STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 to 02/20/2026, Surveyor conducted 2 complaint investigations at Brookdale Madison West AL. Three deficiencies were identified. Two of 3 deficiencies were repeat violations. See Statement of Deficiency (SOD) XE2212, dated 04/16/2025, SOD XE2213, dated 08/19/2025, and SOD 56PG11, dated 02/16/2022. One complaint was substantiated. One complaint was unsubstantiated. Census: 62	N 000		
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 each resident received prompt and adequate treatment appropriate to the resident's needs. Resident 1 had been assessed to require assistance with repositioning every 2-3 hours due to skin integrity concerns. From 09/19/2025 (admission to hospice) to 02/11/2026 (day of survey), Resident 1 was not provided adequate treatment resulting in a stage 2 pressure injury, ongoing redness/raw skin issues to his/her	N 353		

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
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 1	N 353		

peri-area and experiencing pain from his/her skin concerns.

From 01/12/2026 through 02/11/2026, Resident 1 experienced 59 occurrences of call light wait times exceeding 20 minutes.

This is a repeat deficiency. See Statement of Deficiency (SOD) XE2212, dated 04/16/2025.

Findings include:

On 12/31/2025, the Department received a complaint alleging concerns with personal hygiene and long call light response times.

On 02/11/2026, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the facility on 08/01/2025 with a diagnosis of muscular dystrophy. Resident 1 was his/her legal decision maker. Resident 1 discharged on 02/13/2026. Resident 1's ISP dated 12/29/2025 documented: "Bathroom assistance: Resident will have bathroom needs met with staff assistance. Resident will receive routine urinary catheter care per staff assistance and/or prompts. Resident will receive staff assistance due to additional needs associated with uncontained bladder or bowel accidents. [Resident 1's] foley catheter was removed the week of 11/10/2025, hospice monitored [his/her] ability to empty bladder completely and no longer retain urine. Resident was unable to completely void and the foley catheter was replaced. Resident used tabbed brief for bowel incontinence and episodes of any leaking around the foley. Two person or mechanical lift: [Resident 1] needs 2 persons to assist with [his/her] hoyer lift for transfers to and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 2	N 353		

from [his/her] hospital bed, wheelchair, and recliner. Skin care: [Resident 1] will be encouraged to practice pressure relieving techniques to prevent skin breakdown to [his/her] bony prominences."

Example 1: Skin concerns

Resident 1's patient care order dated 10/02/2025 documented: "Complete peri care with soap and water three times a day and as needed."

Resident 1's hospice care plan dated 09/19/2025 documented:

"-Coordination of care needs. Collaboration with facility staff throughout admission process, including [Wellness Director D] and other care staff.

-[Resident 1] is at risk for impaired skin integrity. No new skin breakdown noted or reported at the time of admission assessment. Facility staff responsible for this task when hospice team not present. Barrier cream to be applied to [Resident 1's] coccyx area after peri cares for the purpose of skin protection. Facility staff responsible for this task when hospice team not present. Nystatin powder to be applied to affected skin in peri area by qualified clinician 3x daily or after peri cares. Facility staff responsible for this task when hospice RN not present.

-[Resident 1] will be assisted and/or encouraged to reposition/change pressure points every 2-3 hours. Facility staff responsible for this task when hospice team is not present."

Resident 1's hospice notes completed by a RN documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 3 "-10/01/2025: ...Writer assisted [hospice aide] in changing [Resident 1's] brief, which was soiled with urine and stool ...Upon assessment of [Resident 1's] catheter, writer noted incontinence associated dermatitis in the folds around [Resident 1's] groin ....Writer to update [Family Member C] and [Wellness Director D] on new orders for skin breakdown treatment. -10/02/2025: ...Writer completed peri cares as [Resident 1's] brief appears to have been soiled for a long time as the stool is hard and crusted to [his/her] skin and the brief had some dark urine present. -10/21/2025: ....Writer assisted in turning [Resident 1] and [Resident 1] did experience pain when [s/he] was turned but the pain subsided after. [Resident 1] has a small pressure injury to [his/her] bottom, writer assessed this area before zinc cream was applied. Writer ordered a foam wedge for [Resident 1] so facility staff and [hospice] staff can ensure [Resident 1] gets turned throughout the day to try to prevent the pressure injury from getting worse. -11/07/2025: ...[Hospice aide] performed incontinence cares and showed writer [Resident 1's] bottom. [His/her] currently has no breakdown to [his/her] bottom but [his/her] bottom is red. -11/11/2025: [Hospice staff], [Family Member C], and [Associate Director B] were all present for a care conference ....[Wellness Director D] and [Administrator A] who were both supposed to be present for this meeting could not make it today but they did not notify [hospice] so [Associate Director B] who mainly works in memory care met with [hospice] staff and [Family Member C]	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 4	N 353		

