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 _____	R-C 05/12/2026

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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 On 05/06/2026 with information gathered through 05/12/2026, Surveyors conducted a standard licensing survey, 3 complaint investigations and a verification visit at Sage Meadows of Middleton, a CBRF located in Middelton, WI. As a result of the survey, 9 violations of Chapter DHS 83 were issued. Two violations from previous Statement of Deficiency (SOD) Y2BI11 dated 01/20/2026 were corrected. Two complaints were substantiated, one complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed. Census: 40	{N 000}		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training	N 247		

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

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N 247	Continued From page 1 topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 3 employees reviewed had documented completed training in personal cares and dietary. Caregivers E and F did not have documented completed training in personal cares or dietary. Findings include: On 05/06/2026 at 12:00 PM, Surveyor requested employee files for Caregiver E and Caregiver F to ensure compliance. Personal Cares	N 247		

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N 247	Continued From page 2 Surveyor reviewed Caregiver E's file. Caregiver E was hired 11/24/2025. Caregiver E did not have documentation of completed training in personal cares. There was no evidence in Caregiver E's file indicating s/he was exempt from this training. Surveyor reviewed Caregiver F's file. Caregiver F was hired 11/24/2025. Caregiver F did not have documentation of completed training in personal cares. There was no evidence in Caregiver F's file indicating s/he was exempt from this training. Dietary Surveyor reviewed Caregiver E's file. Caregiver E was hired 11/24/2025. Caregiver E did not have documentation of completed training in dietary. There was no evidence in Caregiver E's file indicating s/he was exempt from this training. Surveyor reviewed Caregiver F's file. Caregiver F was hired 11/24/2025. Caregiver F did not have documentation of completed training in personal cares. There was no evidence in Caregiver F's file indicating s/he was exempt from this training. On 05/06/2026 at 12:15 PM, Surveyor interviewed Director of Operations-B (DO-B). DO-B stated that the facility was attempting a Change of Ownership (CHOW) and the previous company took all records with them. DO-B acknowledged that Caregiver E and Caregiver F both work at the facility and assist residents with personal cares and also serve meals and snacks. DO-B acknowledged that all employees must be trained in personal cares and dietary prior to performing those tasks. DO-B stated that if the training doesn't get sent from previous company, "We will just have to eat the cite."	N 247		

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N 247	Continued From page 3 Surveyor gave DO-B until 05/07/2026 at 4 PM to provide further information. As of 05/07/2026 at 4 PM no further information was provided.	N 247		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the privacy of residents' personal information and records. Two laptop computers were left open and unattended in a common area where resident information could easily be seen by anyone walking by. Findings include: On 05/06/2026 at 9:30 AM, Surveyor observed 2	N 346		

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N 346	Continued From page 4 laptop computers with resident private information showing on the screen. Several residents and visitors walked by the computers and could easily see private resident information. On 05/06/2026 at 9:50 AM, Surveyor observed 2 laptop computers with resident private information showing on the screen. Several residents and visitors walked by the computers and could easily see private resident information. Surveyor was able to access resident information on the computers. On 05/06/2026 at 10:15 AM, Surveyor observed 2 laptop computers with resident private information showing on the screen. Several residents and visitors walked by the computers and could easily see private resident information. Surveyor was able to observe and access private resident information on both computers. On 05/06/20206 at 11:45 AM, Surveyor interviewed Director of Operations B (DO-B) DO-B acknowledged that laptop computers that have resident information should not be accessible to anyone when not in use. DO-B acknowledged that laptop computers should have the screen locked and folded down when not in use to ensure privacy.	N 346		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication	N 352		

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N 352	Continued From page 5 is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner. From 03/24/2026 to 03/29/2026, Resident 2 was administered his/her Quetiapine 200 mg after it was discontinued on 03/23/2026. On 04/21/2025, 04/22/2026, and 04/23/2026, Resident 2 was administered both his/her extended and immediate release tablets of Metoprolol 25 mg after staff did not remove the extended-release blister pack from the medication cart after being discontinued on 04/20/2026. Resident 3's Buprenorphine 20 mcg/hr patch was not given as prescribed due to unavailability. Findings include: On 04/11/2026, the Department received a complaint alleging concerns with medications. On 05/06/2026, Surveyor reviewed resident records and identified the following: Example 1: Resident 2 Resident 2 was admitted to the facility on 06/17/2025 with a diagnosis of dementia. Resident 2 discharged from the facility on 04/28/2026. Resident 2 had an activated healthcare power of attorney. Resident 2's individual service plan (ISP) with an unknown date indicated staff administer his/her	N 352		

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N 352	Continued From page 6 medications. Resident 2's physician orders included: "-Quetiapine 200 mg tablet, with instructions to take 1 tablet by mouth every evening after dinner for Alzheimer's disease, with a start date of 03/06/2026 and end date of 04/02/2026. -Metoprolol Succ ER 25 mg tablet, with instructions to take 1 tablet by mouth daily, with a start date of 12/17/2025 and end date of 04/20/2026. -Metoprolol Tartrate 25 mg tablet, with instructions to take 0.5 tablet (12.5mg) by mouth 2 times daily, with a start date of 04/20/2026 and end date of 04/29/2026." Resident 2's progress notes documented: "04/02/2026: The writer received a call from care staff stating the resident's Quetiapine was not in the med cart. The writer looked in the resident's medication orders, and it was noted it was active medication on the MAR. The writer contacted [Hospice Provider J] for clarification. The [Hospice Provider J] nurse informed the writer that this medication was discontinued on 03/23/2026. The hospice nurse stated [s/he] will send over the DC order again. -03/24/2026: [Hospice Provider J] here to see resident and change medications. D/C Quetiapine tablet extended release. Will be adding Risperidone 0.5 mg BID with [his/her] Lorazepam 0.5 mg BID. Resident also has the Lorazepam 0.5 mg PRN every 4 hours that may be used with PRN Tylenol for comfort, please use this." Resident 2's incident report dated 04/24/2026 documented: "-Writer was asked by AED to placed Metoprolol Tartrate 25 mg (12.5 mg-1 tablet BID) in the Tuscan medication cart that this was a new	N 352		

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medication for the resident. Writer was unaware that the resident was on Metoprolol Succ ER 25 mg 1 tablet once daily. Resident took both am doses for 4.21, 4.22, and 4.23. [S/he] has had no side effects from the medications and has been fine."

