STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017058	A. BUILDING: _____ B. WING _____	R-C 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING MARKET ST CBRF	1870 MARKET ST CROSS PLAINS, WI 53528

(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 09/03/2026, the bureau of assisted living southern regional office conducted a standard survey, 2 verification visits, and a complaint investigation at Milestone Senior Living Market Street a CBRF located in Cross Plains, WI. As a result of the survey, 4 violations of DHS Chapter 83 were issued. The complaint was substantiated. 4 previous violations from statements of deficiencies (SODs) 2W0711 dated 05/07/2026 and 6TEH11 dated 04/14/2026. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed. Census: 19	{N 000}		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record.	N 302		

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

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N 302	Continued From page 1	N 302		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure within 90 days before or 7 days after admission a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse screened each person admitted to the CBRF for tuberculosis (TB) using centers for disease control and prevention standards.

On 09/03/2026, Two of the 3 resident records reviewed did not contain documentation of a TB screening.

FINDINGS INCLUDE:

On 09/03/2026, Surveyor arrived at the facility for a standard survey.

EXAMPLE 1: Resident 4

On 09/03/2026, Surveyor reviewed Resident 4's facility record. Resident 4 was admitted to the facility on 07/30/2026. Resident 4 had an activated power of attorney (APOA). No, documentation for a tuberculosis (TB) screening was in Resident 4's record.

EXAMPLE 2: Resident 5

On 09/03/2026, Surveyor reviewed Resident 5's facility record. Resident 5 was admitted to the facility on 03/13/2025. Resident 5 had an APOA. No, documentation for a TB screening was in Resident 5's record.

EXIT INTERVIEW:

On 09/03/2026 at 3:00 PM, Surveyor discussed

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N 302	Continued From page 2 the above concerns with Administrator A, Director B, Nurse I, Regional J, and Regional K. Administrator A, Director B, Nurse I, Regional J, and Regional K acknowledged Resident 4 nor Resident 5's facility record contained documentation of a TB screening was performed by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before or 7 days after admission.	N 302		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that each resident received all prescribed medications in the dosage and at intervals prescribed by a practitioner. On 08/20/2026 at approximately 4:00 PM, Resident 4 was administered 90 units of insulin when s/he was prescribed to be administered 10 units of insulin. Resident 4 was transported via ambulance to a local emergency room and admitted to an inpatient unit. This is a repeat violation from previous statement of deficiency (SOD) H30V11 dated 03/26/2021. FINDINGS INCLUDE:	N 352		

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N 352	Continued From page 3 On 08/28/2026, the Department received a complaint about medication administration practices at facility. On 09/03/2026 at approximately 9:00 AM, Surveyors arrived at facility for a complaint investigation. On 09/03/2026, Surveyor reviewed Resident 4's facility record. Resident 4 was admitted to the facility on 07/30/2026. Resident 4 had an activated power of attorney (APOA). Resident 4 was diagnosed with but not limited to type 2 diabetes mellitus and diabetic neuropathy. On 09/03/2026, Surveyor reviewed Resident 4's individualized service plan (ISP). The ISP was signed by Family Member M on 07/29/2026. The ISP document facility staff were to measure Resident 4's blood glucose level and administered his/her medications as prescribed. On 09/03/2026, Surveyor reviewed Resident 4's incident reports. On 08/20/2026 at 4:40 PM, Caregiver L documented Resident 4 received the wrong dosage of insulin. The narrative note documented the following, " ...[Resident 4] has meds @ 4:00PM. Which is a blood sugar and insulin. I was doing many tasks and I miss (sic.) read and I ended up giving too much insulin ..." Resident 4 was sent to a local emergency room via ambulance. On 09/03/2026, Surveyor reviewed Resident 4's August 2026 medication administration record (MAR). The following orders were documented: 1.) " ...INSULIN ASPA INJ FLEXPEN 100 UNIT/ML ...INJECT 10 UNITS SUBCUTANEOUSLY THREE TIMES DAILY WITH MEALS *HOLD IF NOT EATING*	N 352		

