STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 07/09/2025, with information gathered through 07/14/2025, Surveyors conducted a verification visit and 3 complaint investigations at Ashwabay House. Four (4) deficiencies were identified. Three (3) of 3 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on interview and record review, the provider did not report to the department within 3 working days after law enforcement personnel were called to the facility on 04/05/2025 when the building was without a caregiver. Findings include: On 04/07/2025, Regional Director L received an email from Adult Protection K making him/her	N 164		

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
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 164	Continued From page 1	N 164		

aware that it was reported to adult protective services that on the morning of Saturday, 04/05/2025, it was discovered that overnight caregiver was not on the premises and appeared to have abandoned the residents in the home.

On 04/10/2025 the department received a complaint alleging that law enforcement responded to the facility after it had been left without a caregiver.

On 04/20/2025, Surveyor reviewed a police report that documented that on 04/05/2025, when Caregiver H arrived to work for his/her 7:00 a.m. shift, s/he discovered that Caregiver G, who was working the night before, was not on the premises and appeared to have abandoned the 7 residents in the home. Caregiver G's spouse arrived to the facility and asked if Caregiver G had been there all night. Caregiver H then called the police who arrived on scene. Upon arrival, it was reported that while no residents appeared to be injured, 2 residents were found to be wheelchair bound and 4 were reported to have soaked incontinence garments. Caregiver H reported to have taken Caregiver G off the schedule and that s/he would be making a report to DQA and the caregiver registry.

On 07/08/2025, Surveyor looked at the facilities electronic file and did not see that the provider had reported to the department within 3 working days after law enforcement personnel were called to the facility on 04/05/2025.

On 07/09/2025, Surveyors conducted a verification visit and complaint investigation. The facility has a class CNA (non-ambulatory) probationary license as a community based residential facility (CBRF) able to serve up to 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 164	Continued From page 2	N 164		

residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, emotionally disturbed/mental illness, traumatic brain injury, and advanced age.

At approximately 9:50 a.m., Surveyor asked Administrator F if s/he was aware if the incident on 04/05/2025 was reported to the department and documentation of that. Administrator F stated that was before s/he had started so s/he will have to provide Surveyor with that information later. Surveyor told Administrator F that s/he would accept additional information until noon on 07/10/2025.

On 07/10/2025 at 12:05 p.m., Administrator F emailed Surveyor an incident report dated 07/05/2025 that detailed the incident of job abandonment on 04/07/2025 (04/05/2025 according to the police report).

At 12:56 p.m., Surveyor responded to Administrator F, Consultant I and Licensee J, "As we discussed onsite yesterday, I did not see the facility submitted a self-report for the incident on 04/07/2025. Please send documentation that it was reported to the department as I do not see it in the facility's efile."

At 1:23 p.m., Consultant I stated, "[Previous administrator] was also the one responsible for submitting the state report for the 4/7 incident. I am attempting to get a copy of the self-report from [him/her] but haven't received it yet. [Licensee J] had confirmation from [him/her] that it was submitted."

