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 _____	R-C 08/22/2025

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 08/20/2025 to 08/22/2025, Surveyors conducted a complaint investigation and 2 verification visits at Sage Meadows of Middleton. Five deficiencies were identified. Two of 5 deficiencies were repeat violations. See Statement of Deficiency (SOD) GLXI12, dated 02/09/2024, SOD GLXI13, dated 05/02/2024, and SOD 7V0L12, dated 08/20/2025. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. The complaint was substantiated. Census: 38	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or	N 158		

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 _____	R-C 08/22/2025

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 158	Continued From page 1	N 158		

misappropriation of property. The CBRF shall maintain documentation of any investigation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not take immediate steps to ensure the safety of all residents when the provider received allegations on 07/19/2025 that Caregiver M was mistreating residents. The provider did not start an investigation until the day of survey (08/20/2025).

Findings include:

The provider is licensed to care for up to 44 residents in the client groups of advanced age, irreversible dementia/Alzheimer's disease, physically disabled, and developmentally disabled.

On 07/22/2025, the Department received a complaint alleging concerns with a resident's fractured wrist.

On 08/20/2025, Surveyor reviewed Resident 1's record and identified the following:

Surveyor reviewed the provider's investigation dated 07/18/2025 to 07/25/2025 into bruising on Resident 1's wrists:
-"On Friday July 18th at approximately 4:15pm, [Caregiver N] called [Staff J] to notify [him/her], [s/he] noticed a bruise on both of [Resident 1's] wrists. [Staff J] then called [Hospice Agency R] to notify them as [s/he] started the investigation. Hospice arrived at the community to assess [Resident 1] and called [Legal Representative E] to notify [him/her] of the bruises. At this time point in our investigation, we had no risks of findings

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 _____	R-C 08/22/2025

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 158	Continued From page 2	N 158		

identified that there are any safety concerns and were not consistent with abuse. We believe the bruises on [his/her] forearms are consistent with transfers and staff grabbing [his/her] arms to assist with transferring as [Resident 1] has been requiring more assistance with transferring recently. We can't rule out self injury as well as [Resident 1] ambulates around the community on [his/her] own. On Saturday July 19th at approximately 9am, [Legal Representative E] called Middleton Police Department to report the bruises. [Assistant Director F] who was the manager on duty at [provider's name] on Saturday spoke with [Legal Representative E] at the community after the police left. Below are [Assistant Director F's] notes from the conversation with [Legal Representative E] on Saturday: 'While talking with Residents POA, explained to me what occurred Friday night when [s/he] received a call from hospice. POA stated when [s/he arrived at the facility, Resident was sitting in the dining room chair asleep, refusing to eat, POA stated [s/he] took resident back to get [him/her] cleaned up and ready for bed stated while in the process of caring for resident, [s/he] received a call from [Hospice Agency R] nurse stating they will be doing a urgent visit with resident because they received a call from [provider] stating [his/her] wrist was broken, POA stated [s/he] was stunned because [s/he] was in the room with the resident at the time of the call. POA proceeded to state that when the nurse assessed resident, [s/he] noticed the bruising may have occurred less then 24 hours and [s/he] did not think it was broken. POA stated the nurse reported [s/he's] in pain from the bruising. POA stated [s/he] thinks this is all spiraled out of control due to the communication of the staff, [s/he] explained that's why [s/he] would rather the staff contact [him/her] first before calling hospice

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 _____	R-C 08/22/2025

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 158	Continued From page 3	N 158		

also stated [s/he] understand that things this [sic] happened, [s/he's] not accusing anyone, [s/he] did not believe this was malicious POA stated [s/he] more concerned about [his/her] pain and not being able to use [his/her] hands.'

We spoke with [Hospice Agency R] and reviewed their visit notes to assist with completing our investigation. [Hospice Agency R] CNA, who was not [his/her] normal CNA as [s/he] was filling in, visited [Resident 1] Friday morning from 9:40am-10:45am and gave [him/her] a shower. The CNA did not report any findings to [provider] that day. After receiving [his/her] visit note during our investigation, it stated 'bruising/purplish marks on hand and leg' with no other specifications on which side or where on [his/her] extremities. When hospice RN arrived, [s/he] stated 'no bruising on either leg and [s/he] had a bruise on [his/her] UE/forearms and not [his/her] hand.' [Resident 1] was a heavy assist to stand, 2 assist when in bed. [Legal Representative E] mentioned moving [Resident 1] to a different room in facility so [s/he] can get wheeled into the shower which [s/he] can't in [his/her] current room to make it easier. [Resident 1] has a history of being resistive and swatting/combative when cares are being attempted and provided. [Provider] is unsure of any behaviors of concerns during [Hospice Agency R] CNA shower but the [Hospice Agency R] notes say [s/he] was calm/cooperative. [Provider] has statements that [Resident 1] was at [his/her] baseline prior to the shower and after was lethargic and not acting [him/herself]."

