STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 02/03/2026, Surveyors conducted a verification visit at Courtyard at Fitchburg - Memory Care, a CBRF in Fitchburg. Three deficiencies were identified. Three of 3 deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025, SOD HT4311, dated 06/26/2025 and SOD HT4312, dated 10/30/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 20	{N 000}		
{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 record review and interview, the provider did not ensure 2 of 5 residents reviewed received medications as prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025 and SOD HT4312, dated 10/30/2025. From 01/22/2026 to 02/03/2026, Resident 2 did not receive his/her Lorazepam as prescribed.	{N 352}		

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
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 352}	Continued From page 1 Resident 2 did not receive his/her Lantus as prescribed on 12/29/2026. From 12/26/2025 to 02/02/2026, staff administered Resident 17's Midodrine on 3 occurences even though his/her blood pressure fell within parameters to hold the medication. Findings include: On 02/03/2026, Surveyors conducted a verification visit. Surveyors identified the following concerns: RESIDENT 2 On 02/03/2026 at 10:45 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 10/07/2024 with diagnoses included diabetes and dementia. Resident 2's record, dated 12/26/2025 to 02/03/2026, documented the following concerns with prescription orders: Lorazepam Resident 2's record included a physician order, dated 01/22/2026, for Lorazepam 1 mg 3 times daily for behaviors. Resident 2's Medication Administration Record (MAR), dated 01/22/2026 to 02/03/2026, documented Resident 2 was administered Lorazepam .5 mg at 8:00 a.m. and Lorazepam 1 mg at 4:00 p.m. and 10:00 p.m. On 02/03/2026 at 1:00 p.m., Surveyor interviewed Regional Wellness Director C and shared concern that Resident 2 was not receiving Lorazepam 1 mg 3 times daily as ordered. Regional Wellness Director C stated, "That should have been changed in [electronic charting program]."	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 352}	Continued From page 2 On 02/03/2026 at 2:00 p.m., Surveyor reviewed the medication cart with Med Tech U. Med Tech U confirmed the medication cart contained Lorazepam .5 mg for Resident 2's 8:00 a.m. administration rather than 1 mg as ordered. Lantus Resident 2's physician orders included Lantus 100 unit/ml (Start Date: 08/26/2025 / End Date: 01/13/2026) - Inject 15 units in the morning and 11 units at bedtime. The order did not include hold parameters. Resident 2's MAR documented Lantus was held on 12/27/2025 at 7:38 p.m. for a blood sugar (BS) of 61. A notation stated "Blood sugar too low to give insulin." On 02/03/2026 at 1:00 p.m., Surveyor interviewed Regional Wellness Director C and asked why Resident 2's Lantus was held when the order did not include hold parameters. Regional Wellness Director C replied, "That's company policy." Regional Wellness Director C provided Surveyor with a "Blood Sugar Testing" policy that stated, "If BS is below 70, give one of the following: glass of juice, glass of non-diet soda, glass of milk, 1 Tbsp of honey or 1 Tbsp of sugar, etc., and recheck level in 15 minutes. If still less than 70 repeat treatment as above, recheck in 15 minutes, and call Wellness Director." Surveyor discussed that the policy did not state to hold medication and that Resident 2's record did not include documentation of a recheck or discussion with a Wellness Director. Regional Wellness Director C confirmed s/he did not have follow up documentation. Regional Wellness Director C stated the Wellness Director would instruct staff to hold the medication.	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 352}	Continued From page 3 RESIDENT 17 Resident 17 was admitted to the provider on 06/24/2024 with a diagnosis of dementia. Resident 17's most recent individual service plan (ISP) dated 01/07/2026 indicated staff administer his/her medications. Resident 17's physician orders included "Midodrine 5 mg tablet with instructions to take 1 tablet by mouth 3 times a day with meals *4hrs apart* *Hold if systolic BP is over 120**Hold if systolic BP (top number) is greater than 120 *This medication raises blood pressure. Start date: 12/11/2025." Resident 17's MAR from 12/26/2025 to 02/02/2026, documented the following: -01/02/2026 (12pm administration): Blood pressure documented as 143/84, Midodrine administered. -01/18/2026 (12pm administration): Blood pressure documented as 143/81, Midodrine administered. 01/28/2026 (4pm administration): Blood pressure documented as 128/59, Midodrine administered. EXIT On 02/03/2026 at approximately 2:25 p.m., Surveyors reviewed medication concerns with Regional VP of Operations B, Regional Wellness Director C and Executive Director J. All individuals made note of the concern and did not make follow up comments.	