STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR SENIOR LIVING	6550 SCHROEDER RD MADISON, WI 53711

(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 11/04/2025, the bureau of assisted living southern regional office conducted a complaint investigation at Brightstar Senior Living (AKA Hattie's Glen) a CBRF located in Madison, WI. As a result of this survey, 4 violations of DHS Chapter 83 were identified. The complaint was unsubstantiated. Census: 19	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the department within 3 working days after law enforcement personnel were called to the CBRF because of an incident that jeopardized the health, safety, and welfare of Resident 1. FINDINGS INCLUDE: The facility provided care to the following client groups: irreversible dementia/Alzheimer's	N 164		

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 164	Continued From page 1	N 164		

disease.

On 10/27/2025, the Department received a complaint with allegations of police presence at facility.

On 11/04/2025, Surveyor arrived at facility for a complaint investigation.

On 11/04/2025 at approximately 9:15 AM, Surveyor requested all self-reports filed with the Department in 2025 from Receptionist K.

On 11/04/2025 at approximately 10:25 AM, Surveyor requested all self-reports filed with the Department in 2025 from Administrator A and Resident 1's facility record.

On 11/04/2025, Surveyor reviewed all self-reports filed with the Department in 2025. Surveyor did not review any self-report with documentation of law enforcement personnel being summoned to the facility during October 2025.

On 11/04/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 03/20/2019. Resident 1 had Family Member E listed as his/her activated power of attorney. Resident 1 was diagnosed with but not limited to: major depressive disorder, restless leg syndrome, multiple sclerosis, generalized muscle weakness and history of urinary tract infections (UTI).

On 11/04/2025 at approximately 11:50 AM, Surveyor asked Administrator A is s/he had any self-reports for the month of October 2025. Administrator A left to review records in his/her office. Administrator A returned and stated s/he did not have any self-reports for the month of

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BRIGHTSTAR SENIOR LIVING	6550 SCHROEDER RD MADISON, WI 53711

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N 164	Continued From page 2	N 164		

October 2025. Surveyor then asked Administrator A if anything reportable happened at the facility during the month of October 2025. Administrator A denied knowledge of any reportable incidents occurring during the month of October 2025. Surveyor asked Administrator A if s/he as the facility administrator was aware of any reportable incidents occurring at facility during the month of October 2025. Surveyor asked Administrator A who caregivers would have reported to during the night from 10/01/2025 to 10/02/2025. Administrator A stated Facility Nurse H would have been on-call to assist caregivers with resident needs. Administrator A stated Facility Nurse H was not available due to strep throat. Administrator A did offer to have Facility Nurse H write a statement for Surveyor.

On 11/04/2025 at 12:00 PM, Surveyor discussed the above concerns with Administrator A, Assistant Director B, Executive C, and Manager D. Administrator A and Assistant Director B were physically present during the interview. Executive C and Manager D had joined the meeting via speaker phone. Administrator A, Assistant Director B, Executive C, and Manager D. Manager D stated on 10/01/2025 Caregiver J assessed Resident 1 was experiencing altered mental status and summoned an ambulance to transport Resident 1 to an ER. Manager D acknowledged this was the first ambulance trip Resident 1 took to the ER that night. Assistant Director B stated the hospital had called him/her that night and told him/her that facility staff were not allowing Resident 1 to re-enter the facility. Assistant Director B acknowledged facility staff had refused to allow Resident 1 to return to his/her home, and Resident 1 returned to the ER via ambulance. Assistant Director B acknowledged hospital had called local police

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 164	Continued From page 3	N 164		

because of Resident 1 being turned away from the facility. Assistant Director B stated s/he had been called by the local police to discuss Resident 1's return to the facility. Administrator A, Assistant Director B, Executive C, and Manager D acknowledged on 10/02/2025 police were summoned to escort Resident 1 back to the facility to verify facility staff would allow Resident 1 to return to their home. Administrator A acknowledged a self-report was not sent to the Department.

