| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019367 | A. BUILDING: _____ B. WING _____ | C 01/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAGE MEADOWS OF MIDDLETON - 5330 | 5330 CENTURY AVE MIDDLETON, WI 53562 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>On 01/20/2026, Surveyor conducted a complaint investigation at Sage Meadows of Middleton.<br><br>Two deficiencies were identified.<br><br>The complaint was substantiated.<br><br>Census: 46 | N 000 | | |
| N 160 | 83.12(2)(c) Report to law enforcement and coroner<br><br>Investigating and reporting abuse, neglect, or misappropriation of property. Other reporting. Filing a report under sub. (1) or (2) does not relieve the licensee or other person of any obligation to report an incident to any other authority, including law enforcement and the coroner.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure law enforcement was notified when the provider was made aware of allegations of misappropriation of resident funds.<br><br>Findings include:<br><br>On 11/19/2025, the Department received a complaint alleging concerns with resident funds.<br><br>On 01/20/2026, Surveyor conducted a complaint investigation and identified the following:<br><br>On 01/20/2026 at 11:35 AM, Surveyor interviewed Resident 1. Resident 1 reported back in May 2025 s/he told Assistant Administrator B that after going to the hospital and returning to the facility, s/he had discovered his/her coin purse was missing | N 160 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019367 | A. BUILDING: _____ B. WING _____ | C 01/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAGE MEADOWS OF MIDDLETON - 5330 | 5330 CENTURY AVE MIDDLETON, WI 53562 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 160 | Continued From page 1 | N 160 | | |

including approximately $300 dollars and his/her credit cards. Resident 1 stated s/he had fallen while playing the piano and s/he had put his/her coin purse inside their basket that was attached to their 4 wheeled walker. Resident 1 stated s/he wanted to take his/her coin purse with them to the hospital due to the amount of money inside, but was told by Caregiver C that s/he did not need their coin purse and his/her walker would be put inside their room with the door locked. Resident 1 stated s/he did not hear anything from the provider about their investigation so in July 2025, s/he formally filed a grievance. Resident 1 stated a few more months passed without any updates from the provider and in November 2025, s/he met with an Ombudsman about the situation. Resident 1 stated the provider never offered to call the police regarding the incident. Resident 1 stated s/he understands that the money will never be reimbursed but s/he was upset with the untimeliness of the investigation and the facility not providing any updates until November 2025. Resident 1 stated after the meeting with the Ombudsman, s/he did speak with someone from Koru Health regarding the investigation, but they never gave me a written summary of their investigation.

Resident 1 was admitted to the facility on 03/17/2025. Resident 1 was their own legal decision maker.

Resident 1's grievance form dated 07/11/2025 documented:
"Issue/Concern/Complaint: An investigation on May 22, 2025, has never been reported back to me although I asked 5-6 times what was happening. The investigation was about missing

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019367 | A. BUILDING: _____ B. WING _____ | C 01/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAGE MEADOWS OF MIDDLETON - 5330 | 5330 CENTURY AVE MIDDLETON, WI 53562 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 160 | Continued From page 2 | N 160 | | |

over $300 that was in my coin purse which [Caregiver C] strongly told me to leave back home and not take with me to the emergency room (ER), and later I returned around 2:30 AM on the 23rd was gone ..... with $ and all my credit cards." There was no follow up information completed on the grievance form.

Surveyor reviewed the provider's investigation which included witness statements. The following was completed by Assistant Administrator B dated 05/26/2025:
"On 05/24/2025, I was home, I received a call [Resident 1], unsure of the time it was in the afternoon. [Resident 1] voiced [his/her] concerns about an incident on 5-23-2025 when [s/he] was sent out to the hospital after [his/her] fall. [Resident 1] stated to me that [his/her] wallet is missing. I did ask [Resident 1] if [s/he] recalled taking it out the building with [him/her] or did [s/he] leave it in the building. [Resident 1] first stated [s/he] believed [s/he] took it with [him/her], then [s/he] stated [s/he] remembered [Caregiver C] telling [him/her] to leave it. [S/he] couldn't fully remember. I did inform [Resident 1] that I would speak to staff for more information and I will dig further into this when I get to work Monday morning. I did speak with [Caregiver C], [Caregiver C] informed me that [s/he] tried to encourage [Resident 1] to leave [his/her] wallet to ensure [s/he] didn't lose it when [s/he] go out to the hospital. [Caregiver C] charted on ECP. Monday when I came into work, I did make contact with [Resident 1], I spoke with [Resident 1], I tried to look around in [his/her] room for the wallet. I was not able to find it in [his/her] room. I called the Middleton Emergency Department to speak with the [man/women] that transported [him/her]. I also

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019367 | A. BUILDING: _____ B. WING _____ | C 01/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAGE MEADOWS OF MIDDLETON - 5330 | 5330 CENTURY AVE MIDDLETON, WI 53562 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 160 | Continued From page 3 | N 160 | | |

contacted the UW hospital lost and found department twice, I still did not get a response from them."

The following was completed by Assistant Administrator B dated 06/02/2025:
"On 6-2-2025 approx between 1 or 2pm, I was finally able to speak with one of the EMT workers that was hear [sic] the day [Resident 1] was sent out to the hospital on 5-23-2025. I asked [him/her] if [s/he] had any recollection of [Resident 1] taking [his/her] wallet out of the building when [s/he] was transported. [S/he] stated [s/he] do recall, [s/he] did not take it along. I asked [him/her] if [s/he] could recall what [s/he] had with [him/her], [s/he] stated [s/he] had a book and a newspaper. [S/he] stated the wallet was placed in the walker and care staff locked it in [his/her] room."