{N 352}		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 431}	Continued From page 4 to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 6 residents reviewed had their health monitored. Resident 2's diabetes were not monitored as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025, SOD HT4311, dated 06/26/2025 and SOD HT4312, dated 10/30/2025.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 431}	Continued From page 5 Findings include: On 02/03/2026 at approximately 10:45 a.m., Surveyor reviewed Resident 2's record. Resident 2's physician orders included Insulin Lispro 100 unit/ml (Start Date: 12/05/2026 / End Date: 01/13/2026) - Inject 5 units 3 times daily with meals plus sliding scale Blood sugar (BS) 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, >500=6 units. *If less than 70 treat with 15 g of carbs (if not eating meal) and recheck in 15 min until >100. Call clinic if reading is not more than 70 after 30 minutes. If >400, treat with sliding scale and recheck in 15 minutes. If not <400 after 1 hour, call clinic. An additional Insulin Lispro 100 unit/ml (Start Date: 01/19/2026 / End Date: 01/24/2026) stated to contact physician for BS greater than 350. Resident 2's record documented the following concerns with diabetic management: - 01/06/2026 5:30 p.m. BS 66. Documentation stated, "Rechecked in 15 minutes. It was 77." *Documentation did not include follow up after the BS check of 77. - 01/08/2026 12:22 p.m. BS 54. Documentation of follow up was a progress note, dated 01/13/2026, that stated late entry for 01/08/2026 - Rechecked residents blood sugar. Went up to approximately 100. *Documentation was completed 5 days after the BS reading and did not include exact BS reading. - 01/09/2026 9:29 a.m. BS 50. Documentation of follow up was a progress note, dated 01/13/2026, that stated late entry for 01/09/2026 - Rechecked BS after meal and was approximately 110 (between 100 and 120).	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 431}	Continued From page 6 *Documentation was completed 4 days after the BS reading and did not include exact BS reading. - 01/22/2026 5:04 p.m. BS 404. *A recheck was not documented and a notification to physician was not documented. A progress note, dated 01/22/2026 at 10:00 p.m., documented Resident 2 was sent out later that evening following a BS of 571 documented at 9:36 p.m. A progress note, dated 01/23/2026, stated Resident 2 returned to the facility with no new diagnosis and no new orders. On 02/03/2026 at approximately 1:00 p.m., Surveyor interviewed Regional Wellness Director C and reviewed health monitoring concerns with Resident 2's diabetic management. Regional Wellness Director C reviewed Resident 2's record and stated s/he was unable to locate records to indicate additional monitoring had occurred for BS readings outside parameters.	{N 431}		
{N 432}	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs.	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 432}	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 5 residents reviewed received medication administration services to meet their needs. This is a repeat deficiency. See Statement of Deficiency (SOD) HT4312, dated 10/30/2025. Resident 2 did not receive his/her PRN medications for hypoglycemia when s/he had a blood sugar of 26. Resident 11 did not receive PRN medication for pain control when exhibiting signs of pain. Resident 18 did not receive PRN medication for pain control when exhibiting signs of pain. Findings include: On 02/03/2026, Surveyors reviewed resident records and identified the following medication administration concerns: Example 1 - Resident 2: On 02/03/2026 at 10:45 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 10/07/2024 with diagnoses including diabetes and dementia. Resident 2's record included a progress note, dated 12/29/2025, that stated "Staff went into [Resident 2]'s room during rounds and found [Resident 2] unresponsive. They called the med tech and [s/he] took [his/her] blood sugar and it was [capillary blood sugar] 26. [Individual] came and got [Regional Wellness Director C] and [Resident 2]	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 432}	Continued From page 8 was unresponsive, but would yell out with repositioning. 