instead. Writer, [hospice staff], and [Family Member C] all brought up concerns regarding [Resident 1's] care from the facility. [Associate Director B] did report the facility is only 50% staffed so could be where some of the problems are stemming from. However writer explained [hospice] main concern is [Resident 1's] overall hygiene. Writer explained that when [hospice aide] comes to see [Resident 1] on Monday's, [Resident 1] is always "red and raw" on [his/her] peri area. Writer explained that yesterday when writer was performed peri care and catheter care, writer had to take breaks while wiping/cleaning this area as it caused [Resident 1] pain just to be cleaned. Writer asked if [Resident 1] is on some sort of schedule to be checked/changed. [Associate Director B] was unsure of the answer to this question however [s/he] did say [s/he] will look into this. [Associate Director B] also reported that at [his/her] next all staff meeting, [s/he] will be going over proper peri care verbally and with pictures. [Associate Director B] explained that the staff at the facility are trained to use the hoyer lift which writer was unsure of as [Resident 1] only leaves [his/her] bed when [hospice] is present, not with facility staff.

-11/18/2025:..[Family Member C] reported that [Resident 1] was very anxious for writer and [hospice aide] to arrive as [Resident 1] really wanted a good clean up ....[Resident 1] has mild pain when [s/he] is turned but [s/he] reported it is tolerable pain. [Resident 1] still had redness to [his/her] groin folds and [s/he] reported some pain when it was being cleaned. Antifungal powder was applied to this area. [Resident 1] also has some redness to [his/her] bottom and barrier cream was applied.

-12/09/2025: .... [Resident 1] has redness and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 5	N 353		

irritation to [his/her] groin folds which become more irritated over this benefit period and nystatin was scheduled to help this. [Resident 1] developed some breakdown to [his/her] sacrum over this benefit period despite having an air pressure mattress and having [hospice] apply barrier cream during visits. Two months ago [Resident 1] did not have breakdown to [his/her] sacrum.

-12/23/2025: ...Writer and [hospice aide] performed incontinence cares and applied antifungal powder. [Hospice aide] applied zinc barrier cream to [Resident 1's] bottom. [Resident 1] struggles to turn in bed and needs assistance to turn.

-12/30/2025: ..... [Resident 1] was in pain as [hospice aide] dried off [Resident 1's] groin folds likely due to facility not cleaning [Resident 1] enough over the weekend and when hospice is not there. [Hospice aide] had to take breaks when ensuring these areas were dry ....[Resident 1's] bottom was read and there was a small opening on [his/her] bottom.

-01/13/2026: ....Writer applied antifungal powder to [Resident 1's] groin folds and [hospice aide] applied barrier cream to [his/her] bottom as [Resident 1] has some breakdown to [his/her] bottom ....[Resident 1] is very weak and needs max assistance with 5/6 ADLs. [S/he] is able to feed [him/herself] independently. [Resident 1] is not able to turn [him/her] self in bed and needs assistance with turning in bed.

-01/16/2026: ...Writer and facility staff performed hygiene cares together as [Resident 1] has muscular stiffness and pain which greatly impairs [his/her] ability to support [him/herself] with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 6	N 353		

repositioning. [Resident 1] was given a sponge bath, clothes were changed, barrier cream was placed on [his/her] buttocks, and antifungal powder was applied to the groin. Throughout the visit [Resident 1] complained of pain with movement and also stated that it resolved as soon as [s/he] could be still.

-01/27/2026: ....Writer and [hospice aide] put a clean shirt and brief on [Resident 1]. [Resident 1's] bottom is red and appears to have slight breakdown so writer applied barrier cream. Writer applied antifungal powder to [Resident 1's] groin folds.

-01/29/2026: ....Writer and [hospice aide] performed incontinence cares on [Resident 1] as [Resident 1] was dirty. [Resident 1] developed breakdown with open skin to [his/her] bottom so writer performed wound care to this area. Wound Care and Assessment: Midline Buttocks/Pressure Ulcer. Date onset: 01/29/2026, Stage 2. Measurements: Length 0.7ccm x width 0.6 cm.