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N 352	Continued From page 4 ...7:00AM ...11:00AM ...4:00PM ...Start Date: 07/30/2026 ..." No, documentation of administration of insulin for the following intervals: 08/01/2026 at 4:00PM, 08/12/2026 at 11:00AM, 08/15/2026 at 11:00AM, 08/20/2026 at 4:00 PM. 2.) "GLUCOSE CHW 4GM ...CHEW 4 TABLETS BY MOUTH AS NEEDED FOR GLUCOSE < 80. RECHECK IN 15 MINUTES. REPEAT UNTIL GLUCOSE IS 80 OR GREATER ...Start Date: 07/30/2026 ..." Zero, administrations were documented. On 09/03/2026, Surveyor reviewed Resident 4's emergency medical service (EMS) report. On 08/20/2026 at 6:18 PM, EMT N documented, " ...Primary Impression: Hypoglycemia ...responded immediately with lights and sirens ...was also notified that the pt. had received too much insulin. CPR33 (Name Of EMT Team) was the first on scene and proceeded into [Name Of Facility]. CPR33 was not greeted by anyone at the door and spent some time searching for the patient's room in accessible areas until an employee granted access to the key card restricted memory care unit where the patient was located. CPPD (Local Police Department Officers) arrived during this time, and CPR33 was led to the patient by two staff members. CPR33 found the pt. sitting on [his/her] bed, surrounded by staff members, looking upset. The patient's chief complaint, called in by staff members, was receiving too much of [his/her] prescribed insulin injection. Staff explained that they had given 90 units of insulin at approximately 18:07 instead of [his/her] usual 10 units. [His/Her] blood sugar prior to the insulin was in the 160's. The staff did not know which type of insulin was given. Staff gave the pt. a glass of orange juice after the insulin administration and the pt. almost finished it	N 352		

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N 352	Continued From page 5 before CPR33 arrival. Staff members also took [his/her] blood glucose a few minutes after the insulin was administered. The BG at that time was 71, reported by the staff. The pt. was upset about the situation and stated, "I am feeling fine." He was able to hold a normal conversation and had no other complaints ...CPR33 got the first BG in the pt.'s room at 18:27 (6:27 PM) and was 71. Immediately after getting the BG and hearing what had happened, the pt. was assisted into the cot and given oral glucose at 18:28. The pt. finished half of the 15g tube shortly after ... the pt. was loaded into the ambulance and requested transport to the [Name Of Local Emergency Room] Due to the extreme dose of insulin administered an IV was started in the left AC with a 20-gauge needle and flushed with 10 mL of normal saline, before beginning transport ...At 18:36 (6:36 PM) another BG was taken and was 73. Because such a large dose of insulin was given, D10 was administered to the pt. at 18:43. After 100 mL of D10 the pt.'s BG was 162. This was at 18:46. The pt. reported feeling the same. All other vitals remained normal and can be found in the report ...While in the patient's room I spoke to the aide that gave the insulin. Aide did not know if the insulin given was short acting or long acting and stated it started with an "M". Aide had an incident report already filled out, and I asked if I could have a copy. Aide stated no, that it was not finished and [s/he] needed to speak to the RN about it. I asked for a face sheet, and Aide said [s/he] did not have one. I asked for a medication sheet and a DNR status, and I was informed by the Aide that they were unable to show me a computer with that information and were unable to print me off any of the above information. I explained that this was unsafe and asked why they did not have any of this information. I was handed the phone to speak with the "Nurse on	N 352		

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N 352	Continued From page 6 call". I was told by this RN that the patient was new to the facility but then explained that [s/he] moved in over a month ago. I was also told that the facility was going up on a new computer system tomorrow and this is why they were unable to print any information. When I asked what this patient's code status was, I was told that [s/he] was "unsure" and that [s/he] could not find this information on [his/her] computer. [S/he] was also not able to find a medication list or allergies. RN was able to give me patients first and last name and date of birth. She also tried to give me patients POA's name and phone number in [Name Of State]. I explained to the RN that I would not be calling the POA, that this was their responsibility. RN was unable to tell me what hospital patient used, but was able to give me [his/her] providers last name. Patient was able to tell me that [Family Member M] lives in [Name Of State] and is [his/her] legal POA ..." On 09/03/2026, Surveyor reviewed Resident 4's hospitalization after visit summary. S/he was admitted to an inpatient unit from the ER and discharged back to facility on 08/21/2026. EXIT INTERVIEW: On 09/03/2026 at 3:00 PM, Surveyor discussed the above concerns with Administrator A, Director B, Nurse I, Regional J, and Regional K. Administrator A, Director B, Nurse I, Regional J, and Regional K acknowledged Resident 4 was prescribed 10 units of insulin at 4:00 PM, but on 08/20/2026 at approximately 4:00 PM s/he was administered 90 units. Administrator A, Director B, Nurse I, Regional J, and Regional K acknowledged Resident 4 was sent to a local ER for hypoglycemia and was admitted to an inpatient unit.	N 352		

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N 352	Continued From page 7 CROSS REFERENCE: N0431 DHS Chapter 83.38(1)(g) Health Monitoring CROSS REFERENCE: N0480 DHS Chapter 83.42(3) Access To Resident Records	N 352		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the	N 431		

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provider did not ensure Resident 4 was provided with health monitoring services adequate to his/her needs.