A review of Resident 2's March - April 2026 medication administration record (MARs) documented the following:
-Quetiapine 200 mg tablet was documented as administered on 03/24, 03/25, 03/26, 03/27, 03/28, 03/29.
-Metoprolol Succ ER 25 mg was documented as administered on 04/21, 04/22, 04/23.
-Metoprolol Tartrate 25 mg was documented as administered on 04/21, 04/22, 04/23.

Example 2: Resident 3

Resident 3 was admitted to the facility on 06/17/2025 with a diagnosis of Alzheimer's disease. Resident 3 discharged from the facility on 04/28/2026. Resident 3 had an activated healthcare power of attorney. Resident 3's ISP with an unknown date indicated staff administer his/her medications.

Resident 3's physician orders included:
"-Buprenorphine 20 mcg/hr patch, with instructions to apply patch to skin weekly for chronic pain, with a start date of 03/04/2026 and end date of 04/29/2026."

Resident 3's April 2026 MAR documented the following:
-04/15/2026: Buprenorphine-No Pass Reason: waiting on pharmacy
-04/22/2026: Buprenorphine-No Pass Reason: waiting on pharmacy

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N 352	Continued From page 8 On 05/12/2026 at 11:00 AM, Surveyor interviewed and shared findings with Director A, Director of Operations B, Assistant Director G, Nurse H, Regional Nurse L, and LPN M. Nurse H reported s/he was asked to put Resident 2's Metoprolol Tartrate blister pack in the med cart not realizing Resident 2 had 2 blister packs of Metoprolol. Nurse H acknowledged s/he was responsible for the error. Nurse H reported Resident 10 did not experience any negative outcome. The management team did not provide comment after Surveyor noted Resident 3's Buprenorphine was not available for 2 administrations and his/her record did not contain any follow up with the pharmacy. The management acknowledged an understanding of the above findings.	N 352		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure each resident lived in a safe environment, that safeguarded residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are	N 358		

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N 358	Continued From page 9 hazardous to anyone and conditions that are hazardous to the resident because of the residents 'conditions or disabilities. Two of 4 dryers on same floors as residents had a large buildup of dryer lint, dust and clothes behind the dryer causing a fire hazard. Findings include: On 05/06/2026, at 11:30 AM, Surveyor toured the physical environment. There was a dryer on the first floor that had a large build up of dryer lint, dust and clothes behind the dryer, causing a potential fire hazard. There was a dryer on the second floor that had a large build up of dryer lint, dust and clothes behind the dryer, causing a potential fire hazard. On 05/06/2026 at 11:45 AM, Surveyor interviewed Director of Operations B (DO-B). DO-B acknowledged that there was a large buildup of dryer lint, dust and clothes behind 2 dryers that could potentially cause a fire. DO-B stated that the affected areas would be cleaned immediately and monitored ongoing.	N 358		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case	N 389		

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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 the Individual Service Plan (ISP) was updated when there was a change in needs and physical or mental condition for 1 of 2 residents reviewed.

Resident 3's ISP was not updated to include new fall interventions after Resident 3 experienced 4 falls between January - March 2026.

Findings include:

On 05/11/2026, Surveyor reviewed Resident 3's record and identified the following:

Resident 3 was admitted to the facility on 06/17/2025 with a diagnosis of Alzheimer's disease. Resident 3 discharged from the facility on 04/28/2026. Resident 3 had an activated healthcare power of attorney. Resident 3's ISP (unknown date) documented: "Fall Risk: [Resident 3] is a high fall risk. Ensure pathways are clear and clutter free as well as ensuring nothing is hanging/dangling from [his/her] walker. Care staff to notify community RN of changes or concerns." The ISP did not include new fall interventions after 4 falls between January-March 2026.

Resident 3's incident reports documented:

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"-01/03/2026: Writer was walking around the unit collecting dishes from lunch. When writer got to the back hallway, writer heard someone calling out for help. Writer entered the residents room and found [him/her] laying on the ground with [his/her] head towards the door and [his/her] feet by [his/her] piano. When writer asked what happened, resident stated that [Resident 2] had pushed [him/her] after [s/he] had asked for help with the door to their room. Resident said [s/he] bumped [his/her] head. Writer put a blanket under residents head and went to go get another staff member to help assist resident up off of the floor. Resident was assisted onto [his/her] chair Said that [his/her] lower back and head had just mild pain. [S/he] also stated that [s/he] is sad that [his/her] [husband/wife] wants nothing to do with [him/her] and that [s/he] wants [him/her] out of [his/her] life. Staff reassured [him/her] that [s/he] doesn't mean it and that [s/he's] just having a moment. Resident was asked if [s/he] wanted to get sent out to get looked at. Resident declined and said that [s/he's] going to be okay. Vitals and ROM were completed. POA contacted but there was no answer. A voicemail was left stating to have [him/her] give writer a call back. [Assistant Director G] was notified.

-01/05/2026 @ 6:26 PM: Fall report. Location-resident bathroom. Resident explanation and description of incident was left blank.

-03/22/2026: Resident was caught going into another resident's room and staff was trying to assist [him/her] from the room the resident started shouting "This my house and my room turn the [expletive] music down," which led the resident of the room to come, and they started going back and forth. The resident's family was trying to calm the owner of the building down, but

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[s/he] did not like the fact [s/he] had someone in [his/her] room. As the writer was trying to get resident out the room the resident elbowed writer in the stomach and forced [his/her] down to the floor which led [him/her] to fall really bad on the right side of [his/her] face which the right upper corner of [his/her] eyebrow to bleed. Staff did contact POA and asked if [s/he] would like to send [him/her] out and [s/he] stated "No that's not necessary and [s/he] wanted staff to finish cleaning the wound and wanted staff to put a bandage over it." Residents POA and [boyfriend/girlfriend] came, and the [boyfriend/girlfriend] wanted to look and take care of the womb [sic] [him/herself] due to [him/her] being a physician. Residents POA and [boyfriend/girlfriend] did stay to help staff with making sure resident goes back to [his/her] room and making [him/her] feel comfortable. The family did suggest that resident and [husband/wife] eat in their rooms and they will sit with them for a few hours just to make sure things are going okay. Writer did contact [Assistant Director G] to let [him/her] know about the incident.