-02/03/2026: ...Writer performed an assessment and then writer and [hospice aide] changed [Resident 1]. [Resident 1] was very soiled, [s/he] soiled through [his/her] brief and onto the chuck pad. [Resident 1] was in pain as writer and [hospice aide] cleaned [him/her] up as [his/her] skin is very irritated. [Resident 1's] groin folds and [his/her] scrotum are very irritated and writer and [hospice aide] have to be very gentle when cleaning this area due to pain and irritation. The wound on [Resident 1's] bottom has gotten worse and [his/her] skin is more discolored, starting to develop a deep purple color surrounding the wound ....[Wellness Director D] was busy after writer's visit so writer emailed [Wellness Director D] about visit and [Resident 1's] worsening skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 7	N 353		

breakdown and writer's concerns with [his/her] skin. Writer also stressed the importance of facility staff checking [Resident 1] routinely for incontinence ....Writer called [Family Member C] to update [him/her] about the visit and after sharing with [him/her] [Resident 1's] worsening skin breakdown, [Family Member C] was upset and frustrated."

A review of Resident 1's hospice notes dated 09/29/2025 to 02/11/2026 noted after each RN visit, the hospice nurse would summarize his/her visit with staff, Wellness Director D if available, or send Wellness Director D an email summary of their visit.

Surveyor reviewed Resident 1's progress notes dated 09/10/2025 to 01/19/2026. The only entry regarding Resident 1's repositioning needs or skin concerns were documented on 12/16/2025: "Per the last conversation with this writer [Wellness Director D] and [hospice social worker] on 12/12/2025. A log has been created to reflect the activity in the resident's apartment. Resident has been added to a frequent turn schedule, and it is to be documented for [his/her] compliance or refusal to this care or any other activity/care provided to [him/her]. This writer suggested this activity as staff frequently offer care and the resident refuses to have the care provided. Staff informed of the importance of having this documentation to in fact show that information the resident is providing to hospice and family may indeed conflict with the actually occurrences during [his/her] times of care." The above log did not start until 01/09/2026, evidenced by the start date observed by the Surveyor on the day of survey.

From 09/29/2025 to 12/14/2025, the provider did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 8	N 353		

not have a system in place to ensure staff were repositioning Resident 1 every 2-3 hours. On 12/15/2025, the provider implemented a log which contained handwritten pages secured to a clip board that was placed in Resident 1's room where staff were supposed to document date/time, reason for visit, turned in bed (y/n), and staff initials. The log was not consistently completed each day and many "N's" were documented if turned in bed. It is important to note, after the log was implemented, Resident 1 continued to experience skin concerns evidenced by the above hospice notes and the development of a stage 2 pressure injury on 01/29/2026.

