STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013981	A. BUILDING: _____ B. WING _____	C 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILTON SENIOR LIVING LLC	600 W SUNSET DRIVE MILTON, WI 53563

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U 000	INITIAL COMMENTS On 09/23/2025 to 09/24/2025, Surveyor conducted a complaint investigation at Milton Senior Living LLC. One deficiency was identified. The complaint was unsubstantiated. Census: 56	U 000		
U 267	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order. This Rule is not met as evidenced by: Based on record review and interview, the	U 267		

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

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provider did not ensure the tenant's right to receive all prescribed medications in the dosage and at the intervals prescribed for Tenant 1.

Between 07/20/2025 to 07/22/2025, staff did not administer 8 doses of Tenant 1's scheduled Oxycodone while s/he was actively passing.

Findings include:

On 09/23/2025, Surveyor reviewed Tenant 1's record and identified the following:

Tenant 1 was admitted to the facility on 03/15/2024 with a diagnosis of severe aortic valve stenosis. Tenant 1's record indicated s/he had an activated healthcare power of attorney. Tenant 1 was on hospice and passed away on 07/22/2025. Tenant 1's care plan dated 03/14/2025 indicated staff administer medications. Tenant 1's physician orders included: "Oxycodone 5 mg tablet with instructions to take 1 tablet by mouth every 4 hours for pain, with a start date of 06/27/2025."

Tenant 1's observation notes documented:
"-07/22/2025 at 2:30 PM written by Director A: Prior to resident passing, [Hospice RN B] reported that staff did not provide medications for resident during NOC shift on 07/21/2025. RN spoke at length with [Family Member C] about this concern and informed [him/her] that [s/he] appeared to be agitated and restless upon [his/her] arrival this AM. RN requested that writer notify staff that resident should continue to receive [his/her] comfort medications crushed via syringe with a small amount of water.
-07/22/2025 at 2:15 PM written by [Hospice provider]: Focused visit performed d/t: EOL symptoms/needs addressed and recommendations: Call placed to [Family Member

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U 267	Continued From page 2 C] with ETA. On arrival to facility, caregiver reported that patient did not have a dose of [his/her] comfort meds overnight or this morning as staff reported [s/he] was comfortable. On arrival to patient's room, [Family Member C] present, patient moaning and restless. Requested that [Caregiver E] administer PRN Lorazepam and Oxycodone. Vitals WNL, lungs sound decreased, although difficult to hear due to moaning. [Caregiver E] administered PRNs via syringe, education provided on how much water is used due to increased secretions over the last few days ....Patient's breathing improved and moaning stopped by end of visit. [Caregiver E] shared that staff did not administer any meds overnight as [s/he] couldn't swallow. [Family Member C] expressed frustration with [him/her] not having [his/her] medication as [s/he] was very uncomfortable this morning. Updated provided to [Director A] .... Death summary-Patient condition at end of life (EOL) (comfortable, struggling with sx, etc.): patient was uncomfortable at RN visit this morning, more comfortable at end of visit and comfortable at time of passing. -07/22/2025 at 12:00 PM: [Hospice RN B] to facility at this time to confirm resident has passed and to contact family. -07/22/2025 at 11:00 AM: Writer went to check on resident at this time and noticed that resident wasn't breathing. Writer took a pulse ox meter to check resident's pulse which resident didn't have one. Writer reached out to [hospice provider] to update them. [Hospice provider] will be sending a nurse. -07/22/2025 at 8:30 AM: Writer received a fax from [Hospice provider] from visit on 7/20/2025 ....Training provided: Please continue to adm [sic] scheduled opiod [sic], position as ordered side to side use oral swabs to remove any secretions coughed up. Hold non comfort meds. Utilize prn	U 267		

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opioid if RR rapid or Lorazepam if restless contact [Hospice provider] 24-hour triage for concerns further decline.
-07/11/2025 at 1:15 PM written by [Hospice provider]: ...[Caregiver D] reported that patient is hardly eating or drinking, they are not giving [his/her] meds in a syringe."

Surveyor reviewed Tenant 1's July 2025 medication administration record (MAR) which documented the following missed doses of Tenant 1's scheduled Oxycodone:
"-07/20/25 4:00pm No Pass Reason: Refused by Patient: Resident couldn't swallow and hospice had to come.
-07/20/25 8:00pm No Pass Reason: Refused by Patient: didn't do [his/her] pill because [s/he] didn't have that much of strength to swallow any of [his/her] pill.
-07/21/25 12:00am-No Pass Reason: Refused by Patient: Resident too weak and hasn't gotten any of [his/her] medications today/resident asleep.
-07/21/25 4:00am- No Pass Reason: Refused by Patient: Resident too weak and hasn't gotten any of [his/her] medications today/resident asleep.
-07/21/25 4:00pm-No Pass Reason: Refused by Patient: resident was too weak to take scheduled meds.
-07/21/25 7:00pm-No Pass Reason: Refused by Patient.
-07/22/2025 12:00am-No Pass Reason: Refused by Patient: Resident can't swallow.
-07/22/2025 4:00am-No Pass Reason: Refused by Patient: Resident too weak to take this medication."

On 09/23/2025 at 11:30 AM, Surveyor interviewed Director A. Surveyor asked for clarification on entries made in Tenant 1's record regarding missed medication prior to him/her passing.

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Director A reported after Tenant 1 passed away, Hospice RN B approached him/her about NOC shift staff not administering comfort meds. Director A spoke with the provider's nurse and confirmed Tenant 1 missed 2 doses of Oxycodone due to staff noting Tenant 1 was having issues with swallowing. Surveyor expressed concern due to staff not providing Tenant 1's scheduled Oxycodone s/he was moaning, restless, and agitated when being assessed by Hospice RN B on the morning on 07/22/2025. Director A acknowledged the concern and stated Tenant 1 received 2 doses on 07/22/2025 at 8am and 12pm, but by that time, the provider was playing catch up to keep Tenant 1 comfortable.

On 09/23/2025 at 3:49 PM, Surveyor interviewed Hospice RN B via phone. Hospice RN B reported s/he visited Tenant 1 on 07/22/2025 between 9-9:30 AM and observed Tenant 1 moaning, restless, and agitated. Hospice RN B stated staff told him/her that NOC staff did not administer 2 doses of scheduled Oxycodone because Tenant 1 looked comfortable and was too weak to swallow. Hospice RN B reported hospice staff had provided education on this before and the expectation would be for staff to still administer comfort meds via syringe. Hospice RN B reported s/he spoke with Director A and s/he provided reeducation to staff right away. Hospice RN B reported Tenant 1 did receive his/her 8am and 12pm doses on 07/22/2025, but we were playing catch up to make him/her comfortable.

On 09/24/2025 at 1:53 PM, Surveyor interviewed Director A via phone. Director A acknowledged an understanding of the concerns. Director A reported the provider reeducated staff right away. Director A stated s/he is going to ask the hospice

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U 267	Continued From page 5 agency to provide training at the facility's next staff meeting on comfort medications. Director A noted going forward the provider's nurse is going to monitor comfort medications for any tenants who are end of life.	U 267		