The investigation included the following written statements by staff:

On 07/19/2025, Caregiver O signed and dated

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 _____	R-C 08/22/2025

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 158	Continued From page 4 the following statement: "Things I was able to observe in the few last weeks when I work in M1 down. I have seen [Caregiver M] be arsive [sic] and a lil ruff [sic] with residents, as well yelling at residents ...[Resident 6] [s/he] reported over and over on how [s/he] can't talk to [Caregiver P] and [Caregiver M] because they always mean. As well [Caregiver M] has forced [Resident 7] to eat and yelling and grab [his/her] face to eat." On 08/20/2025 at 11:00 AM, Surveyor interviewed Assistant Director F regarding the written statement from Caregiver O dated 07/19/2025. Assistant Director F reported s/he worked on 07/19/2025 as the manager on duty and gathered statements from staff related to Resident 1's wrist bruising. Assistant Director F reported Caregiver O wanted to talk with him/her about what s/he had observed, but Assistant Director F noted s/he was passing medications, so s/he asked Caregiver O to fill out a written statement. Assistant Director F confirmed s/he had reviewed Caregiver O's statement and provided all statements to HR Q. Assistant Director F stated after providing statements to HR Q s/he backed off the investigation. Assistant Director F stated s/he was not aware of an investigation into Caregiver M but wanted to check with corporate. Surveyor asked what s/he did to immediately protect the residents when reviewing Caregiver O's statement. Assistant Director F noted Caregiver M was never taken off the schedule pending an investigation. Surveyor reviewed the provider's schedule for July to August 2025. Caregiver M worked the following dates after Assistant Director F received the initial allegations of caregiver misconduct on 07/19/2025:	N 158		

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 _____	R-C 08/22/2025

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 158	Continued From page 5 -07/19/2025, 7-3pm and 3-11pm -07/20/2025, 7-3pm and 3-11pm -07/21/2025, 3-11pm -07/22/2025, 3-11pm -07/23/2025, 3-11pm -07/24/2025, 3-11pm -07/26/2025, 7-3pm and 3-11pm -07/27/2025, 11-7am -07/28/2025, 3-11pm -07/29/2025, 3-11pm -07/30/2025, 3-11pm -07/31/2025, 11-7am -08/01/2025, 3-11pm -08/02/2025, 3-11pm On 08/20/2025 at 12:21 PM, Surveyor interviewed Assistant Director F and Executive Director G. Surveyor asked about the provider's investigation into allegations against Caregiver M that s/he received on 07/19/2025. Assistant Director F reported after talking to corporate, s/he did not have evidence of an investigation into Caregiver M. Assistant Director F reported Caregiver M would be put on leave and the provider was starting an investigation today. The provider failed to immediately protect all residents when Assistant Director F and the provider received written reports of allegations of Caregiver M mistreating the residents. The provider did not document the investigation and conclusion of the allegations received on 07/19/2025. Cross Reference: N0161 83.12(3)(a) Investigate Injuries Of Unknown Source	N 158		

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 _____	R-C 08/22/2025

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 161	Continued From page 6	N 161		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure injuries of an unknown sources were investigated for 1 of 1 resident reviewed who had injuries of an unknown source. Resident 1 had documentation of a bruise on his/her left arm with unknown origin that was not investigated. Findings include: On 08/20/2025, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 04/11/2023 with diagnosis of dementia. Resident 1's incident report dated 06/17/2024 documented: "Incident classification: Unknown Source. Briefly describe what occurred: Resident had a large BM and had to be assisted with a shower. When doing [his/her] shower writer and staff saw that the resident had a bruise on [his/her] left arm. Family or Representative Notified? Yes. Supervisor Notified? Yes. Did resident sustain any injuries? Yes. Notes: Bruise on left arm." On 08/20/2025 at 12:21 PM, Surveyor	N 161		

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 _____	R-C 08/22/2025

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 161	Continued From page 7 interviewed Assistant Director F. Surveyor asked if the provider investigated Resident 1's injury of unknown source from 06/17/2025. Assistant Director F stated s/he did not think so, but s/he would need to review Resident 1's record more and get back to the Surveyor. On 08/21/2025 at 1:18 PM, Surveyor sent the following email to Assistant Director F: "[Assistant Director F], yesterday I never heard back if [Resident 1's] bruising from 6/17/2025 was investigated? Can you please confirm if it was or not?" On 08/22/2025 at 3:41 AM, Assistant Director F sent the following email to the Surveyor: "Hello [Surveyor], I truly apologize for the late response, yesterday was a very busy day, We are currently following up on the bruising on 6/17/25, I will have an update for you no later than Monday. Thank you for your patience and understanding." The provider did not have evidence of investigating Resident 1's bruising from 06/17/2025 and was currently following up on the bruising after Surveyor's multiple requests. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect	N 161		
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.	N 196		