On 11/05/2025, Surveyor reviewed IR#2025-00435558 from the local police department. On 10/02/2025 at 2:22 AM, Officer K documented the following, "10/02/2025 00:28:58 (12:28 AM) ...[Resident 1] GOT DISCAHRGED (sic.) AND SUPERIOR AMBO (ambulance) TOOK [Resident 1] HOME TO ABOVE ADDRESS AND STAFF REFUSED TO LET [Resident 1] GO IN THE FACILITY
10/02/2025 00:29:12 (12:29 AM)...PT IS NOW BEING BROUGHT HACK TO SMER (emergency room)
10/02/2025 00:30:28 (12:30 AM)...17 HAS TRIED MULTIPLE NUMBERS FOR THOSE ON SITE AND THEY ARE REF (sic.) TO ANSWER THE PHOEN (sic.)
10/02/2025 01:34:30 (1:34 AM)...Ultimately, I was able to get a hold of someone in a Supervisor position that was able to get in contact with the Hospital. The resolve is to have [Resident 1] return to senior living facility tonight and the staff can figure out the situation further in the morning when Managers/directors are on scene and available. Currently (sic.) awaiting for EMS to arrive (sic.) with [Resident 1]. Hospital nurse request PD (police department) wait till [Resident 1] is in room before leaving.
10/02/2025 02:21:35 (2:21 AM)...Superior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

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N 164	Continued From page 4 EMS(2484) transported [Resident 1] to facility and [Resident 1] was placed into room without incident. PD and EMS cleared from facility shortly after ...". CROSS REFERENCE: N0214 DHS Chapter 83.15(3)(a) Administrator Shall Supervise Daily Operation CROSS REFERENCE: N0355 DHS Chapter 83.32(3)(k) Rights Of Residents: Self Determination	N 164		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on record review and interview, Administrator A didn't supervise the daily operation of the CBRF. S/He didn't provide the supervision necessary to ensure Resident 1 received proper treatment and their rights were respected. On 11/04/2025, Surveyor requested documentation of notable incidents which	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 214	Continued From page 5	N 214		

occurred to Resident 1 during the month of October 2025 from Administrator A. Surveyor reviewed Resident 1's facility record. Documentation of Resident 1's experience of being refused re-entrance into facility upon return from ER and the police presence summoned in response was absent from Resident 1's facility record.

On 11/04/2025 from approximately 10:25 AM to 11:55 AM, Surveyor asked Administrator A three times if s/he was aware of any recent notable incidents involving Resident 1 that Surveyor should be made aware of. Administrator A reported s/he could not recall any recent incidents that Surveyor should be made aware of.

On 11/04/2025 at 12:00 PM, Surveyor interviewed Administrator A, Assistant Director B, Executive C, and Manager D. During interview Assistant Director B and Manager D verbalized knowledge of facility staff not allowing Resident 1 to return to their home from the ER, which resulted in local police being summoned to the facility. Following Assistant Director B and Manager D's statements. Administrator A acknowledged s/he didn't report police presence at facility via self-report to the Department, or provide documentation about the incident to Surveyor upon request.

FINDINGS INCLUDE:

The facility provided care to the following client groups: irreversible dementia/Alzheimer's disease.

On 10/27/2025, the Department received a complaint with allegations of police presence at facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR SENIOR LIVING	6550 SCHROEDER RD MADISON, WI 53711

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N 214	Continued From page 6 On 11/04/2025, Surveyor arrived at facility for a complaint investigation. As a result of this survey the complaint was substantiated. The following 4 violations of DHS Chapter 83 were identified: 1.) 83.12(4)(b) Reporting When Law Enforcement Is Called 2.) 83.15(3)(a) Administrator Shall Supervise Daily Operation 3.) 83.32(3)(k) Right Of Residents: Self-Determination 4.) 83.35(3)(d) Service Plans Updated Annually Or On Changes On 11/04/2025 at approximately 10:25 AM, Surveyor requested all self-reports filed with the Department in 2025 from Administrator A and Resident 1's facility record. On 11/04/2025, Surveyor reviewed all self-reports filed with the Department in 2025. Surveyor didn't review any self-reported documentation of law enforcement personnel being summoned to the facility during October 2025. On 11/04/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 03/20/2019. Resident 1 had Family Member E listed as his/her activated power of attorney. Resident 1 was diagnosed with but not limited to: major depressive disorder, restless leg syndrome, multiple sclerosis, generalized muscle weakness and history of urinary tract infections (UTI). On 11/04/2025 at approximately 11:50 AM, Surveyor asked Administrator A if s/he had any more self-reports for the month of October 2025. Administrator A left to review records in his/her office. Administrator A returned and stated s/he	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR SENIOR LIVING	6550 SCHROEDER RD MADISON, WI 53711

