STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 02/11/2026, the bureau of assisted living southern regional office conducted 2 complaint investigations at Brookdale Madison West AL/MC a CBRF located in Madison, WI. As a result of this survey, 4 violations of DHS Chapter 83 were identified. Two of 2 complaints were substantiated. Census: 28	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 ensure Resident 1's legal representative was immediately notified of a significant change in his/her physical and mental condition. On 12/04/2026, Facility staff observed Resident 1 to be more confused than usual. This observation was reported to his/her primary care provider (PCP). The following day Resident 1's PCP prescribed an antibiotic treatment for a urinary	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
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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	N 169		

tract infection (UTI).

From 12/05/2025 through 12/08/2025, Provider hadn't reported Resident 1's increased confusion, UTI diagnosis or initiation of antibiotic treatment to his/her activated power or attorney (Family Member H).

On 12/09/2025 at approximately 5:00 PM, Family Member H was notified Resident 1 was being transported to a local emergency room (ER).

This is a repeat violation from previous statement of deficiency J77X11 dated 08/26/2021.

FINDINGS INCLUDE:

On 12/23/2025 and 01/06/2026, the department received complaints related to resident treatment.

On 02/11/2026, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to facility on 01/15/2020.

On 02/11/2026, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 07/28/2025. Resident 1's ISP documented Family Member H as his activated power of attorney (APOA). Resident 1 was diagnosed with but not limited to ...dementia, urinary tract infection, anxiety and depression.

On 02/11/2026, Surveyor reviewed Resident 1's observation notes from 08/01/2025 to 01/12/2026:
1.) On 08/28/2025 at 11:30 AM, Previous Nurse C documented Resident 1 suffered an unwitnessed fall and was sent to an ER. Resident 1 was diagnosed with a bladder infection and closed fracture to the nasal bone. Resident 1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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	N 169		

prescribed the antibiotic Cefdinir 300 mg BID (twice daily) for 7 days to treat the bladder infection.

2.) On 12/04/2025 at 12:41 PM, Previous Nurse C documented the following, "Writer called [Name of Medical Clinic] ...writer also reported new concerns with resident, with resident dropping and seeing some decline in ADLs ..."

3.) On 12/05/2025 at 9:18AM, Nurse B documented the following, "This order is outside the recommended dose of frequency ...Nitrofurantoin Monohyd Macro Oral Capsule 100 MG (Nitrofurantoin Monohyd Macro) Give 1 capsule by mouth two times a day for urinary infection related to URINARY TRACT INFECTION, SITE NOT SPECIFIED (N39.0) for 5 days ...This dose fails general dose range check based on drug inputs and/or the patient information provided. This drug's dose should be adjusted based on renal function. Manual screening required ..."

4.) On 12/09/2025 at 2:10 PM, Caregiver D documented the following, "Care partner stated resident stayed in bed due to not being able to stand. Will notify nurse ..."

5.) On 12/10/2025 at 11:20 AM, Nurse B documented the following, "Resident experienced increased confusion and weakness during the shift and worsened. Due to increasing decline, 911 was called and the resident was transported to UW Hospital. Resident was admitted for Hypernatremia (sic.) and dehydration. [Family Member H] was notified of the transport and me (sic.) the resident at the hospital ..."

On 02/17/2026, 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
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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	N 169		

managed care organization (MCO) progress notes. The following was documented:
1.) On 12/10/2025 at 2:54 PM. MCO Nurse K documented the following, " ... Member has had a change of condition ...CARE MANAGEMENT ... Admitted to: UW Hospital ... Date of admission: 12/09/2025 ...Reason for admission: Hypernatremia ...Date of discharge: 12/17/2025 ....Discharged to: [Name of Nursing Home]...Preadmission Living Situation: [Name of Faciltiy] ...Member Baseline Impairments: Member is now a total care and on hospice ...Factors possibly contributing to this hospitalization: Member was staggeringly dehydrated, Na (sodium) 176 upon admission. Staff did not report findings to APOA, but were apparently treating member for UTI d/t AMS for two days before sending her out for evaluation based on VS. Upon admission to ER, member A&O x1 and remains so in addition to being a total care. Imaging revealed several large stones that would require intervention, however, medical team and [Family Member H] decided member is too fragile to successfully undergo anesthesia. Member also now has long term indwelling foley catheter ..."