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 _____	R-C 08/22/2025

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 196	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. From 09/28/2023 to 08/21/2025, the provider did not comply with all the laws governing the CBRF as evidenced by 16 deficiencies identified and 5 complaints substantiated. The current survey included investigation of 1 complaint and 2 verification visits. As a result, 5 deficiencies were identified. The provider did not comply with the special orders outlined in a Notice and Order letter sent by the Department on 04/14/2025. Findings include: Example 1: Obtain and maintain compliance with laws governing the CBRF: On 05/24/2023, the provider was issued a probationary license. On 09/28/2023, Surveyor conducted 2 complaint investigations. As a result of the survey 3 deficiencies were identified in Statement of Deficiency (SOD) GLXI11, dated 09/28/2023. One of 2 complaints were substantiated. On 02/09/2024, Surveyor conducted a complaint investigation, probationary survey, and verification visit. As a result of the survey 3 deficiencies were identified in SOD #GLXI12. On 05/02/2024, Surveyor conducted 2 complaint investigations and a verification visit. As a result of the survey 2 deficiencies were identified in	N 196		

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 _____	R-C 08/22/2025

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 196	Continued From page 9 SOD #GLXI13. One of 2 complaints were substantiated. On 05/22/2024, Surveyor conducted a verification visit. As a result of the survey 0 deficiencies were identified. On 01/30/2025, Surveyor conducted 2 complaint investigations. As a result of the survey 2 deficiencies were identified in SOD #7V0L11. One of 2 complaints were substantiated. On 04/29/2025, Surveyor conducted a complaint investigation. As a result of the survey 1 deficiency was identified in SOD #BKUT11. The complaint was substantiated. On 08/20/2025, Surveyor conducted a complaint investigation and 2 verification visits. As a result of the survey 5 deficiencies were identified. The complaint was substantiated. Example 2: Repeat violations of laws governing the CBRF. 1) 83.32(3)(h) Rights Of Residents: Receive Medication SOD #GLXI12, dated 02/09/2024, SOD #7V0L11, dated 01/30/2025 and SOD #7V0L12, dated 08/20/2025. 2) 83.37(1)(i) Prn Psychotropic Medications SOD #GLXI11, dated 09/28/2023 and SOD #GLXI12, dated 02/09/2024. 3) 83.35(3)(d) Service Plans Updated Annually Or On Changes SOD #GLXI11, dated 09/28/2023, SOD #GLXI12 dated 02/09/2024, SOD #GLXI13, dated 05/02/2024, and SOD #7V0L12, dated	N 196		

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 _____	R-C 08/22/2025

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 196	Continued From page 10 08/20/2025. Example 3: Number of Complaints Substantiated 1) SOD #GLXI11, dated 09/28/2023, 1 complaint substantiated. 2) SOD #GLXI13, dated 05/02/2024, 1 complaint substantiated. 3) SOD #7V0L11, dated 01/30/2025, 1 complaint substantiated. 4) SOD #BKUT11, dated 04/29/2025, 1 complaint substantiated. 5) SOD #7V0L12, dated 08/20/2025, 1 complaint substantiated. Example 4: Special Orders On 08/20/2025, Surveyor reviewed Department records and identified the following: On 04/14/2025, SOD #7V0L11 and a Notice and Order letter were issued to the licensee. On 10/31/2024, Statement of Deficiency (SOD) FV3E11 and a Notice and Order letter were issued to the licensee. The Notice and Order letter included the following information under SPECIAL ORDERS: "1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall ensure each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by the practitioner. The resident has the right to refuse medication unless the medication is court ordered. WITHIN 45 DAYS of receipt of this notice, the licensee shall develop (or review) and implement a written procedure to address: Medication Management and Administration -Including how the provider will: (a) document medication orders, medication administration,	N 196		

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 _____	R-C 08/22/2025

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 196	Continued From page 11 and missed/refused doses; (b) administer medications to ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; (e) monitor for adverse side effects; (f) Page 3 of 5 Sage Meadows of Middleton April 14, 2025 obtain prescription medications and refills in a timely manner; and (g) ensure medications are securely stored. All managers and resident care staff with responsibilities for medication administration and management will receive training on the procedure required by Order #1. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. A copy of the written procedure will be made available to the department representatives upon request. 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) for Resident 1 with a copy of Statement of Deficiency 7V0L11 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request." On 08/20/2025 at 11:00 AM, Surveyor requested evidence the provider followed Order #1 and #2 from Assistant Director F.	N 196		

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 _____	R-C 08/22/2025

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 196	Continued From page 12 On 08/20/2025 at 1:55 PM, Surveyor conducted an exit conference and shared findings with Assistant Director F and Executive Director G. Surveyor noted the email evidence of Order #2 was only sent to Resident 1's case manager and did not contain evidence the SOD was sent to Legal Representative E. Both staff acknowledged an understanding of the concerns. Assistant Director F reported s/he did not have evidence Order #1 was followed. Executive Director G stated s/he was in his/her 2nd week of employment and s/he would work with Assistant Director F to get the provider back into compliance. Summary: The licensee did not ensure the facility and its operation complied with all laws governing the CBRF. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 83.12(3)(a) Investigate Injuries Of Unknown Source N0352 83.32(3)(h) Rights of Residents: Receive Medications N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes	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 prescribed by a practitioner. The resident has the right to refuse medication unless the medication	{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 _____	R-C 08/22/2025