-03/31/2026: This morning around 7:03 AM - as usual - I entered the residents room to wake them up and help them get ready for breakfast. However, when I opened the door, I found [him/her] lying on the floor; [s/he] looked sad and was clutching [his/her] chest in pain. [S/he] said [s/he[had fallen but could not recall what time it had happened. Staff went out to get help to lift [him/her] up; when I returned [s/he] had already managed to get up on [his/her] own. I asked if [s/he] was in pain or if she had injured any part of [his/her] head or body, but [s/he] only mentioned that [his/her] chest hurt. Upon entering the room, I found [Resident 2] lying on the floor; the room look disheveled, with items scattered across the

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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 389	Continued From page 13 floor. Recommended steps to help prevent a recurrence of event: to remove recliners or couch from room as it is too congested with furniture." On 05/12/2026 at 11:00 AM, Surveyor interviewed and shared findings with Director A, Director of Operations B, Assistant Director G, Nurse H, Regional Nurse L, and LPN M. Surveyor questioned who was responsible for updating resident ISPs. Director A stated nursing team was responsible. Surveyor asked why Resident 3's ISP was not updated after 4 falls and only interventions included keep pathways clear/nothing hanging from walker. Nurse H stated the provider had a care conference sometime in March but the ISP was not updated. Nurse H stated the provider did have Legal Representative K remove furniture from Resident 3's room after the fall on 3/31 and acknowledged this intervention did not get updated to the ISP. The management team acknowledged an understanding of the concerns and did not provide further comment.	N 389		
N 422	83.37(3)(f) Medication storage: internals and externals. Internal and external application. The CBRF shall physically separate medications for internal consumption from medications for external application. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that external medications were physically separated. Three of 4 medication carts had creams, eye drops in same medication tray as insulin, and other injectable medications.	N 422		

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N 422	Continued From page 14 Findings include: On 05/06/2026 at 10:00 AM, Surveyor observed the first medication cart on the second floor. There were creams, eye drops not physically separated from other medications. Caregiver C stated s/he did not know that was required but made sense as to not contaminate other medications if they leak. On 05/06/2026 at 10:15 AM, Surveyor observed the second medication cart on the second floor. There were creams, eye drops not physically separated from other medications. Caregiver C stated s/he did not know that was required but made sense as to not contaminate other medications if they leak. On 05/06/2026 at 11:15 AM, Surveyor observed the medication cart on the second floor. There were creams, eye drops not physically separated from other medications. Caregiver D stated that it made sense to physically separate liquid and creams/ointments to not contaminate other medications. Caregiver D stated that the medications would be put in plastic bags immediately and ongoing.	N 422		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that	N 433		

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N 433	Continued From page 15 may be harmful to themselves or others. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure services were provided to manage residents' behaviors. Resident 2's record included a substantial amount of documented incidents of aggression/agitation towards staff and other residents as a result of his/her disease progression. The provider did not ensure an effective behavior management plan was implemented. From January - April 2026, the provider staff documented 6 incidents where Resident 2 had been aggressive towards Resident 3 related to his/her disease progression. The provider did not assess and develop interventions to mitigate risk to the health and safety of Resident 3. The provider had been made aware in 2025 how Resident 3 was being treated while cohabitating with Resident 2. The provider did not issue a 30-day notice until mid-April 2026, did not consult with outside services on behavioral interventions, and did not provide a safe living environment for Resident 3. Findings include: The provider is licensed as a Class CNA non-ambulatory facility, and has capacity up to 52 residents in the following client groups: advanced aged, irreversible dementia/Alzheimer's, physically disabled, and developmentally disabled. On 04/11/2026, the Department received a	N 433		

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complaint alleging care concerns.

Example 1: Aggression towards staff and other residents

Record Review:

On 05/06/2026, Surveyor reviewed Resident 2's record and identified the following:

Resident 2 was admitted to the facility on 06/17/2025 with a diagnosis of dementia. Resident 2 discharged from the facility on 04/28/2026. Resident 2 had an activated healthcare power of attorney. Resident 2 was on hospice services. Resident 2's individual service plan (ISP) unknown date documented s/he required assistance with all activities of daily living: "Bathing 2-person assist: due to potential aggression/behaviors, [Resident 2] requires 2 care staff for showers. Care staff are to redirect and reapproach [Resident 2] if [s/he] is agitated. Med Passer will administer PRN Quetiapine 1 hour before showers. Care staff to document any behaviors that occur and if [Resident 2] declines assistance or becomes physical. Care staff to notify community RN of changes of concerns. Aggressive/Combative Behavior: [Resident 2] can become aggressive or agitated at times with daily tasks. Care staff are to reapproach or redirect [Resident 2] as necessary. Care staff to document if [Resident 2] is behavioral and if [s/he] refuses daily cares. Care staff to notify community RN of changes or concerns. Communication: [Resident 2] needs assistance from care staff to ensure needs are met."

Resident 2's incident reports documented: "-01/05/2026: I went in to help resident to changed depend [s/he] was very aggressive and

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kicked me in my stomach. I'm currently pregnant and [s/he] bent my fingers with a tight grip stating [s/he] wasn't getting up. I tried to explain I'm here to help [him/her] cause [s/he] had bm and was wet as well. I had to use my other hand for [him/her] to let my fingers go. I took a step back so [s/he] wouldn't kick me again and stated again I was here to help [him/her] so I then left [his/her] room and told my manager what happened and [s/he] refused to help [him/her] at that time.

-01/10/2026: writer / coworker assisted patient with morning cares. During cares resident head butted writer in the head leading to a concussion. Writers head was hurting, eyes were sensitive to light and vomiting occurred.

-01/14/2026 @ 7:38 AM: I received a call from care staff on my way into work stating they need assistance with completing personal cares for resident. Writer went in to assist with cares resident was in urgent need to be cleaned up for the day. The writer spoke soft and calmly to the resident, informing [him/her] step by step what kind of assistance I was going to give [him/her]. Resident begin to swing, punch, squeeze and head bunt writer. Care staff and writer were able to finally get resident into the bathroom, resident sat down on the toilet, resident calmed down for a few seconds, when care staff kneel down to place a clean under pants on resident, resident kicked care staff in [his/her] chest very hard, resident then begin to scratch squeeze and bend writer hand back, resident again head bunt writer above my eye. Care staff were able to get residents lower clothing and shoes on. Once this was completed care staff and I stepped back to allow resident to stand up. Writer told care staff to go under residents' arm and writer did the same, writer turned resident facing the wall and assisted

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resident to hold on to the bar, so care staff could complete peri care. Because resident continued to struggle and resist help. Care staff tried again to assist with pulling [his/her] underpants up and again resident again began to swing and punch writer. The care for this resident is coming too hard to deal with, I am afraid one of our staff as well as [his/her] [husband/wife] will get hurt trying to care for this resident, [s/he] is very strong and violent. This resident is not a 1 or 2 person assist, sadly it takes 3 staff to completed cares for resident.