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N 214	Continued From page 7	N 214		

didn't have any self-reports for the month of October 2025. Surveyor then asked Administrator A if anything reportable happened at the facility during the month of October 2025. Administrator A denied knowledge of any reportable incidents occurring during the month of October 2025. Surveyor asked Administrator A if s/he as the facility administrator was aware of any reportable incidents occurring at facility during the month of October 2025. Administrator A reported s/he couldn't recall any notable incidents.

On 11/04/2025 at 12:00 PM, Surveyor discussed the above concerns with Administrator A, Assistant Director B, Executive C, and Manager D. Administrator A and Assistant Director B were physically present during the interview. Executive C and Manager D had joined the meeting via speaker phone. Manager D stated on 10/01/2025 Caregiver J assessed Resident 1 was experiencing altered mental status and summoned an ambulance to transport Resident 1 to an ER. Manager D acknowledged this was the first ambulance trip Resident 1 took to the ER that night. Assistant Director B stated the hospital had called him/her that night and told him/her facility staff were not allowing Resident 1 to re-enter the facility. Assistant Director B acknowledged facility staff had refused to allow Resident 1 to return to his/her home, and Resident 1 was returned to the ER. Assistant Director B acknowledged hospital had called local police in response to Resident 1 being turned away from the facility. Assistant Director B stated s/he had been called by the local police to discuss Resident 1's return to the facility. Administrator A, Assistant Director B, Executive C, and Manager D acknowledged on 10/02/2025 police were summoned to escort Resident 1 back to the facility to verify facility staff would allow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR SENIOR LIVING	6550 SCHROEDER RD MADISON, WI 53711

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N 214	Continued From page 8	N 214		

Resident 1 to return to their home. Administrator A acknowledged a self-report was not sent to the Department, and Surveyor was not provided documentation of the incident upon request.

On 11/05/2025, Surveyor reviewed IR#2025-00435558 from the local police department. On 10/02/2025 at 2:22 AM, Officer K documented the following, "10/02/2025 00:28:58 (12:28 AM) ...[Resident 1] GOT DISCAHRGED (sic.) AND SUPERIOR AMBO (ambulance) TOOK [Resident 1] HOME TO ABOVE ADDRESS AND STAFF REFUSED TO LET [Resident 1] GO IN THE FACILITY
10/02/2025 00:29:12 (12:29 AM)...PT IS NOW BEING BROUGHT HACK TO SMER (emergency room)
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10/02/2025 01:34:30 (1:34 AM)...Ultimately, I was able to get a hold of someone in a Supervisor position that was able to get in contact with the Hospital. The resolve is to have [Resident 1] return to senior living facility tonight and the staff can figure out the situation further in the morning when Managers/directors are on scene and available. Currently (sic.) awaiting for EMS to arrive (sic.) with [Resident 1]. Hospital nurse request PD (police department) wait till [Resident 1] is in room before leaving.
10/02/2025 02:21:35 (2:21 AM)...Superior EMS(2484) transported [Resident 1] to facility and [Resident 1] was placed into room without incident. PD and EMS cleared from facility shortly after ...".

CROSS REFERENCE: N0164 DHS Chapter 83.12(4)(b) Reporting When Law Enforcement Is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR SENIOR LIVING	6550 SCHROEDER RD MADISON, WI 53711

(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 214	Continued From page 9 Called CROSS REFERENCE: N0355 DHS Chapter 83.32(3)(k) Rights Of Residents: Self-Determination	N 214		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's right of self-determination related to daily routines and other aspects of life which enhanced Resident 1's self-reliance and supported his/her autonomy and decision making was supported. On 10/01/2025, Resident 1 was sent to a local emergency room (ER). While in the ER Resident 1 was treat for a urinary tract infection and prescribed antibiotics. ER discharged Resident 1 from the hospital back to their home at facility. ER sent Resident 1 back to facility in an ambulance with EMS (emergency medical personnel). When EMS and Resident 1 returned to the facility. Facility staff would not unlock the front entrance and refused to acknowledge EMS staff or Resident 1. EMS staff were forced to transport Resident 1 back to the ER. Upon return to the ER. ER Nurse called the local	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR SENIOR LIVING	6550 SCHROEDER RD MADISON, WI 53711

(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 355	Continued From page 10	N 355		

police department. Officer K escorted EMS staff and Resident 1 back to the facility. Officer K stayed with Resident 1 until EMS staff were permitted to return Resident 1 to their room within the facility.

