) 83.12(6) Documentation Of Requirements For Written Report 4.) 83.15(3)(a) Administrator Shall Supervise Daily Operation 5.) 83.17(1) Licensee Conduct Caregiver Background Check 6.) 83.20(2)(a)-(d) Department Approved Training Courses 7.) 83.21(1)-(3) All Employee Training 8.) 83.28(4)(a) Resident Health Screening And Documentation 9.) 83.32(3)(i) Rights Of Residents: Adequate Treatment 10.) 83.35(1)(a) Pre-Admission And Ongoing Assessments 11.) 83.35(3)(b) Service Plan Development: Parties Involved 12.) 83.35(3)(d) Service Plans Updated Annually Or On Changes 13.) 83.37(2)(d) Documentation Of Medication Administration 14.) 83.38(1)(i) Behavior Management 15.) 83.43(1) Environment Safe, Clean, And Comfortable 16.) 83.47(1)(f) Horizontal Evacuation 17.) 83.59(2)(a) One-Hand, One-Motion Door Operation	N 196		

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N 196	Continued From page 3 On 07/31/2024, the bureau of assisted living Southern regional office conducted an on-site survey. As a result of the survey 1 complaint was substantiated and 1 deficiency was identified in SOD T7VK11: 1.) 83.38(1)(g) Health Monitoring On 09/18/2024, the bureau of assisted living Southern regional office conducted an on-site survey. As a result of the survey 1 complaint was substantiated and 8 violations were identified in SOD MXVF13: 1.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 2.) 83.28(4)(a) Resident Health Screening And Documentation 3.) 83.32(3)(h) Rights Of Residents: Receive Medication 4.) 83.32(3)(i) Rights Of Residents: Adequate Treatment 5.) 83.32(3)(l) Rights Of Residents: Least Restrictive Environment 6.) 83.35(3)(d) Service Plans Updated Annually or On Changes 7.) 83.37(2)(d) Documentation of Medication Administration 8.) 83.59(1)(a) Class As, Ana, Cs, Can 2 Grade Level Exits On 12/10/2024, the bureau of assisted living Southern regional office conducted an on-site investigation. As a result of the survey 6 deficiencies were identified in SOD MXVF14: 1.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 196		

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N 196	Continued From page 4 2.) 83.28(4)(a) Resident Health Screening And Documentation 3.) 83.32(3)(h) Rights Of Residents: Receive Medication 4.) 83.32(3)(l) Rights Of Residents: Least Restrictive Environment 5.) 83.35(3)(d) Service Plans Updated Annually or On Changes 1.) 83.38(1)(g) Health Monitoring On 07/21/2025, the bureau of assisted living Southern regional office conducted an on-site investigation. As a result of the survey 2 complaints were substantiated and 1 violation was identified in SOD RFTY11: 1.) 83.35(3)(d) Service Plans Updated Annually or On Changes On 08/26/2025, the bureau of assisted living Southern regional office conducted an on-site survey. As a result of the survey 1 complaint was substantiated and 2 deficiencies were identified in SOD 7IIZ11: 1.) 83.32(3)(k) Rights Of Residents: Self-Determination 2.) 83.59(4)(a) Delayed Egress: Only One Device Permitted On 01/15/2026, the bureau of assisted living Southern regional office conducted an on-site investigation. As a result of the survey 1 complaint was substantiated and 3 deficiencies were identified in SOD 7IIZ12: 1.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 2.) 83.32(3)(h) Rights Of Residents: Receive Medication 3.) 83.32(3)(k) Rights Of Residents:	N 196		

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N 196	Continued From page 5 Self-Determination Example 2: Repeat violations of laws governing the CBRF. 1.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 2.) 83.32(3)(k) Rights Of Residents: Self-Determination 3.) 83.32(3)(h) Rights Of Residents: Receive Medication 4.) 83.32(3)(i) Rights Of Residents: Adequate Treatment 5.) 83.32(3)(k) Rights Of Residents: Self-Determination 6.) 83.32(3)(l) Rights Of Residents: Least Restrictive Environment 7.) 83.35(3)(d) Service Plans Updated Annually or On Changes 8.) 83.37(2)(d) Documentation of Medication Administration 9.) 83.38(1)(g) Health Monitoring Example 3: Number of Complaints Substantiated. 1.) SOD CJWV11 dated 02/13/2024 - 2 complaints substantiated 2.) SOD MXVF11 dated 04/11/2024 - 1 complaint substantiated 3.) SOD MXVF12 dated 06/17/2024 - 2 complaints substantiated 4.) SOD T7VK11 dated 07/31/2024 - 1 complaint substantiated 5.) SOD MXVF13 dated 09/18/2024 - 1 complaint substantiated 6.) SOD RFTY11 dated 07/21/2025 - 2 complaints substantiated	N 196		