INTERVIEW:

On 02/11/2026 at 10:30 AM, Surveyor interviewed Manager E and Caregiver F on the memory care unit. Manager E and Caregiver F stated Resident 1 appeared more confused and they called the PCP to report the increased confusion and PCP responded by ordering the antibiotic for UTI. Manager E stated Resident 1's confusion continued after s/he started the antibiotic. Manager E reported Family Member H wasn't notified of Resident 1's increased confusion, diagnosis of UTI, and initiation of antibiotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 4 treatment. Manager E stated Family Member H was notified of the UTI when Resident 1 was sent to the ER a few days afterwards. On 02/17/2026 at 11:06 AM, Surveyor interviewed Family Member H over the phone. Family Member H stated facility didn't notify him/her Resident 1 was being treated for a UTI or was having any increased confusion. Family Member H stated s/he was very involved with Resident 1's care and didn't know why facility hadn't contacted him/her when Resident 1 was getting sicker. Family Member H stated his/her was first notified when Resident 1 was admitted to the ER with severe dehydration. On 02/20/2026 at 10:00 AM, Surveyor discussed the above concerns with Administrator A, Nurse B and Manager E. Administrator A, Nurse B and Manager E acknowledged Resident 1's legal representative Family Member H wasn't notified of Resident 1's increased confusion, increased weakness, UTI and antibiotic treatment from the 5th of December until s/he was sent to the ER on the 9th. CROSS REFERENCE: N0353 DHS Chapter 83.32(3)(i) Rights of Residents: Adequate Treatment CROSS REFERENCE: N0386 DHS Chapter 83.35(3)(a) Comprehensive Individualized Service Plan	N 169		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF.	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 196	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. From 11/25/2020 to 02/20/2026, the provider did not comply with all the laws governing the CBRF as evidenced by 31 deficiencies identified, 9 repeat deficiencies, and 9 substantiated complaints. This is a repeat deficiency of statement of deficiency (SOD) RRI411 dated 10/07/2021. FINDINGS INCLUDE: Facility is a Class CNA non-ambulatory facility. Has a capacity of 42 residents and serves advanced aged, irreversible dementia & Alzheimer's. Example 1: Obtain and maintain compliance with laws governing the CBRF: On 11/25/2022, Surveyor conducted a survey. As a result of the survey 2 complaints were substantiated and 3 deficiencies were identified in SOD 1KI812: 1.) 83.35(3)(d) Service Plans Updated Annually Or On Changes 2.) 83.44(2)(a) Rooms Clean And Free From Odors On 03/18/2021, Surveyor conducted a survey. As a result of the survey 1 complaint was substantiated and 1 deficiency was identified in SOD 1KI813:	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 196	Continued From page 6 1.) 83.44(2)(a) Rooms Clean And Free From Odors On 06/30/2021, Surveyor conducted a survey. As a result of the survey 1 deficiency was identified in SOD 1KI814: 1.) 83.38(1)(g) Health Monitoring On 08/26/2021, Surveyor conducted a survey. As a result of the survey 1 complaint was substantiated and 2 deficiencies were identified in SOD J77X11: 1.) 83.12(5)(a) Notification: Incident, Injury, Changes 2.) 83.38(1)(b) Supervision On 10/07/2021, Surveyor conducted a survey. As a result of the survey 1 deficiency was identified in SOD RRI411: 1.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws On 06/16/2022, Surveyor conducted a survey. As a result of the survey 4 deficiencies were identified in SOD XXL911: 1.) 83.20(2)(a)-(d) Department Approved Training Courses 2.) 83.21(1)-(3) All Employee Training 3.) 83.25 Continuing Education 4.) 83.39(3) Hand Washing On 02/28/2023, Surveyor conducted a survey. As a result of the survey 3 deficiencies were identified in SOD XXL912: 1.) 83.25 Continuing Education 2.) 83.38(1)(b) Supervision 3.) 441.301(c)(4)(vi)(B)(1) Residential Setting: Living Unit Locks On 08/01/2023, Surveyor conducted a survey. As	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 196	Continued From page 7 a result of the survey 2 deficiencies were identified in SOD JTYV11: 1.) 83.35(3)(c) Implement, Follow The Individualized Service Plan 2.) 83.37(1)(i) PRN Psychotropic Medication On 01/10/2024, Surveyor conducted a survey. As a result of the survey 1 complaint was substantiated and 5 deficiencies were identified in SOD JTYV12: 1.) 83.35(3)(c) Implement, Follow The Individualized Service Plan 2.) 