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 13 is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure residents received his/her prescribed medications in the dosage at intervals prescribed by a practitioner. From 06/01/2025 to 08/20/2025, the Provider did not administer 191 doses of resident medication as prescribed by their practitioner. The is a repeat of statement of deficiency (SOD) GLXI12 dated 02/09/2024 and SOD 7VOL11 dated 01/30/2025. FINDINGS INCLUDE: On 08/19/2025, Surveyors arrived at facility for a verification visit. OBSERVATION: On 08/19/2025 at 9:30 AM, Surveyor observed the contents of the medication cart with Caregiver C. Caregiver C stated staff administered pills from the slots with the number matching the date (EX: pill in slot #5 was administered on 08/05/2025). Caregiver C stated the medication cart had a complete cycle fill at the end of July. Caregiver C denied issue with pharmacy dispensing resident medication to the facility medication cart. Surveyor found Resident 2's a 17.9oz bottle of Polyethylene glycol (Picture 3). The commercial label advertised, "30 Once-Daily Doses." The prescription label had Resident 2's name, an order to administer 17gm in 8oz of liquid once daily, with a refill date of 06/16/2025. Surveyor	{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 _____	R-C 08/22/2025

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 14 picked up Resident 2's bottle of Polyethylene Glycol and felt it was approximately 40% full of powder. Surveyor handed the bottle to Caregiver C s/he then shook it and agreed the bottle felt like it was approximately 40% full of powder. Caregiver C reviewed Resident 2's medication administration record (MAR) on the medication cart laptop. Caregiver C verified Resident 2's Polyethylene Glycol was scheduled to be administered once daily and had been documented as administered nearly every day from June through August. Caregiver C acknowledged Resident 4's Polyethylene Glycol hadn't been administered at the frequency documented in the MAR. Surveyor observed Resident 2's bedtime dose blister pack of Duloxetine 60mg capsules. The prescription label documented a refill date of 07/24/2025. The blister pack had capsules remaining in the #3 thru #10 slots (Picture 7). Caregiver C reviewed Resident 2's MAR and stated the order had been changed but all bedtime Duloxetine orders were consistently documented as "administered," during August 2025. Surveyor picked up Resident 3's 17.9 oz bottle of Polyethylene Glycol (Picture 2). The prescription label documented Resident 3 was to be administered 17gm once daily, with a refill date of 06/16/2025. Surveyor picked up Resident 3's bottle of Polyethylene Glycol and felt it was approximately 30% full of powder. Caregiver C reviewed Resident 3's MAR s/he verified Resident 3's Polyethylene Glycol was scheduled to be administered once daily. From June thru 08/20/2025, the Polyethylene Glycol had been documented as "administered." Caregiver C acknowledged Resident 3's Polyethylene Glycol was not administered at the frequency documented in the MAR.	{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 _____	R-C 08/22/2025

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 15 Surveyor reviewed resident blister packs and found Resident 4's blister pack of Metformin 500mg ER (extended release) Tablets (Picture 4). The prescription label had a refill date of 07/22/2025. Surveyor observed 2 tablets remained in the #6 slot. Caregiver C reviewed Resident 4's MAR and verified Resident 4's Metformin 500mg ER tablets were documented as "administered" on 08/06/2025. Surveyor observed Resident 5's blister pack of his/her evening dose of Quetiapine 25 mg tablet (Picture 5). The prescription label had a refill date of 07/22/2025. Surveyor observed a tablet in the #10 slot. Surveyor observed Resident 5's blister pack of his/her afternoon dose of Acetaminophen (APAP) 500mg tablets (Picture 6). The prescription label documented a refill date of 07/22/2025. Surveyor observed 2 tablets remained in the #19 slot. Caregiver C acknowledged the pills remaining in the 2 blister packs. RECORD REVIEW EXAMPLE 1: Resident 2 On 08/20/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 06/18/2025. Resident 2 had an activated healthcare power of attorney. Resident 2 was diagnosed with but not limited to post-traumatic stress disorder, mild cognitive impairment, essential hypertension, nonrheumatic aortic valve stenosis and diastolic heart failure. On 08/20/2025, Surveyor reviewed Resident 2's June 2025 MAR. The following was documented: 1.) Polyethylene Glycol, "Dissolve 17 Grams in	{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 _____	R-C 08/22/2025