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N 196	Continued From page 6 7.) SOD 7IIZ11 dated 08/26/2025 - 1 complaint substantiated 8.) SOD 7IIZ12 dated 01/15/2026 - 1 complaint substantiated INTERVIEW: On 01/15/2026 at 3:20 PM, Surveyor discussed violations identified in SOD 7IIZ12 with Administrator C. Administrator C acknowledged Resident 5 was administered the wrong medication and was hospitalized because of the medication error. Administrator C acknowledged residents who were legally their own decision maker were forced to ask staff to disarm the 15-second egress alarm to exit and/or enter the units. Administrator C stated none of the residents had a fab-key to enter-exit units in the facility. Administrator A stated s/he would strive to bring facility to compliance as soon as possible. SUMMARY: The licensee did not ensure the facility, and its operation complied with all laws governing the CBRF. The current survey included investigation of 2 complaints, and 2 verification visits. As a result, 3 deficiencies were identified, and 1 complaint was substantiated.	N 196		
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		

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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 observation, interview, and record review, the provider did not ensure Resident 5 received prescribed medications, as required.

On 12/02/2025, Resident 5 was administered another resident's blood pressure medications resulting in a significant drop in Resident 5's blood pressure requiring hospitalization from 12/02/2025 until 12/15/2025.

This requirement is being cited for a third time. See Statement of Deficiency (SOD) MXVF13, issued on 09/30/2024, and SOD MXVF14, issued on 12/17/2024.

The findings are:

On 12/29/2025, the department received a complaint including a resident received another resident's prescribed medications in error resulting in a significant change of condition.

The department received an "Assisted Living Facility Self-Report" from the facility dated 12/03/2025. The report included, [Resident 5] was administered the wrong medications by [Caregiver E] during the AM [morning] medication pass on the morning of 12/02/2025. [Resident 5] received medications that belonged to a neighboring resident on the same hall. As soon as [Caregiver E] realized the medication error, [s/he] reported it to management immediately. [Administrator C] went to the floor to observe the resident [Resident

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N 352	Continued From page 8 5], and to check vitals which were still at a normal level at the time. [Service Coordinator F] then notified all responsible parties as well as the MD [medical doctor]." The report included, "[Resident 5] was monitored closely for any adverse reactions to the medications that were given. Staff and [Former Facility Nurse D] were checking [Resident 5's] blood pressure every hour to track and ensure safe blood pressure levels. [Resident 5's] blood pressure levels continued to decrease and the MD was contacted for further direction, the MD advised we [the facility] send [Resident 5] out to the emergency room for evaulation [sic] and stabalization [sic]. [Resident 5] was then sent out to [emergency room] for observation on 12/02/2025, [Administrator C] called the [emergency room] before the end of the day on 12/02/2025 to get an update on [Resident 5] who at that time had been admitted for continued monitoring." The report included, "[Resident 5] experienced a hypotension [low blood pressure] episode following the medication error. [Resident 5] experienced continued decrease in safe blood pressure levels, which resulted in [Resident 5] being sent out to the [emergency room] due to them dropping to an unstable level. Which resulted in [Resident 5] being admitted at [hospital] to assist in stabalizing [sic] [Resident 5's] blood pressure." On 01/15/2026 at 10:23 A.M., Surveyor conducted an interview with Resident 5. Resident 5 said the caregivers were responsible for administering all of his/her prescribed medications. Resident 5 told Surveyor about his/her reaction to the medication error incident on 12/02/2025. Resident 5 said s/he felt "whacked out" about one half hour after being administered another resident's medications by	N 352		

