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 05/12/2026

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 05/06/2025 to 05/12/2026, Surveyors conducted a standard survey and verification visit at Sage Meadows of Middleton. Eleven deficiencies were identified. Four of 11 deficiencies were repeat violations. See Statement of Deficiency (SOD) 7V0L12, dated 08/22/2025, SOD 7V0L11, dated 01/30/2025, SOD GLXI13, dated 05/02/2024, SOD GLXI12, dated 02/09/2024, and SOD GLXI11, dated 09/28/2023. The previous violation from SOD 7V0L13, dated 12/15/2025 was substantially corrected. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 37	{N 000}		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training	N 247		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 247	Continued From page 1 topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 2 of 2 employee records reviewed (Caregiver X and Caregiver Y) received dietary training within 90 days after assuming their job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. Findings include: On 05/06/2026, Surveyor conducted a standard survey. At 12:00 PM, Surveyor observed Caregiver X and	N 247		

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N 247	Continued From page 2 Caregiver Y serving lunch to residents in the dinning room. On 05/06/2026, Surveyor reviewed Caregiver X's and Caregiver Y's employee records. -Caregiver X was hired 11/24/2025. Caregiver X's record did not include dietary training. -Caregiver Y was hired 11/24/2025. Caregiver Y's record did not include dietary training. On 05/06/2026 at 3:30 PM, Surveyor interviewed Administrator U, Director of Operations V, and Regional Nurse W. Surveyor shared concern for lack of dietary training for the above staff. Administrator U stated s/he was still working with the licensee to obtain employee records prior to November 2025. Surveyor stated documentation would need to be submitted no later than 05/08/2026. As of 05/12/2026, evidence of dietary training for Caregiver X and Caregiver Y was not provided.	N 247		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the	N 346		

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N 346	Continued From page 3 cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the privacy of residents' personal information and records. One laptop computer connected to the medication cart was left open and unattended in a common area where resident information could easily be seen by anyone walking by. Findings include: On 05/06/2026 from 9:03 AM to 9:13 AM, Surveyor observed 1 laptop computer attached to the provider's medication cart was left open and unattended with resident private information showing on the screen. Resident names and room numbers were visible on the screen. Several residents and visitors walked by the computer while private resident information was visible. On 05/06/2026 at 9:13 AM, Surveyor interviewed Administrator U and Director of Operations V. Surveyor shared concerns for resident private information visible to anyone walking by the provider's medication cart. Administrator U stated the 1st floor medication cart was usually stored in the common area. Administrator U stated the computer screen observed by the Surveyor was used by staff to track resident call pendants. The management staff acknowledged the laptop computer should not be accessible to anyone when not in use. The management team stated they would work with their supervisor to change the screen to not include resident information.	N 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 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 7 of 11 resident records reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner. This is a repeat violation. See Statement of Deficiency (SOD) 7V0L11, dated 01/30/2025, SOD 7V0L12, dated 08/22/2025, and SOD GLXI12, dated 02/09/2024. Findings include: On 05/06/2026 at 9:11 AM, Surveyor conducted a standard survey and audited 3 medication carts with Licensed Practical Nurse (LPN) Z. The following was found: Example 1: Resident 10 Resident 10's Azelastine 0.1 % (137 micrograms (MCG)) nasal spray contained a manufacturer's label including the container originally held 30 milliliters (ML). The container included a pharmacy label including Resident 10's practitioner's prescription Azelastine including "Instill 2 sprays into each nostril 2 times daily." The pharmacy label included a delivery date to the facility of 02/24/2026. Surveyor observed	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 05/12/2026

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N 352	Continued From page 5 approximately ¼ of the medication remained within the container. LPN Z verbally confirmed same amount remained and no other containers of the medication were observed in the cart. On 05/06/2026, Surveyor reviewed Resident 10's record. Resident 10 was admitted to the facility on 09/17/2025. Resident 10 had an activated healthcare power of attorney. Resident 10's most recent individual service plan (ISP) dated 11/14/2025 indicated staff administer his/her medications. Resident 10's medication administration records (MARs) dated 02/25/2026 to 05/06/2026, documented: "Azelastine 0.1% (137 MCG) Spry, instill 2 sprays each nostril 2 times daily." The MARs documented the medication had been administered as prescribed besides 3 occurrences (notation blank: 4/2,"DR": 3/30, and "With Family": 4/27.) The bottle of Azelastine only contained a 50-day supply (4 sprays per day divided by 200 actuations = 50). The medication should have been replaced approximately 04/17/2026. "(Azelastine hydrochloride) Nasal Spray, 137 mcg is supplied as a 30-mL package delivering 200 metered sprays in a high-density polyethylene (HDPE) bottle fitted with a metered-dose spray pump unit." (Source: US Food and Drug Administration website, Drug Label, 09/2018, https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/020114s028lbl.pdf (retrieval date - May 18, 2026).) Example 2: Resident 11 Resident 11's Fluticasone nasal spray contained noted a manufacturer's label including the container originally held 16 grams. The container included a pharmacy label including Resident 11's practitioner's prescription for fluticasone including	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