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 16 8oz of Liquid and Drink Daily for Constipation." The scheduled dose start date was 06/18/2025. This was documented as "administered" 10 of the 12 days ordered. On 08/20/2025, Surveyor reviewed Resident 2's July 2025 MAR. The following was documented: 1.) On 07/31/2025, the following medications were documented as, "No Pass Reason: Waiting on pharmacy:" -Furosemide 40mg Tablet, "TAKE 1 TABLET BY MOUTH DAILY." -Hydroxychlor 200mg Tablet, "TAKE 1 TABLET BY MOUTH TWICE DAILY" -Mycophenolate 500mg Tablet, "TAKE 2 TABLETS (1,000mg) BY MOUTH TWICE A DAY ..." -Prednisone 5mg Tablet, "Take 1 Tablet By Mouth Daily Starting 6/28/25." 2.) Polyethylene Glycol, "Dissolve 17 Grams in 8oz of Liquid and Drink Daily for Constipation." The scheduled dose was documented as "administered" for 29 of the 31 days in July. On 08/20/2025, Surveyor reviewed Resident 2's August 2025 MAR. The following was documented: 1.) Duloxetine 60mg capsule, "TAKE 1 CAPSULE BY MOUTH TWICE A DAY." The bedtime dose of Duloxetine 60mg was documented as "administered" from 08/01/2025 to 08/19/2025. 2.) Polyethylene Glycol, "Dissolve 17 Grams in 8oz of Liquid and Drink Daily for Constipation." The scheduled dose was documented as "administered" from 08/01/2025 to 08/20/2025. 3.) From 08/01/2025 to 08/20/2025, The following medications were documented as, "No Pass	{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 _____	R-C 08/22/2025

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 17 Reason: Waiting on pharmacy:" -Furosemide 40 mg Tablet, "TAKE 1 TABLET BY MOUTH DAILY." -Hydroxychlor 200 mg Tablet, "TAKE 1 TABLET BY MOUTH TWICE DAILY" -Mycophenolate 500 mg Tablet, "TAKE 2 TABLETS (1,000mg) BY MOUTH TWICE A DAY ..." -Prednisone 5 mg Tablet, "Take 1 Tablet By Mouth Daily Starting 6/28/25." On 08/20/2025, Surveyor calculated the number of prescribed medications Resident 2 hadn't t been administered from 06/18/2025 to 08/20/2025: 1.) From 06/18/2025 to 08/20/2025, Resident 2 hadn't t been administered 29 scheduled doses of Polyethylene Glycol 17gm powder. 2.) From 08/03/2025 to 08/10/2025, Surveyor calculated Resident 2 hadn't been administered 7 scheduled doses of Duloxetine 60mg capsule. 3.) From 07/31/2025 to 08/20/2025, Surveyor calculated Resident 2 hadn't been administered 20 scheduled doses of Furosemide 40mg. 4.) From 07/31/2025 to 08/20/2025, Surveyor calculated Resident 2 hadn't been administered 39 doses of Hydroxychlor 200mg. 5.) From 07/31/2025 to 08/20/2025, Surveyor calculated Resident 2 hadn't been administered 39 doses of Mycophenolate 500mg. 6.) From 07/31/2025 to 08/20/2025, Surveyor calculated Resident 2 hadn't been administered 20 doses of Prednisone 5mg. On 08/20/2025, Surveyor reviewed Resident 2's	{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 _____	R-C 08/22/2025

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 18 observation notes: 1.) On 07/23/2025 at 4:15 PM, Director F documented a discussion s/he had with [Name of Local Hospital] to discuss having all of Resident 2's prescription medications switched over to a new pharmacy. 2.) On 08/01/2025 at 11:30 AM, Staff J documented the following, "Writer received a call from the [Name of Local Hospital] working with PCP (primary care provider). Writer needed clarification on the medications [Resident 2] was to be taking as well as where [his/her] prescriptions are being sent. RN advised that [Resident 2] was to have [his/her] medication filled through [Name of Local Pharmacy], but bulk items were to be filled through the [Name of Local Hospital]. Requested a MAR to be faxed to facility so we have an updated medication list for [Resident 2] ..." EXAMPLE 2: Resident 3 On 08/20/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 07/05/2024. Resident 3 had an activated power of attorney. On 08/20/2025, Surveyor reviewed Resident 3's June 2025 MAR. Resident 3's Polyethylene Glycol was ordered as, "Dissolve 17 Grams in 8os of Liquid and Drink by Mouth Daily," and was documented as "administered" from 06/01/2025 to 06/30/2025. On 08/20/2025, Surveyor reviewed Resident 3's July 2025 MAR. Resident 3's Polyethylene Glycol was documented as "administered" from 07/02/2025 to 07/31/2025.	{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 _____	R-C 08/22/2025