A review of provider's log dated 12/15/2025 to 02/10/2026 documented the following:
"-12/15/2025 at 4:12 PM to 12/16/2025 at 8:25 AM-no visits to Resident 1's room were recorded.
-12/16/2025 at 4:30 PM to 12/17/2025 at 7:37 AM-no visits to Resident 1's room were recorded.
-12/17/2025 at 10:31 PM to 12/18/2025 at 7:25 AM-no visits to Resident 1's room were recorded.
-12/18/2025 at 9:50 AM to 12/18/2025 at 5:50 PM-no visits to Resident 1's room were recorded
-12/18/2025 at 6:50 PM to 12/19/2025 at 8:01 AM-no visits to Resident 1's room were recorded.
-12/19/2025 at 12:42 PM to 12/21/2025 at 10:00 AM-no visits to Resident 1's room were recorded.
-12/21/2025 at 10:00 AM to 12/22/2025 at 2:00 PM-no visits to Resident 1's room were recorded.
-12/22/2025 at 2:00 PM to 12/23/2025 at 11:00 AM-no visits to Resident 1's room were recorded.
-12/23/2025 at 9:35 AM to 12/24/2025 at 10:45 AM-no visits to Resident 1's room were recorded.
-12/24/2025-included 8 visits to Resident 1's room, but no times of visits were recorded.
-12/25/2025 at 5:00 PM to 12/26/2025 at 10:00 AM-no visits to Resident 1's room were recorded.
-12/26/2025 at 7:16 PM to 12/27/2025 at 7:40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 9 AM-no visits to Resident 1's room were recorded. -12/27/2025-included 1 additional visit to Resident 1's room, but the time of visit was not recorded. -12/28/2025-included 3 visits to Resident 1's room, but no times of visits were recorded. Additionally, 2 of 3 visits noted "n" if turned in bed. -12/29/2025-included 1 visit to Resident 1's room, but the time of visit was not recorded. -12/30/2025-no visits to Resident 1's room were recorded. -12/31/2025-included 3 visits to Resident 1's room, but no times of visits were recorded. Additionally, 2 of 3 visits noted "n" if turned in bed. -01/01/2026 at 5:10 PM to 01/02/2026 at 8:00 AM-no visits to Resident 1's room were recorded. -01/02/2026 at 8:50 PM to 01/03/2026 at 7:30 AM-no visits to Resident 1's room were recorded. -01/03/2026 at 7:24 PM to 01/04/2026 at 9:30 AM-no visits to Resident 1's room were recorded. -01/04/2026 included 4 visits to Resident 1's room, but staff recorded "n" 4 times if turned in bed. -01/04/2026 at 4:00 PM to 01/05/2026 at 8:39 AM-no visits to Resident 1's room were recorded. -01/06/2026-included 5 visits to Resident 1's room, but staff recorded "n" 3 times if turned in bed. -01/07/2026-included 6 visits to Resident 1's room, but staff record "n" 4 times if turned in bed. -01/08/2026 at 12:00 PM to 01/08/2026 at 6:30 PM-no visits to Resident 1's room were recorded. -01/08/2026 at 6:30 PM to 01/09/2026 at 10:00 AM-no visits to Resident 1's room were recorded. -01/09/2026 at 3:15 PM to 01/09/2026 at 7:00 PM-no visits to Resident 1's room were recorded. Additionally, 4 of 6 visits to Resident 1's room noted "n" if turned in bed. -01/12/2026-included 3 visits to Resident 1's room, but staff did not record the time and 2 of 3 visits noted "n" if turned in bed.	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 10 -01/14/2026 at 4:00 AM to 01/15/2026 (AM)-no visits to Resident 1's room were recorded. -01/15/2026 at 2:52 PM to 01/16/2026 at 8:45 AM-no visits to Resident 1's room were recorded. -01/17/2026 at 3:09 PM to 01/17/2026 at 9:15 PM-no visits to Resident 1's room were recorded. -01/17/2026 at 9:15 PM to 01/18/2026 (AM)-no visits to Resident 1's room were recorded. Additionally on 01/18/2026, staff record 1 visit to Resident 1's room at 3:16 PM. -01/18/2026 at 3:16 PM to 01/19/2026 at 9:00 AM-no visits to Resident 1's room were recorded. -01/19/2026 at 5:36 PM to 01/20/2026 at 1:15 PM-included 1 visit to Resident 1's room, but staff did not record the time. -01/20/2026 at 1:15 PM to 01/20/2026 at 6:30 PM-no visits to Resident 1's room were recorded. -01/22/2026 at 4:00 AM to 01/22/2026 at 8:00 AM-no visits to Resident 1's room were recorded. -01/23/2026-included 7 visits to Resident 1's room, but staff recorded "n" 6 of 7 times if turned in bed. -01/24/2026 at 9:35 PM to 01/25/2026 at 4:00 AM-no visits to Resident 1's room were recorded. -01/25/2026-included 10 visits to Resident 1's room, but staff recorded "n" 7 of 10 times if turned in bed. -01/26/2026 at 10:30 AM to 01/26/2026 at 6:15 PM-no visits to Resident 1's room were recorded. -01/26/2026 at 6:15 PM to 01/27/2026 at 9:56 AM-no visits to Resident 1's room were recorded. -01/27/2026-included 4 visits to Resident 1's room, 3 of 4 visits were made by hospice. Comments: "Discussed concerns." -01/28/2026 at 7:20 PM to 01/29/2026 at 3:00 AM-no visits to Resident 1's room were recorded. -01/29/2026 at 3:00 AM to 01/29/2026 at 9:30 AM-no visits to Resident 1's room were recorded. -01/29/2026 at 8:45 PM to 01/30/2026 at 9:18 AM-no visits to Resident 1's room were recorded.	