FINDINGS INCLUDE:

On 10/27/2025, the Department received a complaint with allegations of police presence at facility.

On 11/04/2025, Surveyor arrived at facility for a complaint investigation.

On 11/04/2025 at approximately 9:15 AM, Surveyor requested all self-reports filed with the Department in 2025 from Receptionist K.

On 11/04/2025 at approximately 10:25 AM, Surveyor requested Resident 1's facility record.

On 11/04/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 03/20/2019. Resident 1 had Family Member E listed as his/her activated power of attorney. Resident 1 was diagnosed with but not limited to: major depressive disorder, restless leg syndrome, multiple sclerosis, generalized muscle weakness and history of urinary tract infections (UTI).

On 11/04/2025, Surveyor reviewed Resident 1's ISP signed by Family Member E on 10/10/2025. The front page of ISP documented urinary tract infection as a diagnosis on 02/17/2025. Under the subsection titled, "CHRONIC ILLNESS," the following was documented, "Resident has a history or reoccurring urinary tract infections. Monitor resident for signs and symptoms of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 355	Continued From page 11	N 355		

urinary tract infections including fever, flank pain, unusual urine pattern and discomfort when urinating ...".

On 11/04/2025, Surveyor reviewed Resident 1's observations notes from 09/01/2025 to 11/04/2025:
1.) On 10/01/2025 at 7:00 PM, Facility Nurse H documented the following, "Resident noted to have increased confusion, weakness and increased fatigue. POA made aware and resident sent out to [Local ER] for evaluation/workup. Will await updates."
2.) On 10/02/2025 at 12:00 PM, Facility Nurse H documented the following, "Resident arrived back to the community very early morning this morning. Per after visit summary, "You have a bladder infection. We are going to start you on oral antibiotics to help clear this up. Start Bactrim DS. Take 1 tablet by mouth every 12 hours for 10 days. Order sent to [Name Of Pharmacy]. Diagnosis Acute cystitis without hematuria (blood in urine) and confusion ...Writer reached out to PCP at this time to make aware. Write also reached out to [Name Of Pharmacy] to make sure order was received. Order will be delivered later this afternoon and started tonight. We will continue to monitor the resident and update with any questions or concerns. Resident was doing okay today, did not want to get out of bed, but ate both meals in [his/her] room well. Continues to be weaker, confused and tired."

On 11/04/2025, Surveyor reviewed Resident 1's ER discharge summary. The discharge summary was dated 10/01/2025. Resident 1 was diagnosed with a bladder infection and oral antibiotics were ordered to be dispensed by pharmacy.

On 11/04/2025, Surveyor reviewed Resident 1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 355	Continued From page 12 30-day discharge which was dated 08/11/2025. On 11/04/2025 at 12:00 PM, Surveyor discussed the above concerns with Administrator A, Assistant Director B, Executive C, and Manager D. Administrator A and Assistant Director B were physically present during the interview. Executive C and Manager D had joined the meeting via speaker phone. Administrator A, Assistant Director B, Executive C, and Manager D. Manager D stated on 10/01/2025 Caregiver J assessed Resident 1 was experiencing altered mental status and summoned an ambulance to transport Resident 1 to an ER. Manager D acknowledged this was the first ambulance trip Resident 1 took to the ER that night. Assistant Director B stated the hospital had called him/her that night and told him/her that facility staff were not allowing Resident 1 to re-enter the facility. Assistant Director B acknowledged facility staff had refused to allow Resident 1 to return to his/her home, and Resident 1 returned to the ER via ambulance. Assistant Director B acknowledged hospital had called local police because of Resident 1 being turned away from the facility. Assistant Director B had been called by the local police to discuss Resident 1's return to the facility. Administrator A, Assistant Director B, Executive C, and Manager D acknowledged on 10/02/2025 police were summoned to escort Resident 1 back to the facility to verify facility staff would allow Resident 1 to return to their home. Administrator A, Assistant Director B, Executive C, and Manager D acknowledged Resident 1's right to determine when s/he returns to their home after hospitalization was not followed by facility staff on 10/02/2025. On 11/05/2025, Surveyor reviewed IR#2025-00435558 from the local police	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR SENIOR LIVING	6550 SCHROEDER RD MADISON, WI 53711