On 07/14/2025 at 2:25 p.m., Administrator F confirmed that no documentation was found to confirm the provider notified the department when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 164	Continued From page 3 law enforcement was called to the facility on 04/05/2025. CROSS REFERENCE 83.14(2)(a) Licensee Ensures Facility Complies with Laws 83.36(1)(b) Qualified Staff In Charge, On Duty and Awake 83.36(2) Maintain Current Written Staffing Schedule	N 164		
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 CBRF and its operation comply with all laws governing the CBRF. Findings include: On 07/09/2025, Surveyors conducted a verification visit and complaint investigation. The facility has a class CNA (non-ambulatory) probationary license, effective 08/01/2024, as a community based residential facility (CBRF) able to serve up to 8 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, emotionally disturbed/mental illness, traumatic brain injury, and advanced age. Surveyors have conducted the following surveys since the change of ownership on 08/01/2024:	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 196	Continued From page 4 Statement of deficiency (SOD) TYM311, dated 09/16/2024 Complaint investigation resulting in no deficiencies. SOD ULKH11, dated 02/19/2025 Complaint investigation and standard survey resulting in the following deficiencies: -83.47(2)(e) Post House Rules, Resident Rights, Grievances -83.13(3)(b) Post Long Term Care Ombudsman Program -83.13(3)(c) Other Evacuation Drills SOD 7K3L11, dated 03/20/2025 Complaint investigation resulting in the following deficiencies: -83.17(1) Licensee Conduct Caregiver Background Check -83.21(1)-(3) All Employee Training -83.22(1)-(4) Task Specific Training -83.28(3) Provide Admission Agreement As Required -83.32(3)(h) Rights of Residents: Receive Medication -83.37(2)(d) Documentation of Medication Administration The SOD resulted in a Notice and Order Letter with order to Comply With Requirements as well as the following SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Ashwabay House: Probationary License	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 196	Continued From page 5 1 . Based on the results of the Department's investigation, and pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., the licensee will correct all violations identified in Statement of Deficiency 7K3L11 and will achieve substantial compliance with all laws and administrative rules governing the facility and its operation prior to expiration of the facility's Probationary License. IF the licensee has not achieved substantial compliance with all laws and administrative rules governing the facility and its operation AND IF the violations identified in Statement of Deficiency 7K3L11 remain substantially uncorrected, the PROBATIONARY LICENSE for Ashwabay House may be INVALID and the Department may NOT ISSUE A REGULAR LICENSE for Ashwabay House, 7310 Ashwabay Ln., Madison, WI. This NOTICE is provided in accordance with: - Wis. Stat. § 50.03(4m)(b), whereby, if the applicant for licensure as a community-based residential facility has not been previously licensed under this subchapter or if the community-based residential facility is not in operation at the time application is made, the department shall issue a probationary license. Prior to the expiration of a probationary license, the department shall evaluate the community-based residential facility. In evaluating the community-based residential facility, the department may conduct an inspection of the community-based residential facility. If, after the department evaluates the community-based residential facility, the department finds that the community-based residential facility meets the applicable requirements for licensure, the department shall issue a regular license under sub. (4)(a)1.b. If the department finds that the community-based residential facility does not	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 196	Continued From page 6 meet the requirements for licensure, the department may not issue a regular license under sub. (4)(a)1.b. - Wis. Admin. Code § DHS 83.08(2), whereby the Department shall deny a probationary license or regular license to any applicant who does not substantially comply with any provision of Wis. Admin. Code ch. DHS 83 or Wis. Stat. ch. 50. Survey 7K3L12, dated 07/14/2025 Verification visit and 3 complaint investigations resulting in the following deficiencies: -83.12(4)(b) Reporting When Law Enforcement Is Called -83.14(2)(a) Licensee Ensures Facility Complies with Laws -83.36(1)(b) Qualified Staff In Charge, On Duty and Awake -83.36(2) Maintain Current Written Staffing Schedule On 07/10/2025, at 12:56 p.m., Surveyor emailed Consultant I, Administrator F, and Licensee J noting that the incident reports submitted by the provider when staff left the building unattended on 04/05/2025 and 07/05/2025 contained conflicting information from other documentation submitted by the facility. Surveyor reviewed the documented timeline. At 1:23 p.m., Consultant I responded, "I apologize. I reformatted the top portion of the report for consistency between the two reports and the dates copied over. The original report was done by an outside consultant not associated with [current consulting firm]. [His/her] name was [Consultant O]. [Current consulting firm] didn't have oversight of the Madison buildings January	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 196	Continued From page 7	N 196		

through May. [His/her] formatting was poor and not on the approved Madison 3 Opco form, so I took [his/her] information and put it onto the correct form prior to sending to [Administrator F]. I have corrected the top portion and attached them here. [previous Consultant O] was also the one responsible for submitting the state report for the 4/7 incident. I am attempting to get a copy of the self-report from [him/her] but haven't received it yet. [Licensee J] had confirmation from [him/her] that it was submitted."