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 -01/30/2026 at 12:30 PM to 01/30/2026 at 4:30 PM-no visits to Resident 1's room were recorded. Comments: "No one has changed [him/her] since yesterday." -01/30/2026 at 4:30 PM to 01/31/2026 at 2:00 AM-no visits to Resident 1's room were recorded. -02/01/2026 at 8:23 AM to 02/02/2026 at 8:00 AM-no visits to Resident 1's room were recorded. -02/02/2026 at 8:33 PM to 02/03/2026 at 8:25 AM-no visits to Resident 1's room were recorded. -02/04/026 at 10:20 PM to 02/05/2026 at 2:00 AM-no visits to Resident 1's room were recorded. -02/05/2026 at 5:15 PM to 11:00 PM-no visits to Resident 1's room were recorded. -02/05/2026 at 11:00 PM to 02/06/2026 at 8:01 AM-no visits to Resident 1's room were recorded. -02/06/2026 at 9:03 AM to 4:00 PM-no visits to Resident 1's room were recorded. -02/06/2026 at 5:30 PM to 02/07/2026 at 4:00 AM-no visits to Resident 1's room were recorded. -02/08/2026 at 4:00 AM to 8:50 AM-no visits to Resident 1's room were recorded. -02/08/2026 at 1:16 PM to 02/09/2026 at 8:00 AM-no visits to Resident 1's room were recorded. -02/09/2026 at 8:00 AM to 5:57 PM-no visits to Resident 1's room were recorded. -02/13/2026: [Resident 1] left at 1pm." Example 2: Call light concerns Surveyor reviewed Resident 1's call log record dated 01/12/2026 to 02/11/2026. The following dates exceeded 20 minutes in response time: -01/12/2026: Resident 1 waited 28 minutes for call response -01/12/2026: Resident 1 waited 37 minutes for call response -01/12/2026: Resident 1 waited 21 minutes for call response -01/13/2026: Resident 1 waited 23 minutes for	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 call response -01/15/2026: Resident 1 waited 25 minutes for call response -01/15/2026: Resident 1 waited 26 minutes for call response -01/16/2026: Resident 1 waited 27 minutes for call response -01/17/2026: Resident 1 waited 38 minutes for call response -01/18/2026: Resident 1 waited 38 minutes for call response -01/19/2026: Resident 1 waited 36 minutes for call response -01/20/2026: Resident 1 waited 39 minutes for call response -01/20/2026: Resident 1 waited 25 minutes for call response -01/20/2026: Resident 1 waited 1 hour and 5 minutes for call response -01/21/2026: Resident 1 waited 29 minutes for call response -01/21/2026: Resident 1 waited 46 minutes for call response -01/22/2026: Resident 1 waited 33 minutes for call response -01/23/2026: Resident 1 waited 23 minutes for call response -01/23/2026: Resident 1 waited 1 hour and 4 minutes for call response -01/23/2026: Resident 1 waited 24 minutes for call response -01/24/2026: Resident 1 waited 21 minutes for call response -01/24/2026: Resident 1 waited 29 minutes for call response -01/25/2026: Resident 1 waited 25 minutes for call response -01/25/2026: Resident 1 waited 38 minutes for call response -01/26/2026: Resident 1 waited 25 minutes for	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 call response -01/26/2026: Resident 1 waited 29 minutes for call response -01/27/2026: Resident 1 waited 38 minutes for call response -01/27/2026: Resident 1 waited 26 minutes for call response -01/28/2026: Resident 1 waited 30 minutes for call response -01/28/2026: Resident 1 waited 23 minutes for call response -01/28/2026: Resident 1 waited 41 minutes for call response -01/28/2026: Resident 1 waited 33 minutes for call response -01/29/2026: Resident 1 waited 30 minutes for call response -01/29/2026: Resident 1 waited 39 minutes for call response -01/30/2026: Resident 1 waited 36 minutes for call response -01/31/2026: Resident 1 waited 34 minutes for call response -01/31/2026: Resident 1 waited 34 minutes for call response -02/01/2026: Resident 1 waited 48 minutes for call response -02/01/2026: Resident 1 waited 28 minutes for call response -02/01/2026: Resident 1 waited 52 minutes for call response -02/01/2026: Resident 1 waited 25 minutes for call response -02/01/2026: Resident 1 waited 47 minutes for call response -02/02/2026: Resident 1 waited 37 minutes for call response -02/02/2026: Resident 1 waited 31 minutes for call response -02/03/2026: Resident 1 waited 26 minutes for	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 call response -02/03/2026: Resident 1 waited 21 minutes for call response -02/03/2026: Resident 1 waited 34 minutes for call response -02/04/2026: Resident 1 waited 34 minutes for call response -02/04/2026: Resident 1 waited 28 minutes for call response -02/05/2026: Resident 1 waited 45 minutes for call response -02/05/2026: Resident 1 waited 36 minutes for call response -02/06/2026: Resident 1 waited 21 minutes for call response -02/06/2026: Resident 1 waited 52 minutes for call response -02/07/2026: Resident 1 waited 30 minutes for call response -02/07/2026: Resident 1 waited 29 minutes for call response -02/07/2026: Resident 1 waited 51 minutes for call response -02/07/2026: Resident 1 waited 29 minutes for call response -02/08/2026: Resident 1 waited 26 minutes for call response -02/09/2026: Resident 1 waited 56 minutes for call response -02/11/2026: Resident 1 waited 27 minutes for call response Interviews: On 02/11/2026 at 10:25 AM, Surveyor interviewed Caregiver E regarding the provider's call light system. Caregiver E reported once a resident pushes their call pendant, the request goes to a computer at the receptionist desk near the entrance of the facility. From there, the staff	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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	N 353		