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N 352	Continued From page 9 Caregiver E. Resident 5 said s/he could not describe what s/he meant by "whacked out" and said s/he "almost died." Resident 5 said s/he was sent to the emergency room shortly after the error and was admitted to the hospital's intensive care unit for several days before returning to the facility. Resident 5 told Surveyor Caregiver E did apologize to her/him about the medication error after Resident 5 returned from the hospital. Resident 5 said Caregiver E no longer worked at the facility. On 01/15/2026 at 10:50 A.M., Surveyor conducted an interview with Caregiver G regarding the facility's medication administration process, including medication errors. Caregiver G told Surveyor s/he and other caregivers responsible for administering resident medications recently received "refresher" medication training as a result of a significant medication error involving Resident 5. On 01/15/2026, Administrator C provided Surveyor with Resident 5's record including Resident 5's demographic information with medical diagnoses, a medication error incident report, and Resident 5's hospital discharge summary following the medication error incident on 12/02/2025. Resident 5 was admitted to the facility on 12/06/2021. Resident 5's diagnoses included diabetes with diabetic nephropathy (kidney disease or damage) and multiple sclerosis. Resident 5's medication error report dated 12/02/2025 at 10:15 A.M. included, "[Resident 5] received the wrong medications this morning, [Caregiver E] notified [Service Coordinator F] as soon as the incident happened. [Service Coordinator F] went to the floor to observe what had happened and check on [Resident 5]. Staff	N 352		

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member administered a BP [blood pressure] medication that [Resident 5] does not receive on [his/her] normal medication list. [Caregiver E] was moving too quickly but was re-educated on the 6 rights of medication administration. As well as pulled from passing medications until [Caregiver E] could take the medication refresher course and retrained." The report included, "Vitals were taken - at the time [Resident 5] did not have any side effects, but [Resident 5's] BP [blood pressure] was monitored for an updated reading every 30 minutes and [Resident 5's] BP was slowly dropping and needed to be sent to hospital via ambulance." Resident 5's blood pressure was documented as 82/37 within the incident report.
Resident 5's hospital discharge summary included Resident 5's hospitalization from 12/02/2025 until discharge back to the facility on 12/15/2025. The summary included, "[Resident 5] currently admitted to [hospital] 12/02/2025 [at] 12:33 P.M. for hypotension [low blood pressure] secondary to accidental medication administration, as well as sepsis [a serious, potentially life-threatening systemic condition] due to aspiration pneumonia [an infection caused by inhalation of something other than air into lungs]. Past medical history includes multiple sclerosis resulting in quadirplegia [sic] and neurogenic bladder...tobacco use, h/o [history of] DVT [deep vein thrombosis], chronic pain, and T2DM [type 2 diabetes mellitus]. [Resident 5] presented to the ED [emergency department] from [his/her] ALF [assisted living facility] after accidentally receiving another patient's antihypertensive medications, resulting in severe hypotension [low blood pressure]. Medications included 50 mg [milligrams] of hydralazine and 20 mg of lisinopril. Upon arrival to the ED [Resident 5's] BP [blood pressure] was

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N 352	Continued From page 11 55/35 with MAP [mean arterial pressure] 47 [a low reading]. Labs [drawn, tested] in the ED were concerning for hypokalemia [lower than therapeutic potassium level]...and anemia [lower than therapeutic level of red blood cells]. [Resident 5] underwent fluid resuscitation in the ED, but remained hypotensive and was started on norepinephrine [a medication utilized to increase blood pressure] and transferred to the ICU [intensive care unit]. [Resident 5] was noted to have stage 4 pressure injuries to left ischial and sacrum [left hip and low back regions] and wound care was consulted. [Resident 5] was placed on empiric [initial] antibiotics with vancomycin and zosyn [antibiotic medications] due to profound shock with unclear etiology [cause]. On the morning of 12/04/2025, [Resident 5] became hypoxic [low oxygen level] and norepinephrine requirements increased. [Resident 5] was emergently intubated [tube inserted to maintain airway and support respiration through mechanical ventilation] and started on vasopressin [medication utilized to maintain therapeutic blood pressure] as well." The summary included, "[Resident 5's] BP [blood pressure] improved throughout the day and pressors [blood pressure medications] were weaned off and [s/he] was extubated [tube removed from airway] that afternoon. [Resident 5] had an NGT [nasogastric tube used for feeding, hydration, medication delivery, etc] placed due to ongoing concerns for aspiration with waxing and waning mental status c/w [consistent with] delirium [serious change in mental ability]. [Resident 5] transferred out of ICU on 12/06/2025." Resident 5 discharged from the hospital and returned to the facility on 12/15/2025. On 01/15/2026 at approximately 1:00 P.M.,	N 352		