83.37(1)(i) PRN Psychotropic Medication 3.) 83.39(3) Hand Washing 4.) 83.44(2)(a) Rooms Clean And Free From Odors 5.) 83.46(1)(c) Heating System Maintenance On 05/16/2024, Surveyor conducted a survey. As a result of the survey 1 deficiency was identified in SOD JTYV13: 1.) 83.44(2)(a) Rooms Clean And Free From Odors On 06/26/2024, Surveyor conducted a survey. As a result of the survey 1 complaint was substantiated and 2 deficiencies were identified in SOD KZS511: 1.) 83.35(3)(d) Service Plans Updated Annually Or On Changes 2.) 83.38(1)(h) Health Monitoring On 04/14/2025, Surveyor conducted a survey. As a result of the survey 1 complaint was substantiated and 2 deficiencies were identified in SOD OTH011: 1.) 83.12(4)(c) Reporting Incidents With Serious Injury 2.) 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 196	Continued From page 8 On 02/11/2026, Surveyor conducted a survey. As a result of the survey 2 complaints were substantiated and 4 deficiencies were identified in SOD J30X11: 1.) 83.12(5)(a) Notification: Incident, Injury, Changes 2.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 3.) 83.32(3)(i) Rights Of Residents: Adequate Treatment 4.) 83.35(3)(a) Comprehensive Individualized Service Plan Example 2: Repeat violations of laws governing the CBRF. 1.) 83.12(5)(a) Notification: Incident, Injury, Changes 2.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 3.) 83.25 Continuing Education 4.) 83.35(3)(c) Implement, Follow Individualized Service Plan 5.) 83.35(3)(d) Service Plans Updated Annually Or On Changes 6.) 83.37(1)(i) PRN Psychotropic Medication 7.) 83.38(1)(b) Supervision 8.) 83.39(3) Hand Washing 9.) 83.44(2)(a) Rooms Clean And Free From Odors Example 3: Number of Complaints Substantiated. 1.) SOD 1KI812 dated 11/25/2020, 2 complaints substantiated 2.) SOD 1KI813 dated 03/18/2021, 1 complaint substantiated 3.) SOD J77X11 dated 08/26/2021, 1 complaint substantiated	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 196	Continued From page 9 4.) SOD JTYV12 dated 01/10/2024, 1 complaint substantiated 5.) SOD KZS511 dated 06/26/2024, 1 complaint substantiated 6.) SOD OTH011 dated 04/14/2025, 1 complaint substantiated 7.) SOD J30X11 dated 02/11/2026, 2 complaints substantiated EXIT INTERVIEW: On 02/20/2026 at 10:00 AM, Surveyor discussed the above concerns with Administrator A, Nurse B and Manager E. Administrator A, Nurse B and Manager E acknowledged Resident 1's legal representative Family Member H wasn't notified of Resident 1's increased confusion, increased weakness, UTI and antibiotic treatment from the 5th of December until s/he was sent to the ER on the 9th. Administrator A, Nurse B and Manager E acknowledged facility did complete a comprehensive assessment for the following changes in condition: increased confusion, increased weakness, UTI diagnosis and initiation of antibiotic therapy. Administrator A, Nurse B and Manager E acknowledged Resident 1 was diagnosed with hypernatremia at the ER secondary to dehydration. Administrator A, Nurse B and Manager E acknowledged Resident 1's ISP wasn't signed by him/her, Family Member H and MCO Case Manager G. Administrator A, Nurse B and Manager E acknowledged Resident 1's ISP didn't continue documentation related to Resident 1's history, interventions and/or goal related to diagnosis of recurrent UTIs. Nurse B reported s/he had implemented daily vital signs for future residents diagnosed with an infection. Administrator A, Nurse B and Manager E acknowledged Resident 1 wasn't provided care adequate to his/her needs.	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received prompt and adequate treatment that was appropriate to his/her needs. Resident 1 prior to incident was continent of urine and able to ambulate independently with a walker. On 12/04/2026, Facility staff observed Resident 1 to be more confused than usual. This observation was reported to his/her primary care provider (PCP). The following day Resident 1's PCP prescribed an antibiotic treatment for a urinary tract infection (UTI). From 12/05/2025 thru 12/08/2025, Provider didn't assess Resident 1's change in condition nor report them to his/her activated power or attorney (Family Member H). On 12/09/2025 at approximately 2:00 PM, Staff documented Resident 1 as staying in bed because s/he couldn't stand. On 12/09/2025 at approximately 5:00 PM, Staff found Resident 1 slumped over in the dining room with a low level of consciousness. Staff called 911 and Resident 1 was admitted to a local	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 11	N 353		