911 was called at the same time [Individual] came and got the nurse. [Local emergency services] called and took [Resident 2] to [hospital] ...". Surveyor noted Resident 2's physician orders included the following PRN medications: - Baqsimi 3 mg/actuation nasal spray (Start Date: 08/12/2025) - Instill 1 spray in 1 nostril as needed for severally low blood sugar. If no response after 15 minutes, give additional dose from a new device. - Glutose 15 40% (Start Date: 08/12/2025) - Take 1 packet by mouth or sublingually as needed for hypoglycemia. On 02/03/2026 at 1:00 p.m., Surveyor interviewed Regional Wellness Director C regarding Resident 2's hypoglycemic episode on 12/29/2025. Regional Wellness Director C stated s/he was present that day and felt s/he made the right call by contacting 911. Surveyor asked why Resident 2's PRN medications were not administered. Regional Wellness Director C stated s/he would not have administered Glutose 15 40% in the state that Resident 2 was in at the time and s/he was unaware that Resident 2 had orders for the Baqsimi nasal spray. Example 2 - Resident 11 On 02/03/2026 at 1:00 p.m., Surveyor reviewed Resident 11's record. Resident 11 was admitted to the provider's facility on 05/20/2025. Resident 11's individual service plan (ISP), dated 12/09/2025, stated Resident 11 had PRN orders for acetaminophen for pain/fever and morphine for pain	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 432}	Continued From page 9	{N 432}		

or shortness of breath. The ISP stated staff should monitor for signs and symptoms of pain such as crying, wincing, self-isolating and guarding. Resident 11's record included the following progress notes and incident report:

- 01/29/2026 9:00 a.m. Incident Report: Caregiver noted swelling to right arm. Right upper extremity was swollen, warm and tender to touch with slight bruising noted. Pain level 8. EMS called. Health Care Power of Attorney refused transport.
- 01/29/2026 4:30 p.m. Progress Note: Writer notified by care staff that resident appears to be in significant amounts of pain with touching and/or moving right upper extremity. Swelling has increased since earlier today, remains warm to touch, bruising on top of hand more prevalent, redness noted between thumb and index finger on right hand, and area painful with palpation and type of movement, where resident screams out. Health Care Power of Attorney declined 911 being called. Provided education to med tech to utilize PRN Tylenol for pain control, continue with elevation and call hospice with further concerns.
- 01/30/2026 6:15 a.m. Residents right hand was swollen and s/he was in pain when staff tried assisting him/her. PRN Tylenol given during overnight shift.
- 01/30/2026 6:30 a.m. Swelling has significantly decreased, light bruising remains present on top of hand, area remains tender to touch with pain noted upon movement. Left hand appears swollen today, no other abnormalities noted, and no tenderness of pain with palpation or movement. Writer advised staff to continue to use PRN Tylenol for pain and report any new concerns and/or changes.
- 01/31/2026 6:15 a.m. Resident is still in pain, writer noted that resident always yells when staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 432}	Continued From page 10 are assisting him/her. Resident 11's physician orders included a scheduled order of Acetaminophen 325 mg (Start Date: 11/20/2025) - 2 tablets 2 times daily and PRN orders for Acetaminophen 325 (Start Date: 07/03/2025) - 2 tablets every 4 hours as needed for pain or fever (Max 3000 mg/24 hour period) and Morphine Sulfate 100 mg/5 ml (Start Date: 01/23/2026) - .25 ml every 4 hours as needed for pain/shortness of breath. Resident 11's Medication Administration Record (MAR), dated 01/29/2026 to 02/01/2026, documented 1 administration of Acetaminophen 325 mg PRN on 01/29/2026 at 4:54 p.m. (greater than 7 hours after incident report documented pain level of 8 at 9:00 a.m.) and 01/30/2026 at 12:19 a.m. The MAR did not document any additional Acetaminophen PRN administrations as instructed in progress note, dated 01/30/2026 6:30 a.m., including after documented observation of pain on 01/31/2026 at 6:15 a.m. The MAR did not document any administrations of Morphine. On 02/04/2026 at approximately 1:30 p.m., Surveyor interviewed Caregiver V. Caregiver V stated s/he recalled Resident 11's swollen and painful right upper extremity. Caregiver V stated Resident 11 would call out with pain, but that the swollen had now gone down and staff were elevating the right upper extremity with a pillow. Example 3 - Resident 18 On 02/03/2026, Surveyor reviewed Resident 18's record. Resident 18 was admitted to the facility on 10/14/2024 with a diagnosis of obesity and age-related osteoporosis. Resident 18 had an	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 432}	Continued From page 11	{N 432}		

activated healthcare power of attorney. Resident 18's ISP dated 12/10/2025 documented: "Medications administered by staff, Capacity for self direction: cannot make needs known was checked, PRN psychotropic/pain medications: staff will administer [Resident 17's] PRN Acetaminophen (pain) as ordered by [his/her] provider (See MAR). [Resident 17] is able to verbalize pain, however staff will monitor for non-verbal signs (wincing, Rubbing, Crying, Guarding, etc.). Document and report any possible side effects." Further, the ISP stated Resident 18 frequently walks and wanders into other resident rooms and staff to assist when s/he seems lost or confused.