At 2:44 p.m., Consultant I stated, "We've been involved with the owners consistently since last August. I meant specifically the two Madison locations, not Madison 3 Opco as an organization. [Consultant B] was overseeing [another facility of the licensee's] (in Deforest) for March and April. With the changes in leadership ([Manager A] from January-mid March and [Consultant O]/[Caregiver H] from mid-March through mid-May) we did help fill in gaps at Ashwabay and [other Licensee J facility] but never provided consistent oversight during those months. 3/18 was a few days after [Manager A] was let go, and [Consultant B] had just stepped into the Deforest locations. You worked with [Consultant B] on 4/24 in Madison because [Consultant O] was 'unavailable'."

On 07/11/2025, at 11:10 a.m., Surveyor emailed Consultant I, Administrator F, and Licensee J stating, that in reviewing documentation for Ashwabay House, there was documentation concerns related to inconsistencies in staff documenting in the resident MARs who were not in work status at the time of documentation, incident reports, and staff schedules. Surveyor addressed that this was a concern for the accuracy of what was being documented in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 196	Continued From page 8 resident's records vs what cares/medications are being provided to them. Surveyor stated it was difficult to determine what occurred when the records and interviews did not align and that the information requested was not being provided by the provider in a timely matter. At 11:56 a.m., Consultant I responded, "Thank you for working with us to gather this information. As you are aware, there have been several leadership transitions over the past seven months, which have naturally led to some challenges along the way. We understand that this may have resulted in inconsistencies or perceived inaccuracies in certain documentation." Since being issued a probationary license on 08/01/2024, the facility has had 4 surveys, 6 complaints, 13 citations and 2 documented incidents where staff left the facility and the residents unattended for an extended period. The licensee has not ensured the CBRF, and its operation comply with all laws governing this CBRF. On 07/14/2025 at 4:13 p.m., Surveyor reviewed the above concerns regarding non-compliance with Licensee J. Licensee J stated s/he thought s/he previously had people in place that were completing required tasks and has seen improvements with Administrator F.	N 196		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 397	Continued From page 9 safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least one qualified resident care staff was present in the CBRF when one or more residents were present on 04/05/2025 and 07/05/2025, when the facility was left without staff. Findings include: On 04/07/2025, Regional Director L received an email from Adult Protection K making him/her aware that it was reported to adult protective services that on the morning of Saturday, 04/05/2025, it was discovered that overnight caregiver was not on the premises and appeared to have abandoned the residents in the home. On 04/20/2025, Surveyor reviewed a police report that documented that on 04/05/2025, when	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 397	Continued From page 10	N 397		

Caregiver H arrived to work for his/her 7:00 a.m. shift, s/he discovered that Caregiver G, who was working the night before, was not on the premises and appeared to have abandoned the 7 residents in the home. Caregiver G's spouse arrived at the facility and asked if Caregiver G had been there all night. Caregiver H then called the police who arrived on scene. Upon arrival, it was reported that while no residents appeared to be injured, 2 residents were found to be wheelchair bound and 4 were reported to have soaked incontinence garments. Caregiver H reported to have taken Caregiver G off the schedule and that s/he would be making a report to DQA and the caregiver registry.

On 07/06/2025, the department received a self-report documenting that on 07/05/2025, Caregiver M left his/her shift and building without notifying anyone. The building was unattended for approximately 1.5 hours before another staff arrived.

On 07/09/2025, Surveyors conducted a verification visit and complaint investigation. The facility has a probationary class CNA (non-ambulatory) license as a community based residential facility (CBRF) able to serve up to 8 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, emotionally disturbed/mental illness, traumatic brain injury, and advanced age.