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 19 On 08/20/2025, Surveyor reviewed Resident 3's August 2025 MAR. Resident 3's Polyethylene Glycol was documented as "administered" from 08/01/2025 to 08/20/2025. On 08/20/2025, Surveyor calculated Resident 3 wasn't administered his/her Polyethylene Glycol as prescribed 34 times from 06/16/2025 to 08/20/2025. EXAMPLE 3: Resident 4 On 08/20/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 02/27/2025. Resident 4 had an activated power of attorney. On 08/20/2025, Surveyor reviewed Resident 4's August 2025 MAR. The order for Metformin ER 500 mg tablet was written as, "Take 2 Tablets (1000mg) by Mouth Twice a Day With Meals." From 08/01/2025 to 08/19/2025, evening doses of Metformin ER 500 mg were documented as "administered." EXAMPLE 4: Resident 5 Surveyor reviewed Resident 5's record. Resident 5 was admitted to the facility on 04/09/2021. Resident 5 had an activated healthcare power of attorney. On 08/20/2025, Surveyor reviewed Resident 5's August 2025 MAR. The order for Quetiapine 25 mg tablet was written as, "Take ½ Tablet (12.5mg) by Mouth Twice a Day (8am and 8pm)." From 08/01/2025 to 08/19/2025, evening doses of Quetiapine 25 mg was documented as "administered."	{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 _____	R-C 08/22/2025

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 20 INTERVIEWS: On 08/19/2025 at 12:35 PM, Surveyor spoke with Director F and Director G in front of the facility medication cart. Caregiver C provided the keys for Director F to open the medication cart. Surveyor couldn't find Resident 2's blister packs for Furosemide capsules, Hydroxychlor tablets, Mycophenolate tablets or Prednisone tablets. Director F assisted Surveyor with searching the medication cart. Director F acknowledged Resident 2's aforementioned medications weren't currently available in the facility medication cart. Director F stated at the end of July Resident 2 was supposed to switch pharmacy providers. Director F stated s/he made multiple attempts to get Resident 2's medications dispensed for the month of August, but some of the medications hadn't arrived with the new pharmacies cycle fill delivery. Director F stated Resident 2's Furosemide, Hydroxychlor, Mycophenolate and Prednisone hadn't been made available to Resident 2 during the month of August. On 08/20/2025 at 12:45 PM, Surveyor called Pharmacy Technician H with the [Name of Local Pharmacy]. Pharmacy Technician H stated Resident 2's medication orders for Furosemide 40 mg, Hydroxychlor 200 mg, Mycophenolate 500 mg and Prednisone 5 mg had remained active. Pharmacy Technician H stated s/he had access to Resident 2's record. Pharmacy Technician H stated it was documented that pharmacy required orders for refill on those medications. Pharmacy Technician H stated it was documented on 07/25/2025 the pharmacy had faxed the facility, Nurse Practitioner K's office, and Doctor L's office to request refill orders for those 4 medications before the start of the August cycle. Pharmacy Technician H stated pharmacy didn't receive	{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 _____	R-C 08/22/2025

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 21	{N 352}		

responses from the facility, Nurse Practitioner K or Doctor L.

On 08/20/2025 at 1:00 PM, Surveyor called Pharmacy Technician I with the [Name of Local Hospital]. Pharmacy Technician I stated s/he needed prescriber approval to have Furosemide 40 mg and Prednisone 5 mg tablets dispensed to the facility. Pharmacy Technician I stated s/he could get Resident 2's Hydroxychlor 200 mg and Mycophenolate 500 mg tablets dispensed to the facility at this time.

On 08/20/2025 at 2:30 PM, Surveyor discussed the above concerns with Director F and Director G. Director F stated s/he tried multiple times to contact pharmacy to have Resident 2's medication filled. Director F gave Surveyor a handwritten list and stated it documented his/her attempts to contact the pharmacy about Resident 2's missed medication (Picture 1). Director F stated the last time facility attempted to contact the pharmacy about Resident 2's missed medication was on 08/01/2025. Director F acknowledged Resident 2's medications hadn't been administered to him/her as prescribed from 08/01/2025 to 08/20/2025. Director F acknowledged from 08/02/2025 to 08/19/2025 the facility didn't attempt to communicate Resident 2's missed medications with a pharmacy and/or primary care provider. Director F didn't have an explanation as to why Resident 2's bedtime blister pack of Duloxetine 60 mg had capsules remaining in the #3 to #10 slots. Director F and Director G acknowledged Resident 2 nor Resident 3 received his/her scheduled Polyethylene Glycol as prescribed. Director F and Director G acknowledged Resident 4 didn't receive his/her Metformin ER 500 mg tablets as prescribed on 08/06/2025. Director F and Director

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 _____	R-C 08/22/2025

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 22 G acknowledged Resident 5 didn't receive his/her Quetiapine 25 mg tablet as prescribed on 08/10/2025, or his/her Acetaminophen 500 mg tablets on 08/19/2025.	{N 352}		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the individual service plan (ISP) was not updated for Resident 1 when there was a change in resident needs and abilities. Resident 1's ISP was not updated to include aggressive/combative behaviors and usage of as needed (PRN) medications. This is a repeat deficiency. See Statements of Deficiency (SOD) GLXI12, dated 02/09/2024, and SOD GLXI13, dated 05/02/2024. Findings include:	N 389		