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N 352	Continued From page 6 "Instill 2 sprays in each nostril 2 times daily." The pharmacy label included a delivery date to the facility of 02/19/2026. Surveyor observed ½ of the medication remained within the container. LPN Z verbally confirmed same amount remained and no other containers of the medication were observed in the cart. On 05/06/2026, Surveyor reviewed Resident 11's record. Resident 11 was admitted to the facility on 03/17/2025. Resident 11 had an activated healthcare power of attorney. Resident 11's most recent ISP dated 11/20/2025 indicated staff administer his/her medications. Resident 11's MAR dated 02/20/2026 to 05/06/2026, documented: "Fluticasone Prop 50 MCG Spray - Instill 2 sprays in each nostril 2 times daily." The MARs documented the medication had been administered as prescribed. The bottle of Fluticasone only contained a 30-day supply (4 sprays per day divided by 120 actuations = 30). "Each bottle contains a net fill weight of 16 g (grams) and will provide 120 actuations. Each actuation delivers 50 mcg (micrograms) of fluticasone propionate in 100 mg (milligram) of formulation through the nasal adapter. The correct amount of medication in each spray cannot be assured after 120 sprays even though the bottle is not completely empty." (Source: National Institute of Health website, Fluticasone Propionate, 12/2022, https://dailymed.nlm.nih.gov/dailymed/fda (retrieval date - May 18, 2026).) Example 3: Resident 12 At 9:21 AM, Surveyor observed 1 tablet of Resident 12's Levothyroxine Sodium 6 AM blister pack remained. The tablet that remained was dated "Tuesday C23." The pharmacy label on the	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 352	Continued From page 7	N 352		

blister pack included a delivery date to the facility of 04/09/2026. LPN Z reported tomorrow was the provider's cycle refill and all medications should be punched out. LPN Z did not know why Resident 12's Levothyroxine remained in the blister pack. LPN Z confirmed that the provider's system was for staff to punch out tablets/capsules from the numerical bubble pack that corresponded with the date of administration.

On 05/06/2026, Surveyor reviewed Resident 12's record. Resident 12 was admitted to the facility on 03/23/2023. Resident 12 had an activated healthcare power of attorney. Resident 12's most recent ISP dated 03/26/2025 indicated staff administer his/her medications. Resident 12's physician orders included "Levothyroxine 100 MCG tab with instructions to give 1 tablet by mouth daily with a start date of 01/08/2026. Resident 12's April 2026 MAR indicated staff documented Levothyroxine as administered 28 times, 1 refusal, and 1 notation blank (total 30). Resident 12's record did not contain any documentation why Levothyroxine 100 MCB tab remained in the blister pack when staff documented it was administered on 04/23.

Example 4: Resident 13
At 9:21 AM, Surveyor observed 3 tablets of Resident 13's Potassium Noon blister pack remained. The tablets that remained were dated "Saturday C26, Sunday C25, and Wednesday C22." The pharmacy label on the blister pack included a delivery date to the facility of 04/09/2026. LPN Z reported s/he did not know why Resident 13's potassium tablets remained in the blister pack.

On 05/06/2026, Surveyor reviewed Resident 13's record. Resident 13 was admitted to the facility

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SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

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N 352	Continued From page 8 on 01/12/2026. Resident 13 had an activated healthcare power of attorney. Resident 13's most recent ISP (unknown date) indicated staff administer his/her medications. Resident 13's physician orders included "Potassium Er 20 Meq Tab with instructions to give 2 tablets (40 Meq) by mouth daily at Noon, with a start date of 01/28/2026. Resident 13's April 2026 MAR indicated staff documented Potassium as administered 29 times and 1 refusal (total 30). Resident 13's record did not contain any documentation why the Potassium 20 Meq tabs remained in the blister pack when staff documented they were administered on 04/26, 04/25, and 04/22. Example 5: Resident 14 At 9:34 AM, Surveyor observed the provider's 2nd floor medication carts. Surveyor observed 1 tablet of Resident 14's Baclofen Bedtime blister pack remained. The tablet that remained was dated "Wednesday C15." The pharmacy label on the blister pack included a delivery date to the facility of 04/09/2026. Surveyor observed 2 tablets of Resident 14's Baclofen PM blister pack remained. The tablets that remained were dated "Tuesday C9 and Monday C17." The pharmacy label on the blister pack included a delivery date to the facility of 04/09/2026. LPN Z reported s/he did not know why Resident 14's Baclofen tablets remained in the blister packs. On 05/06/2026, Surveyor reviewed Resident 14's record. Resident 14 was admitted to the facility on 07/15/2024. Resident 14 had a guardian. Resident 14's most recent ISP (unknown date) indicated staff administer his/her medications. Resident 14's physician orders included "Baclofen 20mg Tab with instructions to give 1 tablet by mouth 3 times daily for muscle spasticity.	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 05/12/2026