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N 355	Continued From page 13	N 355		

department. On 10/02/2025 at 2:22 AM, Officer K documented the following, "10/02/2025 00:28:58 ...[1] [Resident 1] GOT DISCAHRGED AND SUPERIOR AMBO (ambulance) TOOK [Resident 1] HOME TO ABOVE ADDRESS AND STAFF REFUSED TO LET [Resident 1] GO IN THE FACILITY 10/02/2025 00:29:12KMQ2 [2] PT IS NOW BEING BROUGHT HACK TO SMER (emergency room)
10/02/2025 00:30:28KMQ2 [5] 17 HAS TRIED MULTIPLE NUMBERS FOR THOSE ON SITE AND THEY ARE REF (sic.) TO ANSWER THE PHOEN (sic.)
10/02/2025 01:34:305A2 [6] Ultimately, I was able to get a hold of someone in a Supervisor position that was able to get in contact with the Hospital. The resolve is to have [Resident 1] return to senior living facility tonight and the staff can figure out the situation further in the morning when Managers/directors are on scene and available. Currently (sic.) awaiting for EMS to arrive (sic.) with [Resident 1]. Hospital nurse request PD (police department) wait till [Resident 1] is in room before leaving.
10/02/2025 02:21:355A2 [7] Superior EMS(2484) transported [Resident 1] to facility and [Resident 1] was placed into room without
incident. PD and EMS cleared from facility shortly after ...".

On 11/11/2025, Surveyor reviewed case notes from Resident 1's managed care organization (MCO). Case Manager M documented the following on 10/02/2025, "1230AM ER received call from [Name of EMS Provider]. They made it to the [Resident 1's] facility and the doors were locked. EMS states that staff came to the door, refused to identify themselves, and refused to open the doors. EMS states that they were told that the patient has to be accepted by [Facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

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N 355	Continued From page 14	N 355		

Manager N] or [Administrator A]. EMS was told that they need to call them, but staff refused to provide a phone number to them. RN was able to speak with [Resident 1's Family Member] who did give RN [Facility Manager N's] phone number (XXX-XXX-XXXX) but there was no answer. The voicemail was not identifiable. RN did call [Name Of Local Police Department] to go to the facility to find out how we can get the [Resident 1's] home ...0133AM [Local Police Officer] provided RN with the phone number for [Assistant Director B] who identified [himself/herself] as a supervisor of the facility which is no longer called [Name On Facility License], but rather is under the management of [Name On Building], [Name of Management Company]. [Assistant Director B] informed RN that the patient has been struggling with increased weakness associated with [his/her] MS. [Resident 1] has need (sic.) more care than can be provided at the facility. [Assistant Director B] was informed by [his/her] director and manager, [Administrator A] and [Facility Manager N], that the patient can no loner (sic.) be accepted at the facility and [his/her] contract is void at this time. RN did do a quick chart review which showed no contact with [Resident 1's] primary care team about this decline in status and increased care needs. [Resident 1's Family Member] didn't know that this was needed either. RN also informed [Assistant Director B] what [Name of EMS Provider] encounter when bringing the patient back to [his/her] home. [Assistance Director B] did apologize about that treatment and assured RN that would not happen again. When discussing what would be best for [Resident 1] at this time of night, it was decided that the patient will be allowed back into [his/her] home and allowed to go to sleep. [Assistant Director B] will speak with [his/her] superiors to assure that [Resident 1] and [his/her] family are included in

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	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

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N 355	Continued From page 15 the conversation about where [Resident 1] should go where [his/her] needs can be met during the day tomorrow. [Police Officer] was called back and [s/he] states that [s/he] will be there to facilitate the [Resident 1's] safe return to [his/her] home ....". On 11/11/2025, Surveyor reviewed Resident 1's hospital record. On 10/01/2025 at 11:37 PM, Doctor P documented the following, " ...no signs of significant systemic illness, feel appropriate for outpatient management. On review of prior urine cultures, has had Klebsiella and Raoultella (sic.), both susceptible to Bactrim. Discussed with [Family Member F]. Will start on Bactrim, given first dose here, to return to skilled nursing facility, ED return precautions reviewed." CROSS REFERENCE: N0164 DHS Chapter 83.12(4)(b) Reporting When Law Enforcement Is Called CROSS REFERENCE: N0214 DHS Chapter 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 355		
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	N 389		

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 389	Continued From page 16	N 389		

involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure Resident 2's individualized service plan (ISP) was not updated when there was a change in his/her physical condition.