-02/08/2026: Writer and caregiver went into residents' room in attempt to get [him/her] cleaned and dressed for the day. Upon entry resident was calm and compliant with initiating cares. [S/he] willingly walked into the bathroom with both caregivers. Writer explained to resident what steps were going to take. Writer asked patient if cares could be completed, resident responded "yes." Caregiver started to remove resident pants, resident began screaming, stomping both writer and staff's feet, [s/he] started to throw [his/her] head at us. Writer practiced breathing exercises with patient and [s/he] calmed down. We started to initiate cares again. After a few seconds, resident grabbed staff and tossed [him/her] against the wall and started to swing at [him/her]. Writer grabbed residents hand to stop [him/her] from punching staff. Resident turned around and started to hit writer pushing [him/her] against the bathroom door. Resident grabbed writers wrist with one hand and with the other hand started to bend writers thumb all the way back until cracking noises were heard. [Resident 3] opened the bathroom door and started to shout at [him/her] telling [him/her] to stop hurting us ladies and allow us to care for [him/her]. Writer and staff told [Resident 3] that

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N 433	Continued From page 19 [s/he] should back up because we do not want [him/her] to get hurt. [Resident 3] continued to attempt to get [him/her] to stop causing harm. Resident started screaming and stomping on writers foot and charged at [Resident 3] and punching [him/her] in the chest with a closed fist. Staff and writer attempted to remove resident from [Resident 3] and [s/he] started to attack staff, [s/he] grabbed [his/her] wrist and arms with both hands twisting [his/her] arm, staff tried to remove [his/her] arm from [his/her] hands but [s/he] got ahold of [his/her] hands and started to bend [his/her] fingers back. [S/he] opened [his/her] mouth and tried biting [him/her] in the face. Writer was trying to get resident to stop and [s/he] pushed writer and started to grab [him/her] by [his/her] shirt and swung towards the face. Resident would not let go of either caregiver even with attempts of caregivers trying to get away. [s/he] grabbed both caregivers by the wrist dragging them towards the toilet. Residents back was facing the toilet and both caregivers were facing [him/her]. [s/he] started shaking us and kicking. Both caregivers kept asking [him/her] to let go but [s/he] wouldn't. Threw [his/her] body into the wall / toilet dragging staff and writer down to the floor. Once on the floor [s/he] still wouldn't let go of writer and staff. Writer was able to break loose and attempted to help staff get loose but resident had [his/her] hand wrapped around [his/her] hair and a hand grabbing [his/her] forearm, writer talked [Resident 2] into calming down and [s/he] let go of staff. Caregivers tried to help resident get up and while doing so [s/he] grabbed writers thumb and twisted and bent it. [S/he] started swinging [his/her] arms at us, we gave [him/her] space and when we reproached [s/he] started attacking us again while trying to help [him/her] off the ground. Resident wouldn't allow vitals to be taken, or us near [him/her].	N 433		

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N 433	Continued From page 20 -02/15/2026: care staff came to writer stating [s/he] needed assistance with cares for resident. Resident had a large BM. Writer and coworkers went in to assist with completing cares on resident. Writer informed resident she [sic] by step of what cares were being done, resident was receptive to going into the bathroom. Writer tried to keep all residents attention on writer, so the care staff was able to complete cares, once the writer notified the resident that we were going to put [him/her] on some clean under pants and clothes, resident begin to get very aggressive, resident bent the writers hand back and dug [his/her] nails in the writers hands. Resident head bunt the writers on the forehead, writer stepped back while still holding the residents' hands. Resident continued to bend writers hands back and tried to head-bunt the writer again, but was not successful. The writer was able to talk and guide the resident to sit down on the toilet. The resident did sit down, but in the meantime of care staff were removing the resident's shoes, the resident tried to kick the other care staff in the face. The care staff jumped back and the writer was able to get the resident's shirt off and change [him/her] into [his/her] nightshirt. The writer and co-worker stood the resident up, the writer took both of the resident's hands and placed them around the writer's waist, the resident began to pinch the writer around [his/her] waist area, the care staff was able tog et the resident's shirt off into some clean underpants and nightclothes. The writer then assisted the resident into bed. -02/20/2026: writer along with [2 staff] went to resident room. Staff was giving medication to resident. Writer and staff attempted to talk to resident and get [him/her] changed for bed when resident was lying in bed [s/he] proceeded to kick	N 433		

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N 433	Continued From page 21 [his/her] left foot which hit writer in the stomach so writer and staff back up, staff was at the head of bed trying to give night medication walked passed resident when [s/he] tried to kick staff but staff had [his/her] hand on the side to block [his/her] kick but still kicked [his/her] hand. -3/13/2026: staff heard a loud noise coming from the hallway and when staff ran over to that hallway, staff observed resident on the floor. [Resident 3] had come out of the room 1 minute ago and resident appeared to be following [Resident 3]. Resident was extending [his/her] arms up trying to get staff to help [him/her] up. Care staff got resident up and walked with [him/her] to [his/her] room and assisted [him/her] to sit down in the chair. When walking back to [his/her] room resident was very combative and throwing punches to care staff. -03/16/2026 @12:45 PM: [Resident 2] at around 11:45am, I was directed to [his/her] room to change [his/her] underwere [sic]. Staff was working in the farm house area when 2 Tuscan caregiver came to get me to help to change [Resident 2] as [s/he] was full of stool on [his/her] clothes, pants, and pants [sic]. The bathroom was made in the dining area and when [s/he] arrived at the bathroom the resident became too aggressive, [s/he] took the hands that had been offered to walk [him/her] to the bathroom and squeezed them so hard that the left hand could not feel it at the time. -04/11/2026: [Resident 2] went into another resident room and threw [him/herself] on to their body. The resident was screaming my legs as I was trying to get [him/her] off the resident, [s/he] started swinging on me, [s/he] got up and tried to go into another resident room where [s/he] tried	N 433		

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to throw a punch at me and end up hitting the door causing [him/her] to bleed. [S/he] then got to punching and kicking me again and throwing things at me then twisted my fingers so hard to the point where they were going numb. I was able to get my hand away [s/he] was very aggressive.