Resident 18's physician orders included the following: "Acetaminophen 325 mg with instructions to take 2 tablets (650 mg) by mouth 3 times a day (max 3000mg Apap/24hrs), with a start date of 11/14/2025 and PRN orders for Acetaminophen 500 mg with instructions to take 2 tablets by mouth every 8 hours as needed (pain) (max 3000mg Apap/24hrs), with a start date of 06/21/2025. Resident 18's MAR dated 12/26/2025 to 01/02/2026 did not document any administrations of PRN Acetaminophen.

The provider submitted a self-report dated 01/05/2026. The following was documented: "On December 28th 2025, during AM shift, staff observed a change in [Resident 18's] transfer ability. [Resident 18] needed assistance when standing from a chair, [s/he] usually was independent with transfers. These observations were communicated during shift handoff. No fall was witnessed or reported at that time. On December 29, 2025, on the PM shift after supper,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 432}	Continued From page 12 staff contacted [Regional Wellness Director C]. Wrist was hard swellen [sic] and painful to touch. Wrist was reassessed on December 30th in the morning with no change and PCP was updated requesting further evaluation. On December 30, 2025, [Resident 18] was taken to urgent care by [his/her] [daughter/son POA] for medical evaluation. At that time, [s/he] was diagnosed with a right wrist fracture and treated with a cast before returning to the community. X-ray findings from urgent care included a comminuted impacted intra-articular fracture of the right distal radius with dorsal displacement and angulation. Extensive calcific density material is seen about the distal ulna, which may be related to severe chondrocalcinosis from prior trauma." Resident 18's progress notes documented: "-12/30/2025 at 3:00 PM: Writer contacted [HC POA] regarding swelling, discomfort, and hardness or right wrist. [Family member] will arrive to community within the hour and take resident to urgent care to have right wrist evaluated. Writer made care staff aware of above plan. @ 1:30 PM: Right wrist is swollen and painful and very hard to the touch. No bruising and no redness. Fax sent to [physician] to update and further interventions. Pain started yesterday, but more swollen today when PCP updated. 01/07/2026: This document is an observation that was missed during the shift of December 29, 2025. Upon notification from [staff], I observed a bruise on palm of resident and a swollen arm, and immediately notified [Regional Wellness Director C], who was on site. [Regional Wellness Director C] assessed the resident's arm and informed [staff] and me that it appeared to be fluid retention, and [s/he] would notify resident's doctor. No further	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 432}	Continued From page 13 instructions were provided regarding the resident's arm. 01/09/2026: late entry 12/29/25 while working with [Resident 18] today staff notice that [Resident 18] wouldn't get out the chair without being help when ask was [s/he] in pain [s/he] said [his/her] back was hurting. At shift change the next set of staff members was informed that we thought [s/he] feeling under the weather Upon arriving to work on 12/30/25 I was ask by the other med tech did I see [Resident 18's] arm. I said not [s/he] took me to go look at [Resident 18's] right wrist and I saw it was swollen and we informed [Regional Wellness Director C] ..." Resident 18's incident report dated 12/30/2025 at 9:50 AM documented: "Injury-Unknown Source: Wrist was swellen [sic] and painful to touch at 7pm. Wrist was reassessed the next morning, PCP updated, no response so called [daughter/son] and [s/he] took [Resident 18] to urgent care dx with right wrist fracture. No fall noted." On 02/03/2026, Surveyor reviewed the provider's investigation into Resident 18's injury of unknown source dated 01/05/2026 including staff statements. The following was documented: "Abuse/neglect ruled out through investigation statements 