emergency room (ER). Resident 1 was diagnosed with hypernatremia (high sodium level) secondary to dehydration. A blockage in Resident 1's right kidney was discovered and required surgical intervention for treatment. However, Resident 1's overall condition was deemed too fragile for surgical anesthesia and so s/he was admitted to hospice service. While in ICU Resident 1 was assessed to have become bed bound and required an indwelling foley urinary catheter.

On 12/17/2025, Resident 1 was transferred from the hospital to skilled nursing facility (SNF).

On 01/04/2026, Resident 1 passed away.

FINDINGS INCLUDE:

Facility serves the following client groups: advanced aged, irreversible dementia and Alzheimer's.

RECORD REVIEW:

On 12/23/2025 and 01/06/2026, the department received complaints related to resident treatment.

On 02/11/2026, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to facility on 01/15/2020.

On 02/11/2026, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 07/28/2025. Resident 1's ISP had Family Member H documented as his/her APOA. Resident 1's ISP was not signed by Resident 1 or his/her activated power of attorney (Family Member H). Resident 1 was diagnosed with but not limited to: thyrotoxicosis with diffuse goiter, dementia,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 12	N 353		

urinary tract infection, anxiety and depression. Under the subsection titled, "Meal Portion: Regular," the following was documented, " ...Staff will monitor Joselyn's nutrition, and [s/he] will receive nutrition program interventions as appropriate through the end of the review period..." Under the subsection titled, "Dressing & Grooming," the following was documented, " ... [Resident 1] requires physical assistance of one care staff with dressing and grooming tasks ..." Resident 1 was documented as independent with toileting and continent of urine. Resident 1 was documented using a walker to ambulate.

On 02/11/2026, Surveyor reviewed Resident 1's observation notes from 08/01/2025 to 01/12/2026:
1.) On 08/28/2025 at 11:30 AM, Previous Nurse C documented Resident 1 suffered an unwitnessed fall and was sent to an ER. Resident 1 was diagnosed with a bladder infection and closed fracture to the nasal bone. Resident 1 was prescribed the antibiotic Cefdinir 300 mg BID (twice daily) for 7 days to treat the bladder infection.

2.) On 12/04/2025 at 12:41 PM, Previous Nurse C documented the following, "Writer called [Name of Medical Clinic] ...writer also reported new concerns with resident, with resident dropping and seeing some decline in ADLs ..."

3.) On 12/05/2025 at 9:18AM, Nurse B documented the following, "This order is outside the recommended dose of frequency ...Nitrofurantoin Monohyd Macro Oral Capsule 100 MG (Nitrofurantoin Monohyd Macro) Give 1 capsule by mouth two times a day for urinary infection related to URINARY TRACT INFECTION, SITE NOT SPECIFIED (N39.0) for 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 13	N 353		

days ...This dose fails general dose range check based on drug inputs and/or the patient information provided. This drug's dose should be adjusted based on renal function. Manual screening required ..."

4.) On 12/09/2025 at 2:10 PM, Caregiver D documented the following, "Care partner stated resident stayed in bed due to not being able to stand. Will notify nurse ..."

5.) On 12/10/2025 at 11:20 AM, Nurse B documented the following, "Resident experienced increased confusion and weakness during the shift and worsened. Due to increasing decline, 911 was called and the resident was transported to UW Hospital. Resident was admitted for Hypernatremia (sic.) and dehydration. [Family Member H] was notified of the transport and me (sic.) the resident at the hospital ..."

6.) On 12/22/2025 at 2:39 PM, Previous Nurse C documented the following, "Writer went to visit resident at [Name of Nursing Home] to see how resident was progressing since going to the hospital. Writer spoke with resident [s/he] was taking a nap upon arrival and woke up with the sound of [his/her] name. Resident said that [s/he] was "doing good". Writer talked to ... who said that resident was severely dehydrated, and they were place (sic.) on hospice. resident (sic.) has a foley catheter and needs help feeding, resident is a two person assist with Hoyer lift for transfers ..."

On 02/11/2026, Surveyor reviewed Resident 1's emergency room after visit summary dated 08/28/2025. Resident 1's diagnoses were documented as follows, " ...closed fracture of nasal bone ...frequent falls ...acute cystitis (bladder infection) ..." On page 6, the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 14	N 353		

was documented, " ...Put grab bars and nonskid mats in your shower or tub and near the toilet. Try to use a shower chair or bath bench when bathing ...Get into a tub or shower by putting in your weaker leg first. Get out with your strong side first. Have a phone or medical alert device in the bathroom with you ..." On page 11, was the "Female urinary Tract Infection (UTI): Care Instructions Overview ...to help prevent UTIs ...Drink plenty of water each day. This helps you urinate often, which clears bacteria from your system ..."

On 02/11/2026 at approximately 10:30 AM, Surveyor asked Nurse B for all of Resident 1's facility assessments for the last 6 months. Nurse B reported that only assessments documented by facility on Resident 1 in the last 6 months were in his/her observation notes. Nurse B stated Resident 1 had an annual assessment with PCP.

On 02/11/2026 at approximately 12:00 PM, Surveyor reviewed all assessments completed by facility on Resident 1 within the last 6 months. Surveyor reviewed one documented assessment by Previous Nurse C on 08/28/2025. Nurse B verified the 08/28/2025 assessment was the only documented facility assessment for Resident 1 within the last 6 months.

