STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

(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 01/29/2025-01/30/2025, Surveyor conducted 2 complaint investigations at Sage Meadows of Middleton. Two deficiencies were identified. One complaint was substantiated. One complaint was unsubstantiated. Census: 34	N 000		
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 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 1 of 1 resident record reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1 did not receive his/her Metamucil, Polyethylene glycol, and Lidocaine cream as prescribed. This is a repeat violation. See Statement of Deficiency (SOD) GLXI12, dated 02/09/2024. Findings include:	N 352		

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
	0019366	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

(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 352	Continued From page 1 On 11/15/2024, the Department received a complaint alleging the provider is not administering medications as prescribed. On 01/29/2025 at 11:29 AM, Surveyor observed the provider's medication cart with Caregiver C and identified the following: -Resident 1's polyethylene glycol container noted a manufacturer's label including the container originally held 30 once-daily doses of 17 grams. The container included a pharmacy label including Resident 1's practitioner's prescription for polyethylene glycol including, "Dissolve 17 grams in 8oz of liquid and drink by mouth daily for constipation." The pharmacy label included a delivery date to the facility of 07/05/2024. Surveyor observed approximately 1/2 of the medication remained within the container. Caregiver C verbally confirmed same amount remained and no other containers of the medication were observed in the cart. -Resident 1's Metamucil container noted a manufacturer's label including the container originally held 114 teaspoons. The container included a pharmacy label including Resident 1's practitioner's prescription for Metamucil including "Mix 3.4 GM (about 1 rounded teaspoonful) in 8oz water/juice & drink by mouth twice a day." The pharmacy label included a delivery date to the facility of 09/10/2024. Surveyor observed approximately ½ of the medication remained within the container. Caregiver C verbally confirmed same amount remained and no other containers of the medication were observed in the cart. -Resident 1's Lidocaine tube noted a manufacturer's label including the container	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

(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 352	Continued From page 2 originally held 30 grams. The container included a pharmacy label including Resident 1's practitioner's prescription for Lidocaine including "apply topically to affected area on back & shoulders twice a day." The pharmacy label included a delivery date to the facility on 07/23/2024. Surveyor observed approximately ½ of the medication remained within the container. Caregiver C verbally confirmed same amount remained and no other containers of the medication were observed in the cart. On 01/29/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/11/2023 with a diagnosis of dementia. Resident 1's individual service plan (ISP) dated 03/28/2024 indicated care staff administer Resident 1's medications. Surveyor reviewed Resident 1's July 2024-January 2025 medication administration record (MARs) and identified the following: Resident 1 was administered 208 doses of polyethylene glycol between 07/06/2024-01/29/2025 from a 30 dose container, based on Resident 1's practitioner's order, with ½ of the medication remaining in the container. Resident 1 was administered 268 doses of Metamucil between 09/11/2024-1/29/2025 from a 113 teaspoon container, based on Resident 1's practitioner's order, with ½ of the medication remaining in the container. Resident 1 was administered 356 doses of Lidocaine between 07/24/2024-01/29/2025 from a 30 gram container, based on Resident 1's practitioner's order with ½ of the medication remaining in the container.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

(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 352	Continued From page 3 Resident 1's progress notes documented: 12/10/2024 written by Hospice Nurse D "RN performed comprehensive assessment...[S/he] does complain of some discomfort to [his/her] R shoulder and neck but denies need for further pain meds. [S/he] stated [s/he] has lived with this pain for years and it comes and goes ....No supply needs or med needs." 11/19/2024 written by Hospice Nurse D "RN performed comprehensive assessment..[S/he] denies any pain when writer asked but [s/he] stated [his/her] R should does "act up" at times." 11/05/24 written by Hospice Nurse D "RN performed comprehensive assessment ... [Resident 1] has chronic R shoulder pain which [s/he] feels it is tolerable at time of my visit ....No meds needs and writer ordered more pullups to be delivered." 10/29/2024 written by Hospice Nurse D "RN performed comprehensive assessment ...Staff deny any changes, stated that [s/he] continues to want to sleep a lot but [s/he] has good days also. [S/he] has no med needs or supply needs at this time." 10/01/2024 written by Hospice Nurse D "RN performed comprehensive assessment ....[S/he] stated the only pain [s/he] has is to [his/her] right shoulder which has hurt [him/her] for a long time. Stated [s/he] got surgery on it and it's never been the same since. Stated it's not "bad pain" right now but sometimes it "kills [him/her]."..No supply needs at this time." 09/09/2024 written by care staff "resident was lil mouthy this morning because [s/he] was in pain [s/he] was take to the bathroom 3 times during the night now is dressed and ready for the day." Resident 1's hospice notes dated 11/22/2024 documented:	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

(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 352	Continued From page 4 " ...We talked about [his/her] pain and [s/he] stated [s/he] only has pain in [his/her] R arm, [s/he] said [his/her] pain was tolerable. We discussed [his/her] pain regimen and [s/he] is currently taking Apap 100 mg TID and lidocaine is ordered BID, the tube in the med cart was filled 7/25/2024 so staff are not giving it per the order. Writer and [Legal Representative E] brought this to the [Administrator A's] attention for [him/her] to follow up on it." On 01/29/2025 at 1:56 PM, Surveyor interviewed Administrator A regarding Resident 1's Polyethylene glycol, Metamucil, and Lidocaine cream medications. Administrator A reported after speaking to the pharmacy, the above delivery dates (Polyethylene glycol: 07/05/2024), (Metamucil: 09/10/2024), and (Lidocaine cream: 07/23/2024) were all correct and no other containers of the medications were delivered to the facility. Administrator A acknowledged if the above medications were administered as prescribed the containers would have been emptied much earlier and requests for refills would have been sent to the pharmacy. Surveyor expressed concern with the amount still left in each container and staff continuing to document as administered. Administrator A reported s/he was assuming staff were documenting as given, without administering the medication, but could not be certain without investigating further.	N 352		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

(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 387	Continued From page 5 legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 individual service plans (ISP) reviewed were developed with involvement from the resident and resident's legal representative. Resident 2's ISPs were not developed or signed by his/her legal representative. Findings include: On 01/29/2025, Surveyor reviewed resident records and identified the following: Resident 2 was admitted on 08/19/2024. Resident 2 had an activated healthcare power of attorney. Resident 2's most recent ISP with an unknown date did not contain a signature from his/her legal representative. On 01/29/2025 at 2:30 PM, Surveyor interviewed Administrator A and Operations Manager B. Administrator A acknowledged Resident 2's ISP was not signed by his/her legal representative.	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019366	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

(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 387	Continued From page 6 Administrator A requested additional time to look through Nurse F's email to see if attempts to capture signatures were sent to Resident 2's legal representative. Surveyor noted documentation would need to be submitted no later than 5:00 PM on 01/30/2025. On 01/30/2025 at 3:34 PM, Surveyor received an email from Administrator A reporting after looking through Nurse F's emails, they found an email, Nurse F sent to Resident 2's legal representative but not the actual care plan. Administrator A noted Nurse F is out on medical leave and s/he did not have a way to contact him/her at this time.	N 387		