12/28-12/30/25. Incident ruled as unknown, unwitnessed fall where the resident assisted [him/herself] back up and did not tell anyone. Staff became aware of [his/her] change of condition when signs of change of condition. Statt statements: "I, [Caregiver W] noticed [Resident 18's] right hand & arm was bruised/blue and felt very hard like stone last night on 12/29/25. While I was getting	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 432}	Continued From page 14 [him/her] dressed for bed, I reported the incident to the nurse on site & staff that was working with me, I also told next shift which was NOC & wrote it in task sheet binder." "[Caregiver X]: On the 28th, I noticed that [Resident 18] was asking for help to get out of [his/her] chair which is something [s/he] don't do normally, I helped [his/her] up and [s/he] was complaining of back pain at shift change we informed incoming staff that [Resident 18] was not feeling well they alerted [Regional Wellness Director C] and I did follow up on [Resident 18] on the 29th and that's when I was told [s/he] maybe had fluid buildup on [his/her] hand. I never witnessed a fall or saw how the injury occurred." "[Caregiver P]: I worked both dates and [s/he] kept saying [his/her] arm hurting but I didn't know what was wrong, I reported to [staff] on 12/29/25." "[Caregiver Y]: I worked on the 12/28 and 12/29 at the [provider's name] both noc shift. I didn't observe or noticed anything injuries on [Resident 18] on the 12/28 but I was notified by a staff member about the injury when I was counting the meds the night before [s/he] was sent out to the urgent care. After I was informed about the injury I checked on the resident and noticed that one of [his/her] hand was swollen and harden near [his/her] wrist. And I also informed the AM MedT about the injury and but the nurse was notified about the injury by PM staff already. Someone on PM shift cause they were telling me about the injury and [Regional Wellness Director C] not suggesting the resident shouldn't be sent out because it might be a reaction or something but I didn't recall the person who mentioned that. Yes, I	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 432}	Continued From page 15 was informed about the injury by both the caregivers and the MedT on the night before the resident was sent out to the urgent care I believe." "[Caregiver Z]: I noticed [Resident 18] arm on 12-29-2025 after dinner when [Caregiver W] called me into the room as [s/he] was trying to get [him/her] toileted and changed for bed and we assessed [his/her] arm and noticed it was hard and [s/he] didn't want us to touch it." "[Caregiver AA]: On 12-29-25, [Caregiver W] called me to come look at [Resident 18] and [his/her] wrist. I viewed [Resident 18's] wrist and noticed it was tender to touch, the slightest pressure made [him/her] say "ouch" and pull away. [Regional Wellness Director C] was present in the building and informed." On 02/03/2026 at 9:25 AM, Surveyor interviewed Caregiver P. Caregiver P reported s/he worked 12/28 and 12/29 with Resident 18. Caregiver P reported Resident 18 complained his/her wrist was hurting, so s/he told the med passer. Caregiver P did not know if any PRN medications were given to Resident 18. In summary, Resident 18 started to show a change in condition on 12/28/2025, staff reported his/her wrist was bruised, hardened like stone, tender to touch, the slightest pressure made him/her say "ouch" and pull away, and Resident 18 reported to multiple staff his/her wrist hurt. Resident 18 did not receive PRN medication for pain control when exhibiting signs of pain. EXIT	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, 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 432}	Continued From page 16 On 02/03/2026 at approximately 2:25 p.m., Surveyors reviewed medication concerns with Regional VP of Operations B, Regional Wellness Director C and Executive Director J. All individuals made note of the concern and did not make follow up comments.	{N 432}		