On 02/17/2026, Surveyor reviewed Resident 1's managed care organization (MCO) progress notes. The following was documented:
1.) On 12/10/2025 at 2:54 PM. MCO Nurse K documented the following, " ... Member has had a change of condition ...CARE MANAGEMENT ... Admitted to: UW Hospital ... Date of admission: 12/09/2025 ...Reason for admission: Hypernatremia ...Date of discharge: 12/17/2025 ....Discharged to: [Name of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 15 Home]...Preadmission Living Situation: [Name of Facility] ...Member Baseline Impairments: Member is now a total care and on hospice ...Factors possibly contributing to this hospitalization: Member was staggeringly dehydrated, Na (sodium) 176 upon admission. Staff did not report findings to APOA, but were apparently treating member for UTI d/t AMS for two days before sending her out for evaluation based on VS. Upon admission to ER, member A&O x1 and remains so in addition to being a total care. Imaging revealed several large stones that would require intervention, however, medical team and [Family Member H] decided member is too fragile to successfully undergo anesthesia. Member also now has long term indwelling foley catheter ..." 2.) On 12/23/2025 at 3:10 PM, MCO Nurse K documented a meeting with Family Member H, Administrator A and a facility nurse, " ...RN particiapted (sic.) in meeting with goal of understanding the breakdown of care and what lead to [Resident 1's] decline and hospitalization. [Name of Facility] not forthcoming with information despite [Family Member H's) clear questions. [Name of Facility] denies staffing pattern problems. [Name of Facility], and [Administrator A] specifically states that [s/he] "doesn't believe member was that dehydrated or was not eating or drinking for days." [Administrator A] goes on to state [s/he] "has a hard time believing those tests." [MCO Nurse K] told [Administrator A] it is not [his/her] place to 'believe' tests results administered by a prestigious hospital and assured [him/her] in no uncertain terms that member's sodium levels were accurate and drawn repeatedly d/t their shockingly high level. Additionally, [Name of Facility] reports they have no procedure for	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 16	N 353		

monitoring nutrition or liquid intake of their residents, yet somehow still object to the impartial data and plausible deduction that member was not properly hydrated. [Administrator A] states member should return to [Name of Facility] because they "take good care of [him/her]." Meeting ended d/t lack of productivity ..."

On 02/18/2026, Surveyor reviewed Resident 1's hospital record. The following was documented: 1.) Resident 1 was admitted on 12/09/2025 at approximately 6:00 PM. Resident 1's admitting diagnosis was hypernatremia. Resident 1's previous medical diagnoses included but were not limited to: AKI (acute kidney injury), ARF (acute renal failure), and essential HTN (hypertension).

2.) On 12/10/2025 at 4:39 PM, Doctor I documented the following, "[Resident 1] PMH (previous medical history) of dementia, Graves disease, previous urinary tract infections, previous sepsis. admitted for severe hypernatremia with associated toxic metabolic encephalopathy. Per EMS report, pt is presenting to the ED from an assisted living facility where [his/her] mental status has declined over the past week. Pt reported finished a course of abx for UTI but otherwise has been at baseline health without recent illness ...In the ED, [s/he] is with [Family Member H]. Pt was not responsive to providers during pt interview. [Family Member H] states that the patient seems more "sedated" than usual, stating that the patient is usually much more talkative than [s/he] is in the ED. [Family Member H] states that at baseline [s/he] does not like to drink fluids much and will often turn away liquids or take small sips. [Family Member H] states that the pt has never been admitted for severe elevated sodium, but [s/he' has had sepsis in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 17 past ...Vital signs were stable in the Workup in the ED was significant for Na+ (sodium) of 176, Cl- (chloride) of 143, Cr (creatinine) 2.84, WBC WNL. UA with +LE, +Nitrite, and 21-50 WBC (white blood cell count)... CT A/P prelim read showed large obstructing stone in the R (right) ureter with severe obstructive hydronephrosis (fluid in the kidney) ..." 3.) On 12/10/2025 at 8:45 PM, Doctor J documented the following, " ... [Resident 1] had softer blood pressures at time of our visit to [his/her] room, and this has been a trend per nursing. Given obstruction with infection of [his/her] kidney, there is every possibility we do not have adequate source control to clear [his/her] infection. Discussed this with [Family Member H] who was understanding. Not pursuing procedures which is very reasonable and in keeping with patient goals of care. Discussed whether we would broaden antibiotic therapy or not and agreed that we would continue current empiric therapy as is. Will keep her updated as appropriate." Surveyor reviewed the "Pearson Handbook of Laboratory And Diagnostic Tests With Nursing Implications. According to the handbook: - "Sodium (Na) ...Reference Values ...Serum (blood): Adult: 135-145 mEq/L ...Description ...Sodium has many functions: it helps maintain body fluids, it is responsible for conduction of neuromuscular impulses via the sodium pump; and it is involved in enzyme activity ...Increased Level: Hypernatremia ...observe for sign and symptoms of hypernatremia leg restlessness; a rough dry tongue; and tachycardia ..."(PEARSON HANDBOOK OF LABORATORY AND DIAGNOSTIC TESTS WITH NURSING IMPLICATIONS, 7th edition., 2009, p.356)	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 18 -"Chloride (Cl) (SERUM) ...Reference Values Adult: ...95-105 mmol/L ...Description. Chloride, an anion found mostly in the extracellular (outside of the cell) fluid, plays an important role in maintaining body water balance, osmolality of body fluids (with sodium), and acid-base balance. Most of the chloride ingested is combined with sodium (sodium chloride [NaCL], or salt) ...Clinical Problems ...Increased Level: Dehydration, high serum sodium level, ...cardiac decompensation, ...kidney dysfunction ..." (LABORATORY AND DIAGNOSTIC TESTS WITH NURSING IMPLICATIONS, 7th edition., 2009, p.119) -"Creatinine ...Reference Values ...Adult: Serum: 0.5-1.2 mg/dl ...Description. Creatinine, a by-product of muscle catabolism (breakdown), is derived from the breakdown of muscle creatine and creatine phosphate. The amount of creatinine produced is proportional to muscle mass. The kidneys excrete creatinine when 50% or more nephrons (functional units of the kidney), serum creatinine level increases ...Clinical Problems ...Increased Level: Acute and chronic renal failure, ...heart failure (HF), acute myocardial infarction (AMI), and diet ..." (LABORATORY AND DIAGNOSTIC TESTS WITH NURSING IMPLICATIONS, 7th edition., 2009, p.137) INTERVIEWS: On 02/11/2026 at 9:22 AM, Surveyor asked Nurse B about Resident 1's last days at facility. Nurse B reported Resident 1's primary care provider (PCP) had diagnosed him/her with urinary tract infection (UTI) and had prescribed antibiotics. Nurse B reported Resident 1 was last sent to the	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 19	N 353		