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 _____	R-C 08/22/2025

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 389	Continued From page 23 On 08/20/2025, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 04/11/2023 with diagnosis of dementia. Resident 1 had an activated healthcare power of attorney. Resident 1 discharged from the facility on 07/23/2025 and later passed at an in-patient hospice facility on 07/29/2025. Resident 1's signed ISP dated 04/15/2025 documented: "-Medications: Medications will be administered as prescribed by the medical doctor and ordered accordingly. Care staff should promptly report any adverse changes/concerns to the community registered nurse and document these observations in the electronic health record (ECP) when appropriate. -PRN Psychotropic Medication: [Resident 1] has a PRN order for lorazepam as needed by and ordered by Agrace Hospice. Care staff will administer medications as outline in the Medical Authorization Record (MAR), as prescribed by the Medical Director. Care staff will monitor and report any adverse reactions, alterations, concerns, or challenges to the Community Registered Nurse. -Behavior Patterns: Aggressive/Combative-Does Resident display aggressive/combative behaviors? No. Destructive-Does Resident display destructive behaviors? No." Resident 1's progress notes dated 06/01/2025 to 07/22/2025 documented: -"06/03/2025 completed by Hospice Nurse D: RN performed comprehensive assessment, medication reconciliation, and plan of care review ....Staff reported that [Legal Representative E]	N 389		

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 _____	R-C 08/22/2025

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 389	Continued From page 24	N 389		

has been giving [him/her] energy drinks on occasion in the evening and when [s/he] does [s/he] is up and restless and agitated all night. They states that [s/he] has been more restless and agitated the last several weeks in the evening. [S/he] has been wandering more and at time even striking out at staff as they are trying to redirect [him/her]. Writer will reach out to [Legal Representative E] about not giving the energy drinks and also about getting a prn to help with intermittent sun downing behaviors.
-06/10/2025 completed by Hospice Nurse D: RN performed comprehensive assessment, medication reconciliation, and plan of care review ...Staff stated [s/he] continues to have periods especially in the evenings of increased agitation and restlessness, but they have not used prn quetiapine yet. Writer asked med passer to pass long to PM shift med passer to use the Quetiapine when [s/he] is agitated like that.
-06/11/2025: Resident is very agitated and writer gave [him/her] a PRN staff took [him/her] outside for a little walk and sat out there for about 20 min.
-06/17/2025 at 9:45 AM: Resident was not in a great mood at all, [s/he] did wake up for a little while and allow writer to give [him/her] medications but after that [s/he] went to sleep at the table and would not wake up and refused to eat and drink anything. Hospice did visit [him/her] this morning and gave resident a PRN for agitation.
-06/17/2025 completed by Hospice Nurse D: RN performed comprehensive assessment, medication reconciliation, and plan of care review ...Staff stated [s/he] was awake this morning and was fine but had just recently became agitated. Writer went to [him/her] and tried to wake [him/her] and [s/he] swatted writer. [S/he] was slouched down in the chair so writer and staff assisted in lifting [him/her] up in the chair so

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 _____	R-C 08/22/2025

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 389	Continued From page 25 [s/he] wouldn't slid out. [S/he] woke up and was again swatting at us ...Writer asked staff if they have given any prn quetiapine and they stated no they hadn't. Writer asked them to administer it. Staff stated [s/he's] been 'moody' and 'feisty' all weekend. Writer reminded them to use [his/her] PRN Quetiapine when [s/he] is agitated like this. Writer spoke to [Legal Representative E] and [s/he] reported [Resident 1's] behaviors to be 'fine' when [s/he] was visiting. [S/he] does not want to schedule the Quetiapine as [s/he] stated [his/her] mood is not consistently bad. [S/he] would like the staff to use it when needed and reiterated that they do not need to call prior to administration. [S/he's] okay with them using it as needed per the MD order. -06/17/2025 at 7:15 PM: ...Resident tried to punch and spit writer because [s/he] did not want to get up for dinner. -06/18/2025 at 8:15 AM and 1:45 PM: Gave resident PRN Quetiapine and resident spit it out and also spit at me ....Resident has had a very bad day today, [s/he] has been very upset yelling, cursing, trying to get out the front door. Medpasser did try and give resident PRN this morning but resident spit the medicine out and spit on the med passer as well. -06/22/2025: The resident became aggressive when we picked [him/her] up, began hitting and yelling, and we switched [him/her] between two caregivers ....Having behaviors, yelling, being combative, trying to escape. Talked and listened to resident to calm down, will be given PRN Seroquel ...The resident was very restless, aggressive, wanted to open the security doors, and we told [him/her] [s/he] couldn't and [s/he] was hitting and kicking us and starting to scream. -06/23/2025: Resident was trying to get out of the building, wandering, going into other residents rooms, hitting staff, kicking staff, and with a lot of	N 389		