At approximately 9:50 a.m., Surveyor asked Administrator F for staff schedules, incident reports regarding the building being left unattended, and follow-up and any self-report documentation for 04/05/2025 and 07/05/2025. Administrator F stated that s/he was aware of both incidents of the building being left without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 397	Continued From page 11	N 397		

staff, but the printer was not working and s/he did not have access to staff schedules, so s/he will have to provide Surveyor with that information later. Surveyor told Administrator F that s/he would accept additional information until noon on 07/10/2025.

On 07/10/2025 at 12:05 p.m., Administrator F emailed Surveyor incident reports that documented:
1 of 2
"Madison 3 Opco, LLC Incident Report
Facility Name: Ashwabay House
Date of Incident: July 5, 2025
Time of Incident: Approximately 7:45 AM - 10:30 AM
Date Report Completed: 7/8/2025
Prepared By: [Administrator F), Administrator

Description of Incident:
On the morning of April 7, 2025, at 7:00 AM, day shift staff arrived to begin their scheduled shift. Upon arrival, staff were unable to gain entry into the building as no one answered the door. After repeated attempts to knock and call inside, a resident eventually came to the door and opened it, stating [s/he] had been unable to locate any staff.

Day shift staff immediately searched the building and confirmed that no staff were present on-site. The building had been left unattended for an unknown period of time between the overnight shift on April 6th and the morning of April 7th.

The overnight shift employee assigned to the building was contacted and later reported that [s/he] left due to a family emergency involving [his/her sibling] and a car accident on the Beltline. Follow-up with Madison Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 397	Continued From page 12 confirmed that no such accident occurred during the stated timeframe. Immediate Actions Taken: - Building search conducted by AM staff upon entry - confirmed no staff present. - Employee contacted and questioned regarding absence. - Verification call made to Madison PD to validate reported emergency - confirmed no record of the claimed accident. - Employee was immediately terminated for job abandonment and falsifying information. - All residents were interviewed and assessed following the discovery. - No negative outcomes or injuries were noted among residents. - Facility Administrator and DHS were notified per regulatory guidelines. Preventive Measures: - Staff re-training scheduled on emergency call-out procedures and reporting protocols and requirement of the building be staffed 24/7. Staff re-trained on neglect and importance of not leaving residents unattended. - Audit conducted of overnight staffing schedules and call systems. - Policy reviewed and reinforced regarding no staff abandonment and falsification of information. - Increased monitoring of overnight shifts for 30 days following the incident." 2 of 2 "Madison 3 Opco, LLC Incident Report Facility Name: Ashwabay House Date of Incident: July 5, 2025 Time of Incident: Approximately 7:45 AM - 10:30 AM Date Report Completed: 7/8/2025	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 397	Continued From page 13 Prepared By: [Administrator F], Administrator Description of Incident: On the morning of July 5, 2025, at approximately 9:00 AM, [Administrator F] was contacted by Interim Home Health. A registered nurse had arrived at Ashwabay House to provide scheduled wound care services for a resident and reported that no facility staff were present on-site. [Administrator F] immediately attempted to contact the House Manager, [Caregiver C], who arrived at the facility at approximately 10:30 AM to assess the situation. Internal investigation revealed that [Caregiver M], Resident Assistant (RA), was scheduled to work the overnight shift from 11:00 PM on July 4, 2025, to 7:00 AM on July 5, 2025. [Caregiver M] clocked out at 7:45 AM without being relieved by an incoming staff member. No staff were present in the facility between the time of [his/her] departure and [Caregiver C's] arrival. [Caregiver M] later reported that [s/he] had a family emergency involving [his/her child's] asthma and needed to take [him/her] to the emergency room. [S/he] stated [s/he] attempted to notify both [Administrator F] and [Caregiver C] by phone but was unable to provide phone records or screenshots to verify these attempts. Both [Administrator F] and [Caregiver C] confirmed they did not receive any calls. [Caregiver M] did submit a hospital letter indicating that [his/her child] was seen by medical staff on the date in question. Immediate Actions Taken: " Residents were assessed upon [Caregiver C's] arrival and no injuries or concerns were identified. " [Caregiver M's] employment was immediately terminated due to abandonment and neglectful	N 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 397	Continued From page 14	N 397		

conduct.
" A report was submitted to the Wisconsin Caregiver Misconduct Registry as required under DHS 13.
" The incident was self-reported to the Wisconsin Department of Health Services per DHS 83 requirements.