local emergency room (ER) during second shift. Nurse B stated Resident 1 was diagnosed with dehydration. Surveyor asked Nurse B if Resident 1's fluid intake and output was assessed during UTI. Nurse B stated facility did not measure fluid intake/output for residents without a doctor's order. Nurse B reported that Resident 1 was given water the medication, meals and to keep in his/her room. Nurse B reported that staff witnessed Resident 1 drop his/her utensils, slump over the dining room table and unable to verbally respond to staff questions, and so Nurse B instructed staff to call 911.

On 02/11/2026 at 9:40 AM, Surveyor discussed Resident 1's care with Manager E. Manager E described Resident 1's baseline as able to intake adequate food/fluid, toilet himself/herself, ambulate independently, and oriented. Manager E stated Resident 1 liked to walk around the hallways most days and would visit him/her in their office. Manager E shared frustration with Resident 1's PCP office, "they gave an order for an antibiotic without getting a UA (urinary analysis)."

On 02/11/2026 at 10:30 AM, Surveyor interviewed Manager E and Caregiver F on the memory care unit. Caregiver F reported that Resident 1's baseline with was required a 1 staff assist to the bathroom. Caregiver F reported during his/her time with Resident 1 his/her urine was always a dark yellow, and Caregiver F stated it was dark yellow the day before s/he was sent to the ER. Caregiver F stated staff were instructed to toilet Resident 1 once every 2 hours. Caregiver F stated s/he had been working in the neighboring unit when Resident 1 was sent to the ER. Caregiver F stated s/he was called by the unit staff who said Resident 1 was slumped over and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 20	N 353		

not responding to them. So, I told them to call 911. Manager E and Caregiver F reported concern that Resident 1's urine wasn't tested by the PCP days before Resident 1 was sent to the ER. Manager E and Caregiver F stated Resident 1 appeared more confused and they called the PCP to report the increased confusion and PCP responded by ordering the antibiotic for UTI. Manager E stated Resident 1's confusion continued after s/he started the antibiotic. Manager E reported Family Member H wasn't notified of Resident 1's increased confusion, diagnosis of UTI, and initiation of antibiotic treatment. Manager E stated Family Member H was notified of the UTI when Resident 1 was sent to the ER a few days afterwards.

On 02/11/2026 at 12:30 PM, Surveyor reviewed Resident 1's observation notes with Nurse B. Surveyor asked Nurse B why Resident 1 hadn't been assessed on 12/05/2025 when he has increased confusion and was prescribed an antibiotic. Nurse B stated changes in Resident 1's condition in December 2025 were reported to Previous Nurse C. Nurse B acknowledged in the progress note s/he wrote on 12/05/2026 instructed, "manual screening required, "for resident with kidney issues. Nurse B acknowledged Resident 1 had a history of UTIs. Nurse B acknowledged at approximately 2:00 PM on 12/09/2025 staff assessed Resident 1 was too weak to get out of bed, and s/he wasn't sent to the ER for a few more hours.