On 01/20/2026 at 1:35 PM, Surveyor interviewed Administrator A and Assistant Administrator B regarding Resident 1's misappropriation of funds. Assistant Administrator B acknowledged taking Resident 1's call on 05/24/2025 regarding his/her missing wallet and starting an investigation. Assistant Administrator B reported s/he got different stories from staff stating that Resident 1 had brought his/her wallet with him/her to the hospital, so we were not 100% what had happened. Surveyor asked about the EMT's statement noting that Resident 1 had left his/her wallet in his/her walker at the facility when being transported to the ER. Assistant Administrator B acknowledged the EMT's statement and stated s/he had relayed all details of the investigation to Former Administrator D. Surveyor asked if the provider had reported the incident to law enforcement. Assistant Administrator B stated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019367 | A. BUILDING: _____ B. WING _____ | C 01/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAGE MEADOWS OF MIDDLETON - 5330 | 5330 CENTURY AVE MIDDLETON, WI 53562 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 160 | Continued From page 4<br>"no, not that s/he was aware of." Assistant Administrator B stated Former Administrator D made the decision to not contact law enforcement. Assistant Administrator B reported s/he was unsure of the reasons on why Former Administrator D did not contact law enforcement. Administrator A told Assistant Administrator B we should always contact law enforcement in these cases, "the resident has rights."<br><br>Cross Reference: N0362 83.33(1)(d) Grievance Procedure: written summary | N 160 | | |
| N 362 | 83.33(1)(d) Grievance procedure: written summary<br><br>The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not provide a written summary of grievances, the findings and the conclusions and any actions taken to the resident.<br><br>Findings include:<br><br>On 11/19/2025, the Department received a complaint alleging concerns with resident funds.<br><br>On 01/20/2026, Surveyor conducted a complaint | N 362 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019367 | A. BUILDING: _____ B. WING _____ | C 01/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAGE MEADOWS OF MIDDLETON - 5330 | 5330 CENTURY AVE MIDDLETON, WI 53562 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 362 | Continued From page 5<br>investigation and identified the following:<br><br>On 01/20/2026 at 11:35 AM, Surveyor interviewed Resident 1. Resident 1 reported back in May 2025 s/he told Assistant Administrator B that after going to the hospital and returning to the facility, s/he had discovered his/her coin purse was missing including approximately $300 dollars and his/her credit cards. Resident 1 stated s/he had fallen while playing the piano and s/he had put his/her coin purse inside their basket that was attached to their 4 wheeled walker. Resident 1 stated s/he wanted to take his/her coin purse with them to the hospital due to the amount of money inside, but was told by Caregiver C that s/he did not need their coin purse and his/her walker would be put inside their room with the door locked. Resident 1 stated s/he did not hear anything from the provider about their investigation so in July 2025, s/he formally filed a grievance. Resident 1 stated a few more months passed without any updates from the provider and in November 2025, s/he met with an Ombudsman about my situation. Resident 1 stated the provider never offered to call the police regarding the incident. Resident 1 stated s/he understands that the money will never be reimbursed but s/he was upset with the untimeliness of the investigation and the facility not providing any updates until November 2025. Resident 1 stated after the meeting with the Ombudsman, s/he did speak with someone from Koru Health regarding the investigation, but they never gave me a written summary of their investigation.<br><br>Resident 1 was admitted to the facility on 03/17/2025. Resident 1 was their own legal decision maker. | N 362 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019367 | A. BUILDING: _____ B. WING _____ | C 01/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAGE MEADOWS OF MIDDLETON - 5330 | 5330 CENTURY AVE MIDDLETON, WI 53562 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 362 | Continued From page 6 | N 362 | | |

Resident 1's grievance form dated 07/11/2025 documented:
"Issue/Concern/Complaint: An investigation on May 22, 2025 has never been reported back to me although I asked 5-6 times what was happening. The investigation was about my missing over $300 that was in my coin purse which [Caregiver C] strongly told me to leave back home and not take with me to the emergency room (ER), and later I returned around 2:30 AM on the 23rd was gone ..... with $ and all my credit cards." There was no follow up information completed on the grievance form.

On 01/20/2026 at 12:35, Surveyor interviewed Assistant Administrator B regarding Resident 1's misappropriation of funds. Assistant Administrator B acknowledged taking Resident 1's call on 05/24/2025 regarding his/her missing wallet and starting an investigation. Assistant Administrator B reported s/he wrote up statements and gave details to Former Administrator D. Assistant Administrator B stated s/he was not aware of a written summary provided to Resident 1. Surveyor asked about the long gaps between the reporting of the incident (May 2025), the grievance filed (July 2025), and the results of the investigation verbally shared to Resident 1 (November 2025). Assistant Administrator B stated Resident 1 stopped talking about the incident and ended up bringing it back up to his/her case manager.

On 01/20/2026 at 12:45, Surveyor interviewed Assistant Administrator B. Assistant Administrator B stated s/he talked with Koru Health who reported they got involved with Resident 1's allegations after s/he brought them up to the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019367 | A. BUILDING: _____ B. WING _____ | C 01/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAGE MEADOWS OF MIDDLETON - 5330 | 5330 CENTURY AVE MIDDLETON, WI 53562 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 362 | Continued From page 7<br><br>Ombudsman in November 2025. Assistant Administrator B reported Koru Health had gathered Resident 1's statement but Former Administrator E was supposed to provide a written summary to Resident 1. Assistant Administrator B stated Former Administrator E never completed follow up, so s/he knows Resident 1 never received a written summary. Assistant Administrator B stated the provider only had evidence of the initial grievance taken in July 2025.<br><br>Cross Reference: N0160 83.12(2)(c) Report to law enforcement and corner | N 362 | | |