-04/16/2026 @ 6:34 AM: me and [2 staff] went in [Resident 2's] room to change [him/her] and we went to [his/her] bed and told [him/her] hey [Resident 2] its time to get up and [s/he] started to cooperate alittle but then [s/he] stood up and walked towards the exit. I was holding [his/her] hands to tell [him/her] its ok just be calm Im going to change you, [s/he] said ok but continued to walk to the exit. Staff tried to stop [him/her], [s/he] wouldn't stop so I told [him/her] let [him/her] go. I wipe [him/her] while [s/he] was walks that didn't work because [s/he] was swinging at me to stop so we directed [him/her] back to [his/her] room. [S/he] sat on the bed so then we went in again with trying to change [him/her] while [s/he] was laying down so I'm wiping [him/her] while [s/he] lay down and [s/he] kicked me in my head so I stopped for a minute then I went back in and tried to wipe again and [s/he] kicked me again in the same spot in my temple on my head its all on video on [his/her] camera in [his/her] room then I stopped and staff went in and tried to put [him/her] some clothes on at least but [s/he] hit staff also so [s/he] kept getting mad so we left. I called both POA when calling [s/he] didn't seem to interested when [s/he] got on the phone [s/he] said "(awe ok well I guess Ill have to come up there talk to you later)" [s/he] wouldn't even let me finish tell [him/her] everything that happened, when I talked to other [son/daughter] [she] was very apologetic and [s/he] said "(Im so sorry about everything that happened well be on our way up there right away.)" @ 7:39 AM: resident

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was walking around [his/her] home with feces on [his/her] backside and leg. Staff try to assist in cleaning it off while [s/he] was walking around [his/her] home and that's when [s/he] got physical. Resident kicked staff in head and face two times. Resident also hit me two times with [his/her] hand while trying to put underwear and pants on. After that staff was directed two [sic] leave resident room."

Resident 2's progress notes documented:
"-04/25/2026 written by [Nurse H]: writer was asked to come up to where the resident was at as [s/he] was throwing things, had hit a resident with a plastic cup on the head was hitting staff and was out of control. Writer ran upstairs and tried to talk to the resident, was not able to calm the resident down, tried to get [him/her] to sit down onto a chair. [S/he] grabbed ahold of my L hand and squeezed as hard as [s/he] could, [s/he] then took my R hand and did the same thing. This continued for about 3-4 minutes. [Resident 2] then with [his/her] R foot kicked writer's L thigh and with [his/her] L closed fisted hand punched writer in the R temple area. Writer continued to calmly talk to resident until police arrived, trying to distract [him/her] from the other residents and staff. When the police arrived, writer removed self from the situation. The resident was very angry [s/he] was kicking, throwing and punching staff, [s/he] then kicked me in my legs and punched me in my chest and threw juice all over me, [Resident 3] than told staff to call police, [s/he] was very aggressive [s/he] threw hot coffee and started picking up glass cups and plates and throwing them all over the dining room area where the other residents were eating their supper.

-04/23/2026 written by [Nurse H]: Resident's [family member] spoke with writer this evening

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who was very rude and curt [sic] to writer about 30-day notice. Writer explained to [family member] who the HCPOA of [Resident 2], that it was not about [him/her], that it was about [Resident 2], how things have been happening to other residents and staff and how it was affecting the residents, not just [Resident 2]. [R2's and R3's POA K] stated "that it had to be delivered to [him/her] certified mail or be handed to [him/her] in person, that [s/he] had spoken to the Ombudsmen. And writer stated ...I do not believe so, as we are concerned for the other residents that are here and the staff, not just [Resident 2].

-04/22/2026 written by [Nurse H]: writer called HCPOA and left a voicemail reminding [him/her] that 30-day notice that it was still in effect. That if [s/he] had questions or concerns that [s/he] needed to call the facility back ...Writer also was contacted by [Hospice Nurse I] earlier in the day who, asked if the 30-day notice was given and writer stated "oh yes, it was given on Thursday, 4.16.2026," so that [Resident 2] would need to be out of the facility by 5.16.2026. [S/he] was very understanding about the whole situation. No other questions from hospice.

-04/15/2026: resident has been very aggressive the whole shift to staff members [s/he] has been kicking and swinging on staff when they are trying to get [him/her] from laying in their beds. Resident has not been wanting to be touched by anyone when they are trying to assist [him/her] to get changed even when staff comes on several different approaches.

-04/10/2026: Resident is very combative when trying to wash up and get changed. Resident did not get changed because of hitting staff when doing so. Multiple attempts and reapproaches

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with two person assists. Written by [Assistant Director G]: Writer reached out to [Hospice Provider J] and spoke with [Hospice Nurse I], to inform [Hospice Provider J] if resident has any behaviors of any sort physically with resident and staff or resident's. Staff is required to send resident out for evaluation. Written by [Nurse H]: Writer called and spoke to [R2's and R3's POA K] related to (R/T) resident's behavior and how it has been affecting the staff. Writer explained that if resident has any behaviors hitting, kicking, etc that resident will be sent out to the psych hospital. [R2's and R3's POA K] not happy about this as [s/he] felt that [s/he] should be able to decide if it was necessary. Writer stated that if it is a nursing order and it is detrimental to the resident's health that the facility does not need [R2's and R3's POA K] permission to send the resident out to the hospital. Then [R2's and R3's POA K] stated that [his/her] insurance would not be covering the hospital stay, writer stated, that we could not help that, but we had to protect our staff.

-04/09/2026: writer and coworker gave resident more time and resident is just not having it. Resident is still being aggressive and won't get up from couch in common area. Writer gave resident some time for the medication to settle in and [s/he] even finished eating breakfast before writer attempted again to toilet [him/her]. Resident is still refusing to be toileted changed. Foul smell coming from resident....Writer attempted to change resident but resident started swinging and twisting my arm. Writer did gave [him/her] morning meds and will just give it a minute before [s/he] try's [sic] again. Writer noticed very foul smell upon arrival and until resident is changed I don't doubt it'll go away.

-03/28/2026: resident refused all care was

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combative with staff members even after multiple attempts.