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 _____	R-C 08/22/2025

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 389	Continued From page 26	N 389		

anxiety.
-06/24/2025 completed by Hospice Nurse D: RN performed comprehensive assessment, medication reconciliation, and plan of care review ...Staff stated that most morning [s/he] is sleeping and in bad mood if they try to wake [him/her]. They stated [s/he] probably has 3 out 7 bad mornings but they stated the afternoon and evenings is really when [s/he] 'gets bad.' They stated that [s/he] trys [sic] to elope, walks around without [his/her] walker, yelling at others and gets combative with staff when they try to stop [him/her] and redirect [him/her]. She has used prn quetiapine 7x in the last week. Writer suggested giving med at 4pm as it appears by prn administrations that they are normally giving mostly in the evening after dinner .....[Legal Representative E] stated that [s/he's] okay with scheduling the quetiapine but wants to make sure [s/he's] not 'out of it' and unable to eat.
-07/08/2025 completed by Hospice Nurse D: RN performed comprehensive assessment, medication reconciliation, and plan of care review ...Staff report that [his/her] agitation, restlessness and exit seeking has improved with the scheduled Seroquel but [s/he] still has [his/her] moments and restlessness and does still go to the door trying to get out at times.
-07/16/2025 completed by Hospice Nurse D: RN performed comprehensive assessment, medication reconciliation, and plan of care review ...Staff stated this morning [s/he] did not eat breakfast and didn't want to get up. They stated [s/he] is often still agitated and restless in the afternoon. [S/he] is often wondering around the hallways, [s/he] is talking about death and funerals a lot per staff ....Staff stated the afternoons are the worst time for [him/her] still. [S/he[is getting more confused and was calling staff scoundrels and heathens over the weekend

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 _____	R-C 08/22/2025

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 389	Continued From page 27 per staff. 07/17/2025: ...Writer gave resident [his/her] scheduled 5pm medication. When dinner was served resident started screaming and throwing the food on the floor. Resident spilled all of [his/her] cranberry juice on the table and on the floor." Resident 1' June 2025 medication administration record (MAR) documented: "PRN Medications Log: -06/11/2025: Quetiapine 25mg tab given, description of behavior requiring use: seems very annoyed, repeating the same questions, getting up on [his/her] own, getting confused. -06/17/2025: Quetiapine 25mg tab given, description of behavior requiring use: resident is very agitated and not wanting to wake up or open [his/her] eyes. -06/18/2025: Quetiapine 25mg tab given, description of behavior requiring use: trying to leave out the door, yelling at staff. -06/20/2025: Quetiapine 25mg tab given, description of behavior requiring use: resident is agitated and anxious, exit seeking. -06/21/2025: Quetiapine 25mg tab given, description of behavior requiring use: when ask to sit down [s/he] would yell and try to leave and swing. -06/22/2025: Quetiapine 25mg tab given, description of behavior requiring use: exit seeking, yelling, combative. -06/23/2025: Quetiapine 25mg tab given, description of behavior requiring use: anxiety, restlessness, agitation -06/24/2025: Quetiapine 25mg tab given 2x, description of behavior requiring use: anxiety, agitation, exit seeking, attempting to hit staff, pacing the unit. -06/25/2025: Quetiapine 25mg tab given,	N 389		

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 _____	R-C 08/22/2025

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 389	Continued From page 28	N 389		

description of behavior requiring use: trying to leave, opening doors, yelling.
-06/26/2025: Quetiapine 25mg tab given, description of behavior requiring use: opening the door.
-06/27/2025: Quetiapine 25mg tab given, description of behavior requiring use: resident exit seeking, yelling at staff, restlessness."

Surveyor reviewed written statements by staff into bruising found on Resident 1's wrists.
-Caregiver P wrote the following on 07/19/2025: "the resident has been very aggressive, [s/he] has not wanted to eat like before. [S/he] has behaved very rudely, spitting out medications. [S/he] complains when someone tries to get [him/her] out of bed. In fact [s/he] kicked me on Thursday."
-Caregiver M wrote the following on 07/19/2025: "the resident has been behaving aggressively, [s/he] is asked to sit down but does not listen. [S/he] throws punches, kicks you, spits at you,..and throws food at you. [S/he] has not wanted to eat and when help is offered [s/he] screams."
-Caregiver Q wrote the following on 07/21/2025: "the days that I have worked with the resident. What I can observe is that [s/he] gets anxious and combative at dinner time or after dinner."

On 08/20/2025 at 1:26 PM, Surveyor interviewed Executive Director G. Surveyor asked if Resident 1's ISP dated 04/15/2025 was the most current. Executive Director G confirmed the ISP from 04/15/2025 was the most recent for Resident 1.

On 08/20/2025 at 1:55 PM, Surveyor conducted an exit conference and shared findings with Assistant Director F and Executive Director G. Assistant Director F reported the provider

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 _____	R-C 08/22/2025

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 389	Continued From page 29 completes ISP reviews every 6 months and had systems in place to update ISP's in between reviews. Surveyor questioned why Resident 1's ISP was not updated to reflect aggressive/combative behaviors and usage of as needed (PRN) medications. Assistant Director F did not provide a reason why. Both staff acknowledged an understanding of the concerns. The ISP did not identify updated interventions or approaches for staff to utilize in managing Resident 1's behaviors: aggressive/combative and usage of PRN medication (Seroquel).	N 389		