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N 352	Continued From page 12 Surveyor reviewed Caregiver E's personnel record and documentation of two separate medication refresher trainings conducted on 12/08/2025 and 12/15/2025 provided to Surveyor by Administrator C. Caregiver E's employment dates at the facility were 09/10/2025 through 01/06/2026. Based on review of the two separate medication refresher training documentation, Caregiver E completed the training on 12/08/2025, as well as several other caregivers responsible for administering resident medications. Administrator C told Surveyor Caregiver E was immediately removed from administering resident medications following Resident 5's medication error on 12/02/2025 and the 2 medication refresher trainings were set-up and provided in response to the medication error.	N 352		
{N 355}	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure each resident had the right to self-determination when deciding when to enter and/or exit their home. This is a repeat from pervious statement of deficiency (SOD) 7IIZ11 dated 08/26/2025.	{N 355}		

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{N 355}	Continued From page 13 FINDINGS INCLUDE: On 01/15/2026, Surveyors arrived at the facility for a verification visit. INTERVIEWS & OBSERVATIONS: On 01/15/2026 at 9:00 AM, Surveyor entered the facility and observed a sign on the front desk which stated the following, "July 10,2025 ...Dear residents: The building is licensed as a CBRF on all four floors. With that, comes the requirement to have delayed egress doors on all four floors. Effective 6:30 am on 7/11/25 all four floors will require assistance from a caregiver to enter and exit the floors. There is a doorbell on each side of the door for you to press when you are at the door. Once the doorbell is pressed you will need to wait for a caregiver to come and open the door for you ... [Name of Facility] management team (Picture 1)." On 01/15/2026 at 9:15 AM, Surveyor asked Administrator C about the delayed egress system on unit doors. Administrator C stated that a 15-second delayed egress was placed on all unit exits. Administrator C stated staff had electronic fab keys which disarmed the 15-second lock and alarm on the doors. Administrator C stated none of the residents had been provided electronic fab keys to disarm the 15-second lock and alarm on egressed doors. Administrator C acknowledged residents who were their own decision maker had to ask staff to exit and enter the egressed doors. On 01/15/2026 at 10:07 AM, Surveyor went up to the 3rd floor. Upon exiting the elevator Surveyor turned to the unit entrance door and read signage	{N 355}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019869	A. BUILDING: _____ B. WING _____	R-C 01/15/2026

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{N 355}	Continued From page 14 indicating the door had a 15-second delayed egress system and instructed Surveyor to press the red or black buttons to summon staff for entrance onto the unit (Picture 2). Surveyor pressed the red button and Caregiver I opened the door in less than 30 seconds. Surveyor asked Caregiver I about the unit door. Caregiver I confirmed the unit door had a 15-second locked/alarmed delayed egress. Caregiver I stated when residents want to exit the unit, residents press the red button next to the door and it notifies the staff computer that a resident is waiting by the door. If caregivers are not monitoring the staff computer, residents can then press the black doorbell which loudly chimes for caregivers to respond to the door. Caregiver I explained that staff cannot unlock/disarm the door remotely. Caregiver I stated that if caregivers are busy with other residents, the resident trying to exit the unit must wait for that caregiver to finish their current duty, meet them at the unit door, and then the caregiver can use their fab-electronic key to unlock/disarm the door. On 01/15/2026 at 10:00 AM, Surveyor interviewed Resident 6 in their room. Resident 6 stated s/he was his/her own decision maker, and s/he still had to ask staff permission to get to the elevator. Resident 6 stated the bistro and patio were on the first floor and s/he didn't think it was right s/he had to waste energy waiting for staff to let s/he get to the elevator. Resident 6 reported s/he and other residents had complained to staff about being locked on the units, and they are told that its was "corporate's decision." Resident 6 reported an incident where his/her family member came to visit and when s/he asked for the door to be unlocked, the staff member by the unit computer just told	{N 355}		