On 02/17/2026 at 9:30 AM, Surveyor interviewed MCO Case Manager G over the phone. MCO Case Manager G stated Resident 1 was previously diagnosed with Grave's disease, but denied hyperthyroidism being detected by ER on 12/09/2025. MCO Case Manager G reported that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 21	N 353		

when EMS (emergency medical services) arrived at facility Resident 1 was nearly non-responsive and they had a difficult time finding a pulse. MCO Case Manager G reported that ER had stated Resident 1's urine was a "coke brown," color upon admission. MCO Case Manager G reported Resident 1's overall condition severely declined following ER admission, Resident 1 went from ambulating independently with a walker to becoming bed bound, from being independent with transfers to requiring 2 assist with Hoyer lift, with increased communication deficit. MCO Case Manager G reported Family Member H decided against surgical interventions and Resident 1 was admitted to hospice service. MCO Case Manager G stated s/he had attempted to have a debriefing with facility administration, but facility had denied Resident 1's dehydration with related injuries had occurred. MCO Case Manager G stated Administrator A questioned the validity of hospital clinical laboratory values rather than discuss what could have been done differently to keep Resident 1 hydrated. MCO Case Manager G stated Resident 1 passed away in the nursing home in January 2026.

On 02/17/2026 at 11:06 AM, Surveyor interviewed Family Member H over the phone. Family Member H stated Resident 1's thyroid hormones levels were not elevated when s/he was brought to the ER. Family Member H stated facility didn't notify him/her Resident 1 was being treated for a UTI or was having any increased confusion. Family Member H stated s/he was very involved with Resident 1's care and didn't know why facility hadn't contacted him/her when Resident 1 was getting sicker. Family Member H stated Resident 1 was admitted to the ER with severe dehydration and s/he never walked again. Family Member H stated there was a blockage in Resident 1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 22 kidney which required surgical intervention, but Resident 1's physical condition was too fragile for surgery. So, it was decided Resident 1 would enroll in hospice services. Family Member H stated s/he originally was going to have Resident 1 discharged from the hospital back to the facility until a meeting s/he had with Administrator A. Family Member H stated when s/he asked Administrator A about Resident 1's condition before hospitalization s/he didn't have any clear answers, or plan on how to prevent Resident 1 from dehydrating in the future. Family Member H stated Resident 1 passed away on January 4th. On 02/20/2026 at 10:00 AM, Surveyor discussed the above concerns with Administrator A, Nurse B and Manager E. Administrator A, Nurse B and Manager E acknowledged Resident 1's legal representative Family Member H wasn't notified of Resident 1's increased confusion, increased weakness, UTI and antibiotic treatment from the 5th of December until s/he was sent to the ER on the 9th. Administrator A, Nurse B and Manager E acknowledged facility did complete a comprehensive assessment for the following changes in condition: increased confusion, increased weakness, UTI diagnosis and initiation of antibiotic therapy. Administrator A, Nurse B and Manager E acknowledged Resident 1 was diagnosed with hypernatremia at the ER secondary to dehydration. Administrator A, Nurse B and Manager E acknowledged Resident 1's ISP wasn't signed by him/her, Family Member H and MCO Case Manager G. Administrator A, Nurse B and Manager E acknowledged Resident 1's ISP didn't continue documentation related to Resident 1's history, interventions and/or goal related to diagnosis of recurrent UTIs. Nurse B reported s/he had implemented daily vital signs for future	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353	Continued From page 23 residents diagnosed with an infection. Administrator A, Nurse B and Manager E acknowledged Resident 1 wasn't provided care adequate to his/her needs. CROSS REFERENCE: N0169 DHS Chapter 83.12(5)(a) Notification: Incident, Injury, Changes CROSS REFERENCE: N0386 DHS Chapter 83.35(3)(a) Comprehensive Individualized Service Plan	N 353		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individualized service plan (ISP) comprehensive to his/her needs, desired outcomes, program services, frequency and approaches of services,	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 386	Continued From page 24	N 386		

measurable goals with specific time limits for attainment and specified methods for delivering needed care and who was responsible for delivering the care.

On 08/28/2025, Resident 1 suffered an injury from an unwitnessed fall. Provider sent Resident 1 to an emergency room (ER). Where s/he was diagnosed with closed fracture or the nasal bone and a bladder infection. Resident 1 returned to the facility with an ER discharge summary with instructions to increase water intake for bladder infection prophylaxis (prevention) and have a shower chair installed for fall prevention.

On 02/11/2026, Surveyor reviewed Resident 1's ISP. Resident 1's ISP wasn't signed by him/her and/or legal representatives. Resident 1's ISP didn't include documentation related to recurrent urinary tract infections (UTIs) and/or shower chair.

