STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019367	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5330	5330 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 09/15/2025, Surveyor conducted 2 complaint investigations at Sage Meadows of Middleton. One deficiency was identified. One complaint was substantiated. One complaint was unsubstantiated. Census: 48	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify Resident 1's legal representative when s/he experienced 2 falls and bruising to his/her chest area. Findings include: The provider is licensed to care for up to 52 residents in the following client groups: developmentally disabled, physically disabled, advanced aged, and irreversible dementia/Alzheimer's.	N 169		

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
	0019367	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5330	5330 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 169	Continued From page 1 On 08/07/2025, the Department received a complaint alleging concerns legal representatives were not notified of falls. On 09/15/2025, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted on 12/02/2024 with diagnoses of type 2 diabetes and dementia. Resident 1 discharged on 07/31/2025. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) dated 04/21/2025 indicated Resident 1 was not a fall risk. Resident 1's incident reports documented: -"03/06/2025 at 2:17 PM: Resident just showered and attempted to sit on bed, bed slid back, and resident fell forward into wall and on floor. Resident did not hit [his/her] head and said pain level is 0. Staff helped resident off floor and into recliner. Vital taken. Family or Representative Notified? No. -03/10/2025 at 2:37 PM: Resident was taking a shower and [his/her] soap dropped, and [s/he] tried to pick it up and [s/he] fell. [S/he] was able to get back up and we put on [his/her] clothes. Didn't hit [his/her] head and [s/he] said there was no pain. No injuries sustained. Family or Representative Notified? No." Resident 1's observation notes documented: -07/07/2025: "Resident has large purple bruise on the left side of [his/her] chest. Edit: RN followed up with bruise. The bruise was quite large but appeared to be in its healing stages around the edges. [Resident 1] was unable to answer hot it got there but wanted RN to feel [his/her] chest and "push" on it to feel "the bump." RN asked if	N 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019367	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5330	5330 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 169	Continued From page 2 [s/he] presses on [his/her] chest often and [s/he] said "no." When RN felt [Resident 1's] chest, there was a notable bump under the skin but there was no complaints of pain. Care staff to keep an eye on [Resident 1] and any worsening of the bruise. No concerns of abuse at this time due to [Resident 1] not using [his/her] walker and it is suspected that [s/he] is falling, and staff are not aware. -07/22/2025: Resident has been out with [his/her] [husband/wife] for most of the day. Resident's spouse told staff that resident has a bruise on [his/her] chest and would like for [him/her] to be checked out by a nurse." Resident 1's record did not contain evidence of notification to Legal Representative C for the above falls and bruising. On 08/12/2025 at 4:44 PM, Surveyor interviewed Legal Representative C via phone. Legal Representative C stated s/he was Resident 1's activated healthcare power of attorney. Legal Representative C reported on 07/22/2025 s/he went to pick up Resident 1 from the facility for his/her brother/sister's funeral. Legal Representative C noted upon assisting Resident 1 to change his/her shirt, s/he discovered large bruising on his/her chest wrapping around to his/her back. Legal Representative C stated s/he was never notified of any bruising and was unaware how it occurred. Legal Representative C report concerns with being notified after 2 falls in March 2025. Legal Representative C stated s/he moved Resident 1 out of the facility due to ongoing concerns during his/her admission. On 09/15/2025 at 11:40 AM, Surveyor interviewed Executive Director A and Assistant Director B. Surveyor asked if Legal Representative C was	N 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019367	A. BUILDING: _____ B. WING _____	C 09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS OF MIDDLETON - 5330	5330 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 169	Continued From page 3 notified of the above falls and bruising that occurred to Resident 1. Assistant Director B reviewed Resident 1's incident reports and acknowledged both incident reports noted Legal Representative C was not notified for falls that occurred on 03/06/2025 and 03/10/2025. Surveyor asked if there was another place in the record where notification was documented. Assistant Director B stated there was no other place within the record and staff have been trained on this many times. On 09/15/2025 at 12:11 PM, Surveyor interviewed Executive Director A and Assistant Director B. Surveyor asked about Resident 1's observation note dated 07/07/2025. Assistant Director B reviewed Resident 1's record and noted Clinical Director B wrote the above entry. Surveyor shared concerns that Legal Representative C was never made aware of Resident 1's bruising until s/he discovered it on 07/22/2025. Both staff acknowledged an understanding of the concern. Assistant Director B stated Clinical Director B would follow up with the Surveyor by the end of today on why Legal Representative C was not notified of Resident 1's bruising. As of 09/18/2025, no further evidence was submitted.	N 169		