member working at the front desk will radio care staff to what room requested assistance. Caregiver E reported the front desk computer was only staffed Monday-Friday during normal business hours. On the weekends and after management left, staff had to visually check the computer screen for themselves to see what resident rooms needed assistance. Caregiver E reported this was very hard for staff to manage, especially if they were short staffed.

On 02/11/2026 at 10:40 AM, Surveyor interviewed Resident 1 and Family Member C. Family Member C reported ongoing concerns with staff responding to Resident 1's call light in a timely manner. Surveyor asked if an average response time in minutes could be provided. Resident 1 and Family Member C reported they could not provide an average time as the response time were all over the place. Family Member C reported concerns with staff not providing adequate personal hygiene especially to Resident 1's peri-area. Family Member C stated there was a pattern after Resident 1 was seen by hospice during the week and when they visited again the following Monday, Resident 1 would often be red/raw and in pain from staff not caring for him/her. Family Member C stated s/he had been in tears seeing Resident 1 in this condition and was looking to move him/her to a smaller community. Family Member C acknowledged the facility did implement a log for staff to fill out when they enter Resident 1's room for any reason, but noted it was not always filled out.

On 02/11/2026 at 12:30 PM, Surveyor interviewed Wellness Director D regarding the provider's log in Resident 1's room. Wellness Director D stated the provider implemented a log to track staff's checks on Resident 1 after meeting with hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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		

and hearing their concerns. Wellness Director D reported Resident 1 had some verbal aggression towards staff and s/he did refuse cares at times. Surveyor shared s/he observed the log in Resident 1's room when interviewing him/her and the log did not look like it was filled out every 2-3 hours. Wellness Director D acknowledged staff did not always fill out the log but stated "they should have."

On 02/17/2026 at 1:18 PM, Surveyor interviewed Hospice Nurse F. Hospice Nurse F reported in the beginning a hospice aide saw Resident 1 5x/week and was changed to 3x/week later on. Hospice Nurse F noted s/he saw Resident 1 sometimes 2x/week but a minimum of 1x/week. Hospice Nurse F reported hospice started to notice a pattern after hospice aide would visit on a Thursday, s/he would come again Monday, and Resident 1's peri-area was red/raw. Hospice Nurse F reported s/he told staff and management several times to make sure Resident 1 was checked/changed every 2 hours but was not being done evidenced by his/her skin. Hospice Nurse F reported hospice's main concern was the lack of hygiene care provided to Resident 1's peri-area.

On 02/20/2026 at 10:00 AM, Surveyor interviewed Administrator A, Associate Director B, and Wellness Director D via phone. Surveyor shared concerns for the lack of hygiene care provided to Resident 1 during his/her admission, noting his/her skin was intact upon admission to hospice (09/19/2025) and later developed a stage 2 pressure injury (01/29/2026). Additionally, Surveyor noted Resident 1's record included many entries of Resident 1's peri-area being red/raw and him/her being in pain during brief changes. Wellness Director D acknowledged an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 understanding of the above concerns. Wellness Director D stated s/he was not informed by staff or hospice that Resident 1 developed a pressure injury. Surveyor questioned Wellness Director D not being aware of Resident 1's worsening skin breakdown after Hospice Nurse F had documented talking to staff on 01/29/2026 and emailing Wellness Director D on 02/04/2026. Wellness Director D stated s/he would have to check his/her email to see if it was received. Surveyor asked for clarification on Resident 1's 59 occurrences of call light times over 30 days that exceeded 20 minutes. The management team took note of Surveyor's comments but did not provide any feedback. Summary: the facility did not ensure Resident 1 was provided adequate repositioning needs or personal hygiene to his/her peri-area. The lack of care resulted in Resident 1 developing a stage 2 pressure injury, ongoing redness/raw skin issues to his/her peri-area and experiencing pain from his/her skin concerns. Furthermore, staff did not provide prompt care when Resident 1 experienced 59 occurrences of call light wait times over 30 days that exceeded 20 minutes. Cross Reference: N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 353		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 389	Continued From page 18 the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was accurate to his/her condition and needs. Resident 1's ISP was not updated to include his/her need for assistance with repositioning and skin integrity interventions. The unprovided assistance led to Resident 1 developing a stage 2 pressure ulcer and ongoing redness/raw skin concerns to his/her peri-area. This is a repeat deficiency. See Statement of Deficiency (SOD) XE2213, dated 08/19/2025 and SOD 56PG11, dated 02/16/2022. Findings include: On 12/31/2025, the Department received a complaint alleging concerns with personal hygiene. On 02/11/2026, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 08/01/2025 with a diagnosis of muscular dystrophy. Resident 1 was his/her legal decision	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 389	Continued From page 19	N 389		

maker. Resident 1's ISP dated 12/29/2025 documented: "Bathroom assistance: Resident will have bathroom needs met with staff assistance. Resident will receive routine urinary catheter care per staff assistance and/or prompts. Resident will receive staff assistance due to additional needs associated with uncontained bladder or bowel accidents. [Resident 1's] foley catheter was removed the week of 11/10/2025, hospice monitored [his/her] ability to empty bladder completely and no longer retain urine. Resident was unable to completely void and the foley catheter was replaced. Resident used tabbed brief for bowel incontinence and episodes of any leaking around the foley. Two person or mechanical lift: [Resident 1] needs 2 persons to assist with [his/her] hoyer lift for transfers to and from [his/her] hospital bed, wheelchair, and recliner. Skin care: [Resident 1] will be encouraged to practice pressure relieving techniques to prevent skin breakdown to [his/her] bony prominences." The ISP was not updated to include his/her need for assistance with repositioning every 2-3 hours or skin integrity interventions.