Preventive Measures:
All staff will be retrained on the following:
" Resident neglect and abandonment definitions under DHS 83 and DHS 13.
" The critical requirement for continuous wake staff presence in the facility at all times.
" The proper call-in and escalation procedures during emergencies or unexpected absences.
" The consequences of leaving a building unattended, including potential termination and regulatory reporting."

On 07/10/2025, at 12:56 p.m., Surveyor emailed Consultant I, Administrator F, and Licensee J noting that the incident reports had conflicting information from other documentation and questioned the documented timeline.

At 1:23 p.m., Consultant I responded, "I apologize. I reformatted the top portion of the report for consistency between the two reports and the dates copied over. The original report was done by an outside consultant not associated with [consulting firm]. [His/her] name was [Consultant O]. [Current consulting firm] didn't have oversight of the Madison buildings January through May. [His/her] formatting was poor and not on the approved Madison 3 Opco form so I took [his/her] information and put it onto the correct form prior to sending to [Administrator F]. I have corrected the top portion and attached them here."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 397	Continued From page 15 The CBRF did not ensure that at least one qualified resident care staff was present in the CBRF on 04/05/2025 for an unknown amount of time and on 07/05/2025 for approximately 1.5 hours when 7 residents were present in the CBRF. CROSS REFERENCE 83.12(4)(b) Reporting When Law Enforcement Is Called 83.14(2)(a) Licensee Ensures Facility Complies with Laws 83.36(2) Maintain Current Written Staffing Schedule	N 397		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a current written schedule for staffing the CBRF including each employee's full name, job assignment and time worked. Findings include: On 07/09/2025, Surveyors conducted a verification visit and complaint investigation. At approximately 9:50 a.m., Surveyor asked Administrator F for staff schedules for April, when	N 399		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 399	Continued From page 16	N 399		

the building was left without staff, May for a complaint investigation, and July 2025. Administrator F stated s/he did not have access to staff schedules, so s/he would have to provide Surveyor with that information later. Surveyor told Administrator F that s/he would accept additional information until noon on 07/10/2025.

On 07/10/2025 at 3:45 p.m., Administrator F emailed Surveyor stating, "we are waiting to receive the hours worked report from Heartland. Hopefully we'll have both by tomorrow."

At 4:47 p.m., Consultant I emailed Surveyor an attachment of Caregiver N's total hours worked per week from 05/18/2025 to 06/28/2025.

On 07/11/2025 at 9:23 a.m., Consultant I emailed Surveyor an attachment of an employee labor report that documented how many total hours each employee worked for the month of April, May, and July.

At 10:19 a.m., Surveyor emailed Consultant I, Administrator F, and Licensee J stating, "What I had asked for on Wednesday at both houses was a staff schedule - not just when staff were scheduled, but hours worked (so to include call offs and picked up shifts). This appears to be total hours worked for the month and does not meet that requirement."

At 2:10 p.m., Consultant I attached a staff schedule from 03/30/2025 to 05/31/2025 stating, "I have attached the schedules that I just received from the previously involved consultant. I cannot confirm if they were updated to reflect call ins/staffing changes."

On 07/14/2025 at 2:35 p.m., Surveyor reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020254	A. BUILDING: _____ B. WING _____	R-C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHWABAY HOUSE	7310 ASHWABAY LANE MADISON, WI 53719

(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 399	Continued From page 17 with Administrator F that s/he has not received documentation of July 2025 staff schedule. Administrator F confirmed there was no caregiver schedule and what the provider had was not correct in documenting hours worked, and s/he knows that. CROSS REFERENCE 83.14(2)(a) Licensee Ensures Facility Complies with Laws	N 399		