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

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N 352	Continued From page 9 Resident 14's April 2026 MAR indicated staff documented Baclofen (2:00 PM) as administered 29 times and 1 notation blank (total 30) and Baclofen (8:00 PM) as administered 29 times and 1 "hospital" (total 30). Resident 14's record did not contain any documentation why the Baclofen 20 mg tabs remained in the blister pack when staff documented they were administered on 8pm: 04/15, and 2pm: 4/9 and 4/17. Example 6: Resident 15 Resident 15's polyethylene glycol container noted a manufacturer's label including the container originally held 30 once-daily doses of 18 grams. The container included a pharmacy label including Resident 15's practitioner's prescription for polyethylene glycol including, "Dissolve 1 capful (17 GM) into 8OZ of liquid and drink daily for constipation." The pharmacy label included a delivery date to the facility of 03/10/2026. The container contained an opened date of 03/11/2025 [sic]. Surveyor observed approximately 1/4 of the medication remained within the container. LPN Z verbally confirmed same amount remained and no other containers of the medication were observed in the cart. On 05/06/2026, Surveyor reviewed Resident 15's record. Resident 15 was admitted to the facility on 03/27/2025. Resident 15's most recent ISP dated 03/29/2025 indicated staff administer his/her medications. Surveyor reviewed Resident 15's March 2026-May 2026 MARs and identified the following: Resident 15 was administered 54 doses of polyethylene glycol between 03/11/2026-05/06/2026 from a 30 dose container, based on Resident 15's practitioner's order, with ¼ of the medication remaining in the container. Example 7: Resident 16	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 05/12/2026

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N 352	Continued From page 10 Resident 16's polyethylene glycol container noted a manufacturer's label including the container originally held 30 once-daily doses of 18 grams. The container included a pharmacy label including Resident 16's practitioner's prescription for polyethylene glycol including, "Dissolve 1 capful (17 GM) into 8OZ of liquid and drink daily for constipation." The pharmacy label included a delivery date to the facility of 02/19/2026. Surveyor observed approximately 1/2 of the medication remained within the container. LPN Z verbally confirmed same amount remained and no other containers of the medication were observed in the cart. On 05/06/2026, Surveyor reviewed Resident 16's record. Resident 16 was admitted to the facility on 12/30/2024. Resident 16's most recent ISP dated 04/15/2025 indicated staff administer his/her medications. Surveyor reviewed Resident 16's February 2026-May 2026 MARs and identified the following: Resident 16 was administered 69 doses of polyethylene glycol between 02/20/2026-05/05/2026 from a 30-dose container, based on Resident 15's practitioner's order, with 1/2 of the medication remaining in the container. Interviews: On 05/06/2026 at 2:15 PM, Surveyor interviewed Regional Nurse W. Surveyor shared concern with the amount of medications still left in each container and staff continuing to document as administered. In addition, Surveyor shared concern for scheduled medications being left in blister packs and lack of evidence documented in resident records on why medications remained. Regional Nurse W stated on site nursing staff was supposed to do weekly med cart audits, so s/he did not know how they ended up like this.	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 05/12/2026

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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 11 On 05/06/2026 at 3:30 PM, Surveyor interviewed and shared findings with Administrator U, Director of Operations V, and Regional Nurse W. The management team acknowledged an understanding of the above concerns and did not provide any comment.	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 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 3 of 11 individual service plans (ISPs) reviewed were developed with involvement from the resident and resident's legal representative. Resident 13's, Resident 14's, and Resident 17's ISP did not contain a signature from the resident or 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 _____	R-C 05/12/2026