-03/27/2026: resident resisted care during the shift and attempted to kick staff during care. Care was provided with assistance.

-03/24/2026: [Hospice Provider J] here to see resident and change medications. D/AC Quatrain tablet extended release. Will be adding Dispersion 0.5 mg BID with [his/her] Lorazepam 0.5 mg BID. Resident also has the Lorazepam 0.5 mg PRN every 4 hours that may be used with PRN Tylenol for comfort, please use this.

-03/23/2026: writer with [Hospice Provider J] nurse R/T resident and recent behaviors. Discussed when [s/he] was having [his/her] recent falls (at night) appear to be at same time with/without staff or family present. Discussed medication Lorazepam and increasing it as well as [his/her] quatrain. Will wait for orders.

-03/16/2026: resident had a good breakfast and lunch. Resident ate all [his/her] food. Resident had a bm and I need my coworker from farm to help me because [s/he] started getting aggressive. Resident dug [his/her] nails into me leaving marks from each finger. Resident elbowed me in my face and kicked my stomach.

-03/11/2026: resident was aggressive and combative when writer and other care staff tried to toilet and change [him/her]. Resident punched writer on right arm leaving a bruise. Tried three times to get resident changed and [s/he] would put resistance. Staff was not able to change [his/her] clothes for bedtime.

-03/03/2026: resident needed a change.....Two

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staff attempted to change resident and resident became combative. Staff went to get two more people. Resident was throwing [his/her] hands and trying to punch. Staff ...help residents hands and arms, while other two staff tended to getting [his/her] bottom cleaned and wiped. Resident was stomping on staff's feet and ended up kicking staff in the stomach. Resident stomped on staff's foot. Resident was also grabbing other staffs arms hard and not letting go. Resident was yelling and combative the whole time. Resident got cleaned up to the best of staffs ability. Clean underwear and pants were placed on resident."

A review of Resident 2's March - April 2026 medication administration record (Mars) included the following medication orders:
"-Quatrain 150 mg tablet, with instructions to take 1 tablet by mouth every evening after dinner for Alzheimer's disease, with a start date of 01/25/2026 and end date of 03/05/2026.
- Quatrain 200 mg tablet, with instructions to take 1 tablet by mouth every evening after dinner for Alzheimer's disease, with a start date of 03/06/2026 and end date of 04/02/2026.
-Lorazepam 0.5 mg tablet, with instructions to take 1 tablet by mouth 3 times daily for anxiety, with a start date of 03/07/2026 and end date of 04/08/2026.
-Lorazepam 0.5 mg tablet, with instructions to take 1 tablet by mouth 2 times daily as needed (PRN) for anxiety and agitation. Only give with breakfast and lunch. Do not give Lorazepam in the evening, with a start date of 03/26/2026 and end date of 04/09/2026.
- Lorazepam 0.5 mg tablet, with instructions to take 1 tablet by mouth every 8 hours as PRN for anxiety, with a start date of 01/24/2026 and end date of 03/26/2026.
- Lorazepam 0.5 mg tablet, with instructions to

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take 1 tablet by mouth every 4 hours PRN for anxiety, with a start date of 04/19/2026 and end date of 04/29/2026.
-Buspier 15 mg, with instructions to take 1 tablet by mouth daily for anxiety/agitation, with a start date of 04/06/2026 and end date of 04/29/2026.
-Risperidone 1 mg/ml solution, with instructions to take 0.5 mg (ml) by mouth 2 times daily for anxiety/agitation, with a start date of 03/25/2026 and end date of 04/29/2026.

Resident 2's March 2026 MAR included administration of Resident 2's PRN Lorazepam on the following dates: 03/17 (1), 03/18 (1), 03/19 (1), 03/22 (1), 03/24 (1), 03/25 (1), 03/26 (1). Resident 2's April 2026 MAR did not include administrations of PRN Lorazepam.

Interviews:

On 05/06/2026 at 3:45 PM, Surveyor interviewed Director A, Director of Operations B, and Regional Nurse L regarding Resident 2 and Resident 3. Director of Operations B reported Resident 2 was aggressive towards staff, resistant to cares, and his/her family was difficult to work with.

On 05/11/2026 at 2:55 PM, Surveyor interviewed R2's and R3's POA K via phone. R2's and R3's POA K acknowledged concerns with Resident 2's aggression. R2's and R3's POA K reported due to Resident 2's diagnosis s/he was confused, could not communicate his/her needs, and thought people were trying to hurt him/her. R2's and R3's POA K acknowledged staff were being attacked. Surveyor shared many entries in Resident 2's record included staff reapproaching to complete cares without success. Surveyor questioned if the facility had consulted with him/her about

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behavioral interventions. R2's and R3's POA K stated "no."

On 05/12/2026 at 9:17 AM, Surveyor interviewed Caregiver N via phone. Caregiver N stated due to Resident 2's dementia s/he would get aggressive during brief changes/clean ups. Caregiver N stated s/he was kicked in the chest and had nails dug into his/her skin. Caregiver N stated concerns were reported to management, but nothing was done about it, we were told only to keep reapproaching. Surveyor questioned if Resident 2 had a behavior plan. Caregiver N stated staff only had PRN medication to give 1 hour prior to cares or to keep reapproaching. Caregiver N stated s/he was not aware of any other behavior interventions. Caregiver N stated the PRN intervention was mostly effective for me, but heard other staff it was not effective.

On 05/12/2026 at 10:31 AM, Surveyor interviewed Caregiver O via phone. Caregiver O stated to due to Resident 2's dementia s/he would get aggressive towards staff and Resident 3. Caregiver O stated it took 3, sometimes 4 staff to successfully change him/her. Surveyor questioned if Resident 2 had a behavior plan. Caregiver O stated staff used PRN medication given 1 hour prior to cares or reapproach. Caregiver O stated s/he was not aware of any other behavioral interventions. Caregiver O stated s/he had observed Resident 2 get aggressive with his/her family as well.