Resident 1's patient care order dated 10/02/2025 documented: "Complete peri care with soap and water three times a day and as needed."

Resident 1's hospice care plan dated 09/19/2025 documented:
"-Coordination of care needs. Collaboration with facility staff throughout admission process, including [Wellness Director D] and other care staff.
-[Resident 1] is at risk for impaired skin integrity. No new skin breakdown noted or reported at the time of admission assessment. Facility staff responsible for this task when hospice team not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 389	Continued From page 20	N 389		

present. Barrier cream to be applied to [Resident 1's] coccyx area after peri cares for the purpose of skin protection. Facility staff responsible for this task when hospice team not present. Nystatin powder to be applied to affected skin in peri area by qualified clinician 3x daily or after peri cares. Facility staff responsible for this task when hospice RN not present.
-[Resident 1] will be assisted and/or encouraged to reposition/change pressure points every 2-3 hours. Facility staff responsible for this task when hospice team is not present."

Resident 1's hospice notes documented:
-"Wound Care and Assessment: Midline Buttocks/Pressure Ulcer. Date onset: 01/29/2026, Stage 2. Measurements: Length 0.7 cm x width 0.6 cm.
-02/03/2026: ...Writer performed an assessment and then writer and [hospice aide] changed [Resident 1]. [Resident 1] was very soiled, [s/he] soiled through [his/her] brief and onto the chuck pad. [Resident 1] was in pain as writer and [hospice aide] cleaned [him/her] up as [his/her] skin is very irritated. [Resident 1's] groin folds and [his/her] scrotum are very irritated and writer and [hospice aide] have to be very gentle when cleaning this area due to pain and irritation. The wound on [Resident 1's] bottom has gotten worse and [his/her] skin is more discolored, starting to develop a deep purple color surrounding the wound ....[Wellness Director D] was busy after writer's visit so writer emailed [Wellness Director D] about visit and [Resident 1's] worsening skin breakdown and writer's concerns with [his/her] skin. Writer also stressed the importance of facility staff checking [Resident 1] routinely for incontinence.
-01/29/2026: ....Writer and [hospice aide] performed incontinence cares on [Resident 1] as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 389	Continued From page 21 [Resident 1] was dirty. [Resident 1] developed breakdown with open skin to [his/her] bottom so writer performed wound care to this area. -12/30/2025: ..... [Resident 1] was in pain as [hospice aide] dried of [Resident 1's] scrotum and groin folds likely due to facility not cleaning [Resident 1] enough over the weekend and when hospice is not there. [Hospice aide] had to take breaks when ensuring these areas were dry .... [Resident 1's] bottom was read and there was a small opening on [his/her] bottom. -12/09/2025: .... [Resident 1] has redness and irritation to [his/her] groin folds which become more irritated over this benefit period and nystatin was scheduled to help this. [Resident 1] developed some breakdown to [his/her] sacrum over this benefit period despite having an air pressure mattress and having [hospice] apply barrier cream during visits. Two months ago [Resident 1] did not have breakdown to [his/her] sacrum. -11/18/2025: .... [Resident 1] has mild pain when [s/he] is turned but [s/he] reported it is tolerable pain. [Resident 1] still had redness to [his/her] groin folds and [s/he] reported some pain when it was being cleaned. Antifungal powder was applied to this area. [Resident 1] also has some redness to [his/her] bottom and barrier cream was applied....Written by [Hospice Social Worker]: ...[Hospice] suggests it to be added to [Resident 1's] care plan at the facility for caregivers to check on [him/her] every two hours even if [s/he] has not pressed [his/her] button and for a book to be kept in the room for facility staff and [Hospice] staff to document what date/time they check on [Resident 1] and what cares they offered/if the cares were declined or completed. -11/07/2025: ...[Hospice aide] performed incontinence cares and showed writer [Resident 1's] bottom. [His/her] currently has no breakdown	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 389	Continued From page 22 to [his/her] bottom but [his/her] bottom is red. -10/21/2025: ....Writer assisted in turning [Resident 1] and [Resident 1] did experience pain when [s/he] was turned but the pain subsided after. [Resident 1] has a small pressure injury to [his/her] bottom, writer assessed this area before zinc cream was applied. Writer ordered a foam wedge for [Resident 1] so facility staff and [hospice] staff can ensure [Resident 1] gets turned throughout the day to try to prevent the pressure injury from getting worse." On 02/11/2026 at 10:40 AM, Surveyor interviewed Resident 1 and Family Member C. . Family Member C reported ongoing concerns with staff not providing adequate personal