From 09/20/2025 to 10/31/2025, Resident 2 had developed wounds on both to his/her bilateral upper extremities (BUEs) and his/her right lower extremity (RLE). Resident 2 had been observed by staff bumping his/her lower extremity while attempting to self-propel his/her wheelchair with their feet.

Surveyor reviewed Resident 2's ISP. Resident 2's ISP didn't contain documentation of his/her wounds, wound care orders or behaviors related to wound development.

This is a repeat violation of statement of deficiency (SOD) Y8GO11 dated 06/07/2022 and SOD Y8GO12 dated 02/01/2023.

FINDINGS INCLUDE:

OBSERVATION & INTERVIEW:

On 11/04/2025 at approximately 8:45 AM, Surveyor arrived at the facility for a complaint investigation. Surveyor sat down in the first-floor dining room and observed Resident 2's sleeping in his/her wheelchair. Surveyor observed the skin on Resident 2's RLE had 2 large scabs along the bony prominence of the tibia. The size of the

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 389	Continued From page 17	N 389		

superior scab was approximately 2 inches length and 1 inch width. The size of the inferior scab was approximately 3 inches length and 1 inch width. The skin surrounding the scabs appeared to have been red and swollen.

On 11/04/2025 at 8:55 AM, Surveyor asked Receptionist K about Resident 2's right leg. Receptionist K acknowledged Resident 2's RLE had two scabs. Receptionist K stated hospice provider had been made aware of the wounds. Receptionist K stated Resident 2 had recently stared using his/her feet to "scoot" around in his/her wheelchair and had bumped his/her legs into things,

On 11/04/2025 at approximately 10:11 AM, Surveyor observed Hospice Nurse G assess Resident 2 in the facility livingroom. Surveyor observed Hospice Nurse G lightly palpate the reddened skin on Resident 2's RLE. Resident 2 grimaced and when asked if his/her RLE extremity hurt, s/he said, "yes."

On 11/04/2025 at 10:32 AM, Surveyor interviewed Hospice Nurse G in the hallways. Hospice Nurse G stated Resident 2 currently had multiple wounds being dressed by hospice and monitored by the facility. Hospice Nurse G stated Resident 2 had a skin tear on his/her right upper extremity since the beginning of October. Hospice Nurse G stated facility reported Resident 2 had developed injury to the RLE on Friday 10/31/2025. Hospice Nurse G stated s/he still had not been told how Resident 2 obtained the injuries to his/her RLE. Hospice Nurse G reported swelling of the RLE appeared to have worsened since his/her initial assessment on 10/31/2025. Hospice Nurse G stated facility staff were responsible for monitoring Resident 2's skin and reporting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BRIGHTSTAR SENIOR LIVING	6550 SCHROEDER RD MADISON, WI 53711

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N 389	Continued From page 18	N 389		

concerns to hospice. Hospice Nurse G stated facility staff were also responsible for replacing band-aids if they fall off between hospice visits and applying tubi-grips over the wound dressing on BUEs. Hospice Nurse G reported facility staff had consistently followed orders to maintain bandages, apply daily tubi-grips, and report concerns to hospice. Hospice Nurse G reported hospice sees Resident 2 once weekly and as needed.

On 11/04/2025 at 10:28 AM, Surveyor discussed Resident 2's wounds with Administrator A. Administrator A stated Resident 2's condition had recently worsened. Administrator A stated Resident 2 had recently started using his/her feet to move his/her wheelchair. Administrator A stated s/he believed Resident 2's wounds on the RLE were from him/her bumping his/her legs into his/her surroundings.

RECORD REVIEW:

On 10/27/2025, the Department received a complaint with allegations of police presence at facility.