From 08/01/2026 to 08/15/2026, Resident 4's blood glucose level wasn't documented as ordered for 23 ordered intervals.

FINDINGS INCLUDE:

On 08/28/2026, the Department received a complaint about medication administration practices at facility.

On 09/03/2026 at approximately 9:00 AM, Surveyors arrived at facility for a complaint investigation.

On 09/03/2026, Surveyor reviewed Resident 4's facility record. Resident 4 was admitted to the facility on

07/30/2026. Resident 4 had an activated power of attorney (APOA). Resident 4 was diagnosed with but not limited to type 2 diabetes mellitus and diabetic neuropathy.

On 09/03/2026, Surveyor reviewed Resident 4's individualized service plan (ISP). The ISP was signed by Family Member M on 07/29/2026. The ISP document facility staff were to measure Resident 4's blood glucose level and administered his/her medications as prescribed.

On 09/03/2026, Surveyor reviewed Resident 4's August 2026 medication administration record (MAR). Resident 4 was prescribed insulin to be administered 4 times daily via subcutaneous injection:
1.) Glargine Insulin - administer 45 units twice

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daily at 8:00AM and 8:00PM.
2.) Insluin Aspart - administer 10 units three times daily at 7:00AM, 11:00AM, and 4:00 PM.

Resident 4's doctor ordered blood glucose measurements to be drawn 4 times daily at 7:00AM, 11:00AM, 4:00PM, and 8:00 PM. The following intervals did not contain documentation of blood glucose measurements:
1.) 08/01/2026 at 4:00PM
2.) 08/01/2026 at 8:00PM
3.) 08/03/2026 at 11:00AM
4.) 08/05/2026 at 4:00PM
5.) 08/05/2026 at 8:00PM
6.) 08/06/2026 at 7:00AM
7.) 08/06/2026 at 11:00AM
8.) 08/06/2026 at 4:00PM
9.) 08/06/2026 at 8:00PM
10.) 08/07/2026 at 7:00AM
11.) 08/07/2026 at 11:00AM
12.) 08/08/2026 at 4:00PM
13.) 08/08/2026 at 8:00PM
14.) 08/10/2026 at 7:00AM
15.) 08/10/2026 at 11:00AM
16.) 08/12/2026 at 7:00AM
17.) 08/12/2026 at 11:00AM
18.) 08/13/2026 at 4:00PM
19.) 08/13/2026 at 8:00PM
20.) 08/15/2026 at 7:00AM
21.) 08/15/2026 at 11:00AM
22.) 08/15/2026 at 4:00PM
23.) 08/15/2026 at 8:00PM

EXIT INTERVIEW:

On 09/03/2026 at 3:00 PM, Surveyor discussed the above concerns with Administrator A, Director B, Nurse I, Regional J, and Regional K. Administrator A, Director B, Nurse I, Regional J, and Regional K acknowledged Resident 4 was a

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N 431	Continued From page 10 insulin dependent diabetic and his/her practitioner ordered blood glucose monitoring 4 times daily. Administrator A, Director B, Nurse I, Regional J, and Regional K acknowledged multiple instances in August 2026 where Resident 4 blood glucose level hadn't been documented as measured in his/her MAR. Nurse I clarified that staff only document blood glucose levels in resident MARs. CROSS REFERENCE: N0352 DHS Chapter 83.32(3)(h) Rights Of Residents: Received Medication CROSS REFERENCE: N0480 DHS Chapter 83.42(3) Access To Resident Records	N 431		
N 480	83.42(3) Access to resident records. The employee in charge on each work shift shall have a means to access resident records. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an employee in charge on each work shift had a means to access Resident 4's records. The is a repeat violation from previous statement of deficiency (SOD) 1NLQ11 dated 03/15/2022. FINDINGS INCUDE: Facility is a class CNA non-ambulatory CBRF with a capacity of 22 and provided care to the following client groups: advanced aged, irreversible dementia and Alzheimer's. On 08/28/2026, the Department received a complaint about medication administration	N 480		

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practices at facility.

On 09/03/2026 at approximately 9:00 AM, Surveyors arrived at facility for a complaint investigation.

On 09/03/2026, Surveyor reviewed Resident 4's facility record. Resident 4 was admitted to the facility on 07/30/2026. Resident 4 had an activated power of attorney (APOA). Resident 4 was diagnosed with but not limited to type 2 diabetes mellitus and diabetic neuropathy.