hygiene especially to Resident 1's peri-area. Family Member C stated there was a pattern after Resident 1 was seen by hospice during the week and when they visited again the following Monday, Resident 1 would often be red/raw and in pain from staff not caring for him/her. Family Member C stated Resident 1 was supposed to be encouraged or repositioned every 2-3 hours per hospice, but s/he questioned if this was being done. Family Member C stated s/he never received a copy of Resident 1's ISP that the facility had developed, so s/he was unsure what care they were providing. On 02/20/2026 at 10:00 AM, Surveyor interviewed Administrator A, Associate Director B, and Wellness Director D via phone. The management team acknowledged an understanding of the above concerns. Wellness Director B stated s/he was responsible for updating resident care plans and it was an oversight on his/her part for not updating Resident 1's ISP. No further comment was provided.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 389	Continued From page 23 Cross Reference: N0353 83.32(3)(i) Rights Of Residents: Adequate Treatment	N 389		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that all rooms were kept clean and free from odors. There was a strong odor of urine coming from pipes near Resident 2's bedroom that filled the hallway, and resident rooms were observed to be unkept evidenced by food crumbs, debris, and ants on the floor. Findings include: On 12/31/2025, the Department received a complaint alleging concerns with cleanliness in resident rooms. On 02/11/2026 between 9:40 AM and 2:00 PM, Surveyor toured the facility and observed the following: At 9:40 AM, Associate Director B took the Surveyor on a tour of the facility. Upon entering the hallway near Resident 2's door, Surveyor observed a pungent odor of urine that filled the hallways. Associate Director B reported the odor was coming from Resident 2's bedroom. Associate Director B reported s/he would have staff address the issue. At 2:00 PM, the pungent odor of urine remained in the hallways near	N 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 489	Continued From page 24 Resident 2's apartment. At 10:15 AM, Surveyor interviewed Resident 3 outside his/her bedroom. Resident 3 reported housekeeping could be better at the facility. Resident 3 gave verbal permission for the Surveyor to tour his/her bedroom. Once inside Resident 3's apartment, Surveyor observed a chuck pad on the bed with a large brown faded stain. Inside the bathroom, Surveyor observed bowel movement (bm) in the toilet and toilet paper scattered on the floor. A garbage can next to the toilet was filled with soiled depends and used wipes. The garbage can was overflowing and did not have a lid. The room had a strong odor of bm. At 2:06 PM, the same conditions observed at 10:15 AM were present. At 10:21 AM to 11:30 AM, Surveyor interviewed Resident 1 and Family Member C in his/her bedroom. Family Member C reported ongoing concerns with the facility not providing housekeeping in Resident 1's room. Family Member C reported there was always trash and food crumbs on the floor. Family Member C stated Resident 1's bedroom had issues with ants. At 10:21 AM, Surveyor observed Resident 1's toilet was filled with dark yellowish urine. Family Member C reported staff were supposed to empty Resident 1's catheter into the toilet. Family Member C noted staff do not always flush and s/he often finds this when visiting. At 11:16 AM, Surveyor observed two garbage cans (1 small and 1 large next) to Resident 1's kitchenette. The small can was overflowing with incontinent products (no lid). The large can had a liner but underneath, dried bm was observed stuck to the bottom of the can. At 11:18 AM, Surveyor observed food crumbs and debris covering Resident 1's floor. In	N 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 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 489	Continued From page 25 addition, near Resident 1's recliner, there was a large stain on the carpet. At 11:19 AM, Surveyor observed ants on the floor below a windowsill that was near Resident 1's bed. The ants were observed crawling/eating food crumbs on the floor. At 2:08 PM, the same conditions observed from 10:21 AM to 11:30 AM were present. On 02/20/2026 at 10:00 AM, Surveyor interviewed Administrator A, Associate Director B, and Wellness Director D via phone. Surveyor shared concerns regarding resident rooms not clean and the strong odor of urine. Associate Director B reported after talking to their maintenance director, the odor of urine was coming from pipes at the facility. Associate Director B stated the facility was remolding different parts of the building and maintenance told management they needed to flush toilets more that were not being used to improve the odor. Associate Director B noted the odor was not coming from Resident 2's room but acknowledged it was very strong near his/her apartment. The management staff did not comment why resident rooms were not cleaned throughout the day on 02/11/2026.	N 489		