FINDINGS INCLUDE:

RECORD REVIEW:

On 12/23/2025 and 01/06/2026, the department received complaints related to resident treatment.

On 02/11/2026, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to facility on 01/15/2020.

On 02/11/2026, Surveyor reviewed Resident 1's emergency room after visit summary dated 08/28/2025. Resident 1's diagnoses were documented as follows, " ...closed fracture of nasal bone ...frequent falls ...acute cystitis (bladder infection) ..." On page 6, the following was documented, " ...Put grab bars and nonskid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 386	Continued From page 25	N 386		

mats in your shower or tub and near the toilet. Try to use a shower chair or bath bench when bathing ...Get into a tub or shower by putting in your weaker leg first. Get out with your strong side first. Have a phone or medical alert device in the bathroom with you ..." On page 11, was the "Female urinary Tract Infection (UTI): Care Instructions Overview ...to help prevent UTIs ...Drink plenty of water each day. This helps you urinate often, which clears bacteria from your system ..."

On 02/11/2026, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 07/28/2025. Resident 1's ISP was not signed by Resident 1 or his/her activated power of attorney (Family Member H). Resident 1 was diagnosed with but not limited to: ... dementia, urinary tract infection... Under the subsection titled, "Meal Portion: Regular," the following was documented, " ...Staff will monitor Joselyn's nutrition, and [s/he] will receive nutrition program interventions as appropriate through the end of the review period..." Resident 1 was documented as independent with toileting and continent of urine. Resident 1 was documented using a walker to ambulate. Resident 1 was documented as requiring the assistance of 1-staff member for showering/bathing.

On 02/18/2026, Surveyor reviewed Resident 1's hospital record. The following was documented: 1.) Resident 1 was admitted on 12/09/2025 at approximately 6:00 PM. Resident 1's admitting diagnosis was hypernatremia. Resident 1's previous medical diagnoses included but were not limited to: AKI (acute kidney injury), ARF (acute renal failure), and essential HTN (hypertension).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 386	Continued From page 26 2.) On 12/10/2025 at 4:39 PM, Doctor I documented the following, "[Resident 1] PMH (previous medical history) of dementia, Graves disease, previous urinary tract infections, previous sepsis. admitted for severe hypernatremia with associated toxic metabolic encephalopathy. Per EMS report, pt is presenting to the ED from an assisted living facility where [his/her] mental status has declined over the past week. Pt reported finished a course of abx for UTI but otherwise has been at baseline health without recent illness ...In the ED, [s/he] is with [Family Member H]. Pt was not responsive to providers during pt interview. [Family Member H] states that the patient seems more "sedated" than usual, stating that the patient is usually much more talkative than [s/he] is in the ED. [Family Member H] states that at baseline [s/he] does not like to drink fluids much and will often turn away liquids or take small sips. [Family Member H] states that the pt has never been admitted for severe elevated sodium, but [s/he' has had sepsis in the past ...Vital signs were stable in the Workup in the ED was significant for Na+ (sodium) of 176, Cl- (chloride) of 143, Cr (creatinine) 2.84, WBC WNL. UA with +LE, +Nitrite, and 21-50 WBC (white blood cell count)... CT A/P prelim read showed large obstructing stone in the R (right) ureter with severe obstructive hydronephrosis (fluid in the kidney) ..." INTERVIEW: On 02/11/2026 at 12:00 PM, Surveyor discussed the above concern with Nurse B. Nurse B acknowledged Resident 1's ISP didn't contain documentation related to fall prevention instructions sent from the ER on 08/28/2025. Nurse B stated Resident 1 had not used a shower chair. Nurse B acknowledged Resident 1 had a	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 386	Continued From page 27 history of UTI before December 2025 wasn't documented in the ISP. On 02/17/2026 at 11:06 AM, Surveyor interviewed Family Member H over the phone. Family Member H stated s/he hadn't signed an ISP for Resident 1 in over a year. On 02/20/2026 at 10:00 AM, Surveyor discussed the above concerns with Administrator A, Nurse B and Manager E. Administrator A, Nurse B and Manager E acknowledged Resident 1's ISP wasn't signed by him/her, Family Member H and MCO Case Manager G. Administrator A, Nurse B and Manager E acknowledged Resident 1's ISP didn't contain documentation related to Resident 1's history, interventions and/or goal related to diagnosis of recurrent UTIs. Administrator A, Nurse B and Manager E acknowledged Resident 1's previous diagnoses of acute kidney injury and acute renal failure weren't documented in Resident 1's ISP. CROSS REFERENCE: N0169 DHS Chapter 83.12(5)(a) Notification: Incident, Injury, Changes CROSS REFERENCE: N0353 DHS Chapter 83.32(3)(i) Rights Of Residents: Adequate Treatment	N 386		