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{N 355}	Continued From page 15 him/her, "no". Resident 6 stated s/he had to call his/her family member who was waiting on the first floor to come up to the unit. Resident 6 stated this staff member wasn't a regular staff and s/he hadn't seen him/her since that incident. Resident 6 stated s/he has been locked on the unit like this since his/her admission. Resident 6 stated s/he has waited up to 5 minutes for staff to unlock the unit door for him/her to exit, and that it can be exhausting to wait that long just to gain access to the elevator. Resident 6 mentioned s/he had recently reviewed the facilities resident rule book, and it stated the residents have the right to leave their apartment when they choose. Resident 6 denied being offered a fab-electronic key so s/he could freely exit/enter the unit. On 01/15/2026 at 10:45 AM, Surveyor went to exit the 3rd floor to gain access to the elevator. Surveyor reviewed signage on the door indicating the 15-second delayed locked/alarmed egress system. Surveyor reviewed signage instructing Surveyor to press the red or black button next to the door to summon staff. Surveyor pressed the red button and Caregiver I in less than 30-seconds arrived, swiped his/her fab-electronic key to unlock the door for Surveyor to exit the unit. On 01/15/2026 at 11:40 AM, Surveyor went to the 4th floor. Upon exiting the elevator Surveyor turned to the unit entrance door and read signage indicating the door had a 15-second delayed egress system and instructed Surveyor to press the red or black buttons to summon staff for entrance onto the unit. At 11:40 AM, Surveyor pressed the red button. By 11:43 AM, staff hadn't responded to the red button and Surveyor then pressed the black button. Surveyor could hear the	{N 355}		

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{N 355}	Continued From page 16	{N 355}		

black button chime through the unit's entrance door. In less than 15 seconds from the audible chime Caregiver J opened the unit door for Surveyor.

On 01/15/2026 at 12:00 PM, Surveyor interviewed Resident 1 in his/her room. Resident 1 indicated s/he was his/her own decision maker. Resident 1 reported s/he hadn't been given a fab-electronic key to exit and enter the unit when s/he chooses. Resident 1 reported that all residents had to press button near the door to get staff to open the door for them. Resident 1 reported that since Administrator C had started staff had greatly improved their responsiveness to residents requesting the unit door be unlocked. Resident 1 did say that s/he didn't feel like it was right for residents to be locked on the units without access to their own keys. Resident 1 stated there was an instance where s/he missed an UBER because staff weren't available to unlock/disarm the unit door in time for them to leave.

RECORD REVIEW:

On 01/15/2026, Surveyor reviewed the facilities resident roster. Facility had a census of 58 residents.

On 01/15/2025, Surveyor reviewed a list of all residents who had an activated health care power of attorney. Facility had a total of 22 resident with an activated health care power of attorney.

EXAMPLE 1: Resident 1

On 01/15/2026, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the

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{N 355}	Continued From page 17 facility on 12/05/2022. On 01/15/2026, Surveyor reviewed Resident 1's individualized service plan (ISP) signed by Resident 1 on 12/31/2024. The ISP documented Resident 1 was his/her own decision maker. The ISP documented Resident 1 as "INDEPENDENT" for the following ADLs (activities of daily living): bathing, dressing, eating, grooming, ambulation, oral care, toileting, financial management, laundry, shopping, transportation, and medication management. EXAMPLE 2: Resident On 01/15/2026, Surveyor reviewed Resident 6's facility record. Resident 6 was admitted to the facility on 12/11/2025 and that s/he was his/her own decision maker. On 01/15/2026, Surveyor reviewed Resident 6's ISP signed on 12/15/2025. The ISP documented Resident 6 was "INDEPENDENT" for the following ADLs: eating, nail care, ambulation, transferring, positioning, oral care, finance management, shopping, and transportation. EXIT INTERVIEW: On 01/15/2026 at 3:20 PM, Surveyor discussed concerns with Administrator C. Administrator C acknowledged residents who were legally their own decision maker were forced to ask staff to disarm the 15-second egress lock/alarm to exit and/or enter the floor they lived on. Administrator C stated none of the residents had a fab-key to enter-exit units in the facility.	{N 355}		