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

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N 387	Continued From page 12 This is a repeat deficiency. See Statement of Deficiency (SOD) 7V0L11, dated 01/30/2025. Findings include: On 05/06/2026, Surveyor reviewed resident records and identified the following: -Resident 13 was admitted on 01/12/2026. Resident 13 had an activated healthcare power of attorney. Resident 13's most recent ISP (unknown date) did not contain a signature from his/her legal representative. -Resident 14 was admitted on 07/15/2024. Resident 14 had a guardian. Resident 14's most recent ISP (unknown date) did not contain a signature from his/her guardian. -Resident 17 was admitted on 02/04/2026. Resident 17 had an activated healthcare power of attorney. Resident 17's most recent ISP (unknown date) did not contain a signature from his/her legal representative. On 05/06/2026 at 12:05 PM, Surveyor interviewed Licensed Practical Nurse (LPN) Z regarding missing signatures on resident ISPs. LPN Z reported when s/he started in February s/he was assigned both facilities and s/he was still working on acquiring signatures as resident care conferences come up. LPN Z acknowledged resident ISP's were not signed as required. On 05/12/2026 at 11:00 AM, Surveyor interviewed and shared findings with Administrator U, LPN Z, Assistant Director F, Director of Operations V, Regional Nurse W, and Nurse AA. Surveyor shared resident ISPs provided during survey did	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 _____	R-C 05/12/2026

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SAGE MEADOWS OF MIDDLETON - 5340	5340 CENTURY AVE MIDDLETON, WI 53562

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N 387	Continued From page 13 not include any signature pages. Administrator U stated s/he tried to send the Surveyor records, but the file must have been too large so s/he will send each ISP individually. Surveyor stated documentation would need to be submitted by the end of the day 05/12/2026. As of 05/13/2026, records submitted did not include signed ISP's for Resident 13, Resident 14, and Resident 17.	N 387		
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 provider did not ensure 4 of 11 individual service plans (ISPs) reviewed were reviewed at least annually and signed by the resident's legal representative acknowledging their involvement in, understanding of and agreement with the ISP. Resident 9, Resident 12, Resident 15, and Resident 16 ISPs were not reviewed at least	N 389		

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N 389	Continued From page 14 annually. This is a repeat deficiency. See Statement of Deficiency (SOD) 7V0L12, dated 08/22/2025, SOD GLXI13, dated 05/02/2024, SOD GLXI12, dated 02/09/2024, and SOD GLXI11, dated 09/28/2023. Findings include: On 05/06/2026, Surveyor reviewed resident records and identified the following: -Resident 9 was admitted to the provider on 03/07/2025. Resident 9 had an activated healthcare power of attorney. A review of Resident 9's record showed there was no evidence that Resident 9's ISP was reviewed by his/her legal representative since 04/21/2025. -Resident 12 was admitted to the provider on 03/23/2023. Resident 12 had an activated healthcare power of attorney. A review of Resident 12's record showed there was no evidence that Resident 12's ISP was reviewed by his/her legal representative since 03/26/2025. -Resident 15 was admitted to the provider on 03/27/2025. Resident 15 had an activated healthcare power of attorney. A review of Resident 15's record showed there was no evidence that Resident 15's ISP was reviewed by his/her legal representative since 03/29/2025. -Resident 16 was admitted to the provider on 12/30/2024. Resident 16 had an activated healthcare power of attorney. A review of Resident 16's record showed there was no evidence that Resident 16's ISP was reviewed by his/her legal representative since 04/15/2025.	N 389		

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N 389	Continued From page 15 On 05/06/2026 at 12:05 PM, Surveyor interviewed Licensed Practical Nurse (LPN) Z regarding resident ISP's not being reviewed annually. LPN Z reported when s/he started in February s/he was assigned both facilities and s/he was still working on reviewing ISPs as resident care conferences come up. LPN Z acknowledged resident ISP's were not reviewed at least annually. On 05/12/2026 at 11:00 AM, Surveyor interviewed and shared findings with Administrator U, LPN Z, Assistant Director F, Director of Operations V, Regional Nurse W, and Nurse AA. Surveyor shared resident ISPs provided during survey did not include signature pages to see when the last time they were reviewed. Administrator U stated s/he tried to send the Surveyor records, but the file must have been too large so s/he will send each ISP individually. Surveyor stated documentation would need to be submitted by the end of the day 05/12/2026. As of 05/13/2026, records submitted did not include ISP's reviewed annually for Resident 9, Resident 12, Resident 15, and Resident 16.	N 389		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least	N 404		

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N 404	Continued From page 16 every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on interview and record review, the provider did not arrange on an annual basis, for a physician, pharmacist, or registered nurse to conduct an on-site review of the CBRF's medication administration and medication storage systems for 2024 and 2025. Findings include: On 05/06/2026, Surveyor conducted a standard survey and requested annual reviews of the medication administration and storage review for 2024 and 2025. On 05/06/2026 at 10:35 AM, Surveyor interviewed Administrator U. Administrator U reported the current management company took over in November 2025 and the provider was having trouble accessing records from the licensee. On 05/06/2026 at 3:30 PM, Surveyor interviewed Administrator U, Director of Operations V, and	N 404		