On 05/12/2026 at 11:00 AM, Surveyor interviewed and shared findings with Director A, Director of Operations B, Assistant Director G, Nurse H, Regional Nurse L, and LPN M via phone. Surveyor reviewed the above concerns, including substantial entries of aggression and explained

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N 433	Continued From page 30 Resident 2's ISP had not been updated to provide staff with individualized strategies for more effective responses. Surveyor questioned if Resident 2 had a behavioral assessment completed after repeated acts of aggression towards Resident 3, staff, and other residents. The management team was reviewing Resident 2's record during the call and confirmed Resident 2's record did not contain evidence of a behavioral assessment. Surveyor questioned if outside services were consulted for behavioral interventions. The management team reported hospice was responsible for Resident 2's care management and our staff continued with reapproaching to complete cares. Assistant Director G and Nurse G reported they communicated to hospice about Resident 2's behaviors and a 30-day notice was issued in mid-April related to his/her aggression. Assistant Director G and Nurse H reported hospice did not discuss a behavior plan or additional services needed for Resident 2. Surveyor questioned Resident 2's progress note entry from 01/05/2026 that noted staff was kicked in the stomach while pregnant and when staff went to management for help, help was declined. Assistant Director G stated s/he was aware of the January incident but after reviewing the incident report, it was a different management staff who allegedly did not provide assistance. Assistant Director G stated the provider had dementia training in April for staff. The management team reported R2's and R3's POA K was difficult to work with and would not allow Resident 2 to be sent out for evaluation. The management team acknowledged an understanding of the concerns, but did not provide further comment. On 05/18/2026 at 1:35 PM, Surveyor interviewed Hospice Nurse I via phone. Hospice Nurse I	N 433		

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acknowledged s/he was aware of Resident 2's aggressive/agitation behaviors. Hospice Nurse I stated hospice's CNA was successful with 1 person to complete cares using a calm approach. Hospice Nurse I stated facility staff would usually double up and this would cause Resident 2 to be scared and agitated. Hospice Nurse I stated medication changes were ongoing during Resident 2's admission to assist with his/her agitation. Hospice Nurse I stated the provider never talked to hospice about consulting with outside services regarding Resident 2's behaviors. Hospice Nurse I stated s/he was aware of the 30-day notice, but it was not issued until mid-April. Hospice Nurse I stated s/he felt the facility should have done more training on working with memory care residents.

Example 2: Aggression towards Resident 3

On 05/06/2026, Surveyor reviewed Resident 2's and Resident 3's record and identified the following:

Record Review:

Resident 3 was admitted to the facility on 06/17/2025 with a diagnosis of Alzheimer's disease. Resident 3 discharged from the facility on 04/28/2026. During Resident 3's admission s/he shared a room with Resident 2 as a married couple. Resident 3 had an activated healthcare power of attorney. Resident 3's ISP (unknown date) documented: "Capacity for self-care: independent, Capacity for self-direction: makes needs known, Motivation and Attitude: [Resident 3] has a positive attitude, Interaction: [Resident 3] is independent with interactions in the community and Positive Self Concept: [Resident 3] has a positive self-concept."

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Resident 3's incident reports documented:
"-01/03/2026: Writer was walking around the unit collecting dishes from lunch. When writer got to the back hallway, writer heard someone calling out for help. Writer entered the residents room and found [him/her] laying on the ground with [his/her] head towards the door and [his/her] feet by [his/her] piano. When writer asked what happened, resident stated that [Resident 2] had pushed [him/her] after [s/he] had asked for help with the door to their room. Resident said [s/he] bumped [his/her] head. Writer put a blanket under residents head and went to go get another staff member to help assist resident up off of the floor. Resident was assisted onto [his/her] chair. Said that [his/her] lower back and head had just mild pain. [S/he] also stated that [s/he] is sad that [his/her] [husband/wife] wants nothing to do with [him/her] and that [s/he] wants [him/her] out of [his/her] life. Staff reassured [him/her] that [s/he] doesn't mean it and that [s/he's] just having a moment. Resident was asked if [s/he] wanted to get sent out to get looked at. Resident declined and said that [s/he's] going to be okay. Vitals and ROM were completed. POA contacted but there was no answer. A voicemail was left stating to have [him/her] give writer a call back. [Assistant Director G] was notified."

Resident 2's incident reports or progress notes with aggression towards Resident 3 documented:
"-02/08/2026: Writer and caregiver went into residents' room in attempt to get [him/her] cleaned and dressed for the day. Upon entry resident was calm and compliant with initiating cares. [S/he] willingly walked into the bathroom with both caregivers. Writer explained to resident what steps were going to take. Writer asked patient if cares could be completed, resident

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responded "yes." Caregiver started to remove resident pants, resident began screaming, stomping both writer and staff's feet, [s/he] started to throw [his/her] head at us. Writer practiced breathing exercises with patient and [s/he] calmed down. We started to initiate cares again. After a few seconds, resident grabbed staff and tossed [him/her] against the wall and started to swing at [him/her]. Writer grabbed residents hand to stop [him/her] from punching staff. Resident turned around and started to hit writer pushing [him/her] against the bathroom door. Resident grabbed writers wrist with one hand and with the other hand started to bend writers thumb all the way back until cracking noises were heard. [Resident 3] opened the bathroom door and started to shout at [him/her] telling [him/her] to stop hurting us and allow us to care for [him/her]. Writer and staff told [Resident 3] that [s/he] should back up because we do not want [him/her] to get hurt. [Resident 3] continued to attempt to get [him/her] to stop causing harm. Resident started screaming and stomping on writers foot and charged at [Resident 3] and punching [him/her] in the chest with a closed fist. Staff and writer attempted to remove resident from [Resident 3] and [s/he] started to attack staff, [s/he] grabbed [his/her] wrist and arms with both hands twisting [his/her] arm, staff tried to remove [his/her] arm from [his/her] hands but [s/he] got ahold of [his/her] hands and started to bend [his/her] fingers back. [S/he] opened [his/her] mouth and tried biting [him/her] in the face.

-02/12/2026: writer went in to give resident [his/her] 8pm acetaminophen and resident kept taking them out of [his/her] mouth. [Resident 3] got up to help assist me with getting [him/her] to take [his/her] meds in the middle of [Resident 3] telling [him/her] to take [his/her] meds [s/he]

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grabbed [him/her] right arm tight [Resident 3] stated "[Resident 2] you not going to be rough with me now let me go and take your medications." [Resident 2] then started to look around room and wife tried giving meds again [Resident 2] then hit [Resident 3] on [his/her] arm. [Resident 3] stated "that's enough [Resident 2]" and [s/he] also stated "[s/he] will be without meds and to give them at dinner it makes it easier on [him/her]."