On 11/04/2025, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted to the facility on 09/03/2019. Resident 2's had an activated power of attorney. Resident 2 was on hospice service. Resident 2 was diagnosed with but not limited to: dementia, glaucoma, essential hypertension, unspecified atrial fibrillation and osteoporosis.

On 11/04/2025, Surveyor reviewed Resident 2's observation notes from 01/01/2025 to 11/04/2025: 1.) On 09/20/2025 at 3:30 PM, Facility Nurse H documented the following, "Resident seen by

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	0015502	A. BUILDING: _____ B. WING _____	C 11/04/2025

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N 389	Continued From page 19 Agrace RN today. Per email, "Hi, I went to see [Resident 2] today for a nursing visit for what was thought to be new skin tear wounds ...[Resident 2] could not tell me where new wounds were located, and I found bandages loose around right forearm ...skin tears were clean and not bleeding or draining, wound care completed ...Education and Collaboration: Facility staff were encouraged to call [Name of Hospice Provider] with any additional questions, concerns, changes or needs as they arise ..." 2.) On 09/23/2025 at 10:45 AM, Facility Nurse H documented the following, " ...Per orders, "Wound care of skin tear to right forearm: Wash with foam cleanser, pat dry, apply skin prep and cover with band aid to be changed once weekly with measurements from [Name of Hospice Provider] until EOL ..." 3.) On 10/01/2025 at 4:45 PM, Facility Nurse H documented the following, "Resident seen by [Name of Hospice Provider] today. Per notes, "Writer noted pt has new opening to [his/her] RUE and completed wound care at this time. Writer also placed tubi grips at this time to BUE's (bilateral upper extremities) for protection. 4.) On 10/02/2025 at 12:30 PM, Facility Nurse H documented the following, "Writer received two new orders from [Name of Hospice Provider]. New orders, "Apply tubi grips to right and left arm daily in the morning and remove then in bed at night." Order added to MAR. Next new order, "Wound care of skin tear to RUE: Remove old bandage, cleanse with soap and water or wound cleanser and pat dry, apply skin prep to peri-wound cover with foam bandage. [Name of Hospice Provider] to change every 5-7 days and as needed if dressing becomes too loose or soiled, may discontinue once healed ...". 5.) On 10/23/2025 at 11:45 AM, Facility Nurse H documented Resident 2 had developed a skin	N 389		

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 389	Continued From page 20	N 389		

tear to RUE during shower.
6.) On 10/28/2025 at 1:30 PM, Facility Nurse H documented the hospice nurse had reported Resident 2 had developed a new skin tear on his/her LUE.
7.) On 10/31/2025 at 2:45 PM, Facility Nurse H documented the following, "Writer received email update from [Hospice Nurse G] regarding residents lower extremities. Resident will often try to get out of [his/her] recliner/wheelchair and try to self-propel in [his/her] wheelchair and will bump into objects that are in front of [him/her]. [S/He] often sits out in the common area to help assist with this. Lower extremities are not open at this time. Areas are scabbed over. No interventions needed at this time. Continue to monitor resident and lower extremities and see if and when additional interventions may be needed.

On 11/04/2025, Surveyor reviewed Resident 2's physician orders. On 10/02/2025 at 12:30 PM, the order for tubi-grips to be applied once daily in the morning to BLE and removed at night.

On 11/04/2025, Surveyor reviewed Resident 2's ISP. Resident 2's ISP was signed by Family Member I on 08/25/2025. The ISP didn't contain documentation of Resident 2's wounds or wound care orders. The ISP didn't contain documentation of Resident 2's behavior of attempting to self-propel his/her wheelchair or to get up from his/her wheelchair being the cause of wounds to his/her lower extremities.

EXIT INTERVIEW:

On 11/04/2025 at 12:00 PM, Surveyor discussed the above concerns with Administrator A, Assistant Director B, Executive C, and Manager

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N 389	Continued From page 21 D. Administrator A acknowledged Resident 2 had wounds on 3 of his/her 4 extremities. Administrator A acknowledged Resident 2 recently developed a behavior which caused wounds to his/her RLE. Administrator A acknowledged Resident 2's ISP didn't contain documentation of Resident 2's wounds, wound care, or behaviors related to wound development.	N 389		