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N 404	Continued From page 17 Regional Nurse W. Administrator U stated s/he was still working with the licensee and pharmacy to potentially be given copies of the above inspections. Surveyor stated documentation would need to be submitted no later than 05/08/2026. On 05/11/2026 at 1:25 PM, Administrator U sent the following email to the Surveyor: "We do not have the med cart audits for 2024 and 2025. That is already being scheduled with RockMED this month."	N 404		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the 1st floor medication cart was unsecured. Caregiver X left the 1st floor medication cart unsecured for approximately 5 minutes. Findings include: On 05/06/2026 at 9:03 AM to 9:08 AM, Surveyor observed the provider's 1st floor medication cart unsecured in the common area adjacent to the dining room. Caregiver X was observed taking medication out of the cart, leaving the cart unsecured, and returning at 9:08 AM. Caregiver X stated the 1st floor medication cart serves approximately 15 residents. Residents and visitors were observed walking by the unsecured medication cart.	N 419		

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N 419	Continued From page 18 On 05/06/2026 at 9:13 AM, Surveyor interviewed Administrator U and Director of Operations V. Surveyor shared concerns for the unsecured medication cart. Both staff acknowledged the medication cart should have been secured when not in use. Administrator U stated s/he would provide education to Caregiver X.	N 419		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the living environment was safe, clean, comfortable, and homelike. This is a repeat deficiency. See Statement of Deficiency (SOD) GLXI13, dated 05/02/2024. Findings include: On 05/06/2026, Surveyor toured the facility and made the following observations: At 11:00 AM, Surveyor observed Resident 9's room. Upon proximity to Resident 9's room a pungent odor of urine could be observed at least 1 room away. At 2:30 PM, the same conditions were observed. At 2:30 PM, Surveyor observed the 1st floor	N 481		

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N 481	Continued From page 19 laundry room. The dryer vent was disconnected from the back of the dryer and lint was observed spraying into the air. On 05/06/2026 at 3:30 PM, Surveyor interviewed Administrator U, Director of Operations V, and Regional Nurse W. Surveyor shared concerns with the management team. The management team acknowledged the above concerns and stated they would address the concerns.	N 481		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the gas furnace was inspected at least every 3 years. The facility was unable to provide documented evidence of a furnace inspection completed since 09/23/2022. Findings include: On 05/06/2026, Surveyor conducted a review of	N 504		

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N 504	Continued From page 20 safety records. The furnace inspection provided was dated 09/23/2022. On 05/11/2026 at 3:55 PM, Surveyor interviewed Administrator U regarding the missing furnace inspection. Administrator U confirmed s/he was unable to find a more recent furnace inspection completed at the facility. Administrator U stated the provider had scheduled an inspection to be completed in the near future.	N 504		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the fire detection system (smoke and heat detectors) was tested annually by certified and qualified personnel in accordance with the specifications in NFPA 72 and the manufacture's specifications and procedures. Findings include: The provider is licensed to care for up to 44 residents in the client groups of advanced age, physically disabled, developmentally disabled, and irreversible dementia/Alzheimer's. On 05/06/2026, Surveyor requested the provider's annual smoke and heat detection	N 538		

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N 538	Continued From page 21 inspection report from Administrator U. The fire detection system was last inspected on 12/10/2024. On 05/11/2026 at 3:55 PM, Surveyor interviewed Administrator U regarding the missing smoke/heat inspection. Administrator U confirmed s/he unable to find a fire detection system report for year 2025. Administrator U stated the provider had scheduled an inspection to be completed soon.	N 538		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure enclosed furnace rooms had a self-closing door when located on a common level with resident bedrooms. Three furnace rooms did not have self-closing doors. Findings include: On 05/06/2026 at approximately 2:30 PM, Surveyor toured the facility. The facility is on 2	N 640		

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N 640	Continued From page 22 levels. Surveyor observed 3 furnaces rooms, the 1st furnace room did not have a self-closing mechanism, the 2nd furnace room's self-closing mechanism was broken, and the 3rd furnace room had a set of accordion style doors that did not self-close. All furnace rooms were observed on a common level with resident bedrooms. On 05/06/2026 at 3:30 PM, Surveyor interviewed Administrator U, Director of Operations V, and Regional Nurse W. Surveyor shared concerns with the management team. The management team acknowledged the doors were not self-closing and did not provide further comment.	N 640		