-03/05/2026: caregiver was attempting to change resident inside bathroom. Resident become overly combative and struck [Resident 3] on [his/her] right side of the face. While attempting to rescue [Resident 3] from the attack the resident than struck the caregiver across [his/her] face sending [his/her] glasses flying across the bathroom.

-03/16/2026: resident smelled like bm before lunch like 12:45 pm. I was able to take resident to [his/her] room and I thought it would be easy to get [him/her] cleaned up. Resident tried to hit me in face so I went and grabbed coworker from farm to help maybe [s/he] could get [him/her] to change. [S/he] was not having it and immediately head-butted staff. I was holding [his/her] hands and [s/he] dug every finger nail in me, when I was finally able to switch positions of my hand and [s/he] started bending my fingers. I kept adjusting while [s/he] was bending my fingers and staff was cleaning up [his/her] bm with wipes and water and cleansing foam. [S/he] started elbowing my shoulder and I asked staff to switch after [s/he] was done so once we were able to get [him/her] to sit on the toilet I started changing [his/her] pants and as soon as I took one pant leg out [s/he] kicked me in my stomach hard. [Resident 3] was trying to calm down and [s/he] grabbed

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[his/her] two fingers and bent them so staff tried to get [his/her] hands off [Resident 3] when [s/he] elbowed multiple times in [his/her] right shoulder. I quickly was trying to change [his/her] pants and we helped [him/her] stand up I hurried and pulled them up and then took [him/her] and [Resident 3] to lunch.

-04/11/2026: resident was very combative and violent throughout the night. Resident swung [his/her] hand at another caregiver, causing a skin tear on [his/her] right hand....After [his/her] hand was bandaged, [s/he] was brought to eat dinner and again start hitting different staff at this point causing [his/her] hand to bleed heavily across the entire dinner room while other residents were eating. Once [s/he] was calmed enough to sit down and grabbed other residents food off their plants [sic] while [his/her] hand was covered in blood. [Resident 3] proceeded to relax [him/her] and the resident twisted [his/her] wrist backwards. Resident was found in another resident bed and when I went to help take [him/her] to [his/her] room [s/he] kicked me in the chest and swung and hit me until I was able to direct [him/her] back in [his/her] bed."

Interviews:

On 05/11/2026 at 2:55 PM, Surveyor interviewed R2's and R3's POA K. R2's and R3's POA K acknowledged concerns with Resident 2's aggression towards Resident 3. R2's and R3's POA K reported due to Resident 2's dementia, s/he thought people were trying to hurt him/her and often had aggressive behaviors. R2's and R3's POA K reported Resident 3 would try to intervene when Resident 2 got physical with staff and s/he would end up getting caught in the middle. Surveyor questioned why the facility

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allowed both residents to remain in the same room without a plan to address Resident 2's behaviors. R2's and R3's POA K stated s/he was not aware of any behavior plan, but did acknowledge the facility tried to send Resident 2 out to the hospital once without his/her consent. R2's and R3's POA K stated Resident 2 needed Resident 3 around to make this placement work and s/he relied on Resident 3 for calming (playing piano) and recognition of daily tasks.

On 05/12/2026 at 9:17 AM, Surveyor interviewed Caregiver N via phone. Caregiver N stated s/he witnessed Resident 2 get aggressive with Resident 3. Caregiver N stated Resident 3 would approach Resident 2 during brief changes, while s/he was attacking staff, wouldn't listen to staff directives to back up, and would end up getting attacked. Caregiver N stated s/he was unaware of any discussions regarding separating the residents.

On 05/12/2026 at 10:31 AM, Surveyor interviewed Caregiver O via phone. Caregiver O stated s/he witnessed Resident 2 become aggressive with Resident 3. Caregiver O stated Resident 3 would yell at Resident 2 to allow staff to help and if s/he saw us struggling s/he would end up getting punched, kicked, etc. Caregiver O stated staff had concerns with both residents sharing a room unsupervised but R2's and R3's POA K would not let them separate.

On 05/12/2026 at 11:00 AM, Surveyor interviewed and shared findings with Director A, Director of Operations B, Assistant Director G, Nurse H, Regional Nurse L, and LPN M via phone. The management team acknowledged they were aware of incidents of aggression with Resident 2 towards Resident 3. Assistant Director G reported

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 _____	R-C 05/12/2026

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

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N 433	Continued From page 37 Resident 2 did not attack Resident 3 on purpose; it occurred mostly when Resident 3 tried to verbally assist staff to complete cares and s/he would get caught in the middle. Assistant Director G stated the provider had discussed separating the residents last year after learning how Resident 3 was being treated but R2's and R3's POA K was not agreeable. Assistant Director G and Nurse H reported they communicated to hospice about Resident 2's behaviors and a 30-day notice was issued in mid-April. The management team acknowledged an understanding of the concerns, but did not provide further comment. On 05/18/2026 at 1:35 PM, Surveyor interviewed Hospice Nurse I via phone. Hospice Nurse I reported s/he was aware of at least 1 incident where Resident 2 had been aggressive/agitated towards Resident 3. Hospice Nurse I stated family wanted both residents to remain in the same room. Hospice Nurse I stated the provider never talked to hospice about moving the residents to separate rooms.	N 433		
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 Resident 1's room was free from odors. Resident 1's room smelled very strongly of urine. Findings include:	N 489		

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N 489	Continued From page 38 On 05/06/2026 at 9:30 AM, Surveyor observed the physical environment. Resident 1's bedroom smelled very strongly of urine. The urine smell could be detected from at least 3 rooms away. On 05/06/2026 at 10:00 AM, Surveyor interviewed Director A. Director A acknowledged that Resident 1's room smelled strongly of urine. Director A stated, "We try hard to keep resident rooms clean, but obviously we need to do a better job."	N 489		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the gas furnace was inspected at least every 3 years. The facility was unable to provide documented evidence of a furnace inspection completed since 09/22/2022. Findings include:	N 504		

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	0019367	A. BUILDING: _____ B. WING _____	R-C 05/12/2026

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N 504	Continued From page 39 On 05/06/2026, Surveyor conducted a review of safety records. The furnace inspection provided was dated 09/22/2022. On 05/11/2026 at 3:55 PM, Surveyor interviewed Administrator U regarding the missing furnace inspection. Administrator U confirmed s/he was unable to find a more recent furnace inspection completed at the facility. Administrator U stated the provider had scheduled an inspection to be completed in the near future.	N 504		