On 09/03/2026, Surveyor reviewed Resident 4's individualized service plan (ISP). The ISP was signed by Family Member M on 07/29/2026. The ISP document facility staff were to measure Resident 4's blood glucose level and administered his/her medications as prescribed.

On 09/03/2026, Surveyor reviewed Resident 4's incident reports. On 08/20/2026 at 4:40 PM, Caregiver L documented Resident 4 received the wrong dosage of insulin. The narrative note documented the following, " ...[Resident 4] has meds @ 4:00PM. Which is a blood sugar and insulin. I was doing many tasks and I miss (sic.) read and I ended up giving too much insulin ..." Resident 4 was sent to a local emergency room via ambulance.
On 09/03/2026, Surveyor reviewed Resident 4's emergency medical service (EMS) report. On 08/20/2026 at 6:18 PM, EMT N documented, " ...Primary Impression: Hypoglycemia ...responded immediately with lights and sirens ...was also notified that the pt. had received too much insulin. CPR33 (Name Of EMT Team) was the first on scene and proceeded into [Name Of Facility]. CPR33 was not greeted by anyone at the door and spent some time searching for the

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N 480	Continued From page 12	N 480		

patient's room in accessible areas until an employee granted access to the key card restricted memory care unit where the patient was located. CPPD (Local Police Department Officers) arrived during this time, and CPR33 was led to the patient by two staff members. CPR33 found the pt. sitting on [his/her] bed, surrounded by staff members, looking upset. The patient's chief complaint, called in by staff members, was receiving too much of [his/her] prescribed insulin injection. Staff explained that they had given 90 units of insulin at approximately 18:07 instead of [his/her] usual 10 units. [His/Her] blood sugar prior to the insulin was in the 160's. The staff did not know which type of insulin was given. Staff gave the pt. a glass of orange juice after the insulin administration and the pt. almost finished it before CPR33 arrival. Staff members also took [his/her] blood glucose a few minutes after the insulin was administered. The BG at that time was 71, reported by the staff. The pt. was upset about the situation and stated, "I am feeling fine." He was able to hold a normal conversation and had no other complaints ...CPR33 got the first BG in the pt.'s room at 18:27 (6:27 PM) and was 71. Immediately after getting the BG and hearing what had happened, the pt. was assisted into the cot and given oral glucose at 18:28. The pt. finished half of the 15g tube shortly after ... the pt. was loaded into the ambulance and requested transport to the [Name Of Local Emergency Room] Due to the extreme dose of insulin administered an IV was started in the left AC with a 20-gauge needle and flushed with 10 mL of normal saline, before beginning transport ...At 18:36 (6:36 PM) another BG was taken and was 73. Because such a large dose of insulin was given, D10 was administered to the pt. at 18:43. After 100 mL of D10 the pt.'s BG was 162. This was at 18:46. The pt. reported feeling the same.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017058	A. BUILDING: _____ B. WING _____	R-C 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING MARKET ST CBRF	1870 MARKET ST CROSS PLAINS, WI 53528

(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 480	Continued From page 13 All other vitals remained normal and can be found in the report ...While in the patient's room I spoke to the aide that gave the insulin. Aide did not know if the insulin given was short acting or long acting and stated it started with an "M". Aide had an incident report already filled out, and I asked if I could have a copy. Aide stated no, that it was not finished and [s/he] needed to speak to the RN about it. I asked for a face sheet, and Aide said [s/he] did not have one. I asked for a medication sheet and a DNR status, and I was informed by the Aide that they were unable to show me a computer with that information and were unable to print me off any of the above information. I explained that this was unsafe and asked why they did not have any of this information. I was handed the phone to speak with the "Nurse on call". I was told by this RN that the patient was new to the facility but then explained that [s/he] moved in over a month ago. I was also told that the facility was going up on a new computer system tomorrow and this is why they were unable to print any information. When I asked what this patient's code status was, I was told that [s/he] was "unsure" and that [s/he] could not find this information on [his/her] computer. [S/he] was also not able to find a medication list or allergies. RN was able to give me patients first and last name and date of birth. She also tried to give me patients POA's name and phone number in [Name Of State]. I explained to the RN that I would not be calling the POA, that this was their responsibility. RN was unable to tell me what hospital patient used, but was able to give me [his/her] providers last name. Patient was able to tell me that [Family Member M] lives in [Name Of State] and is [his/her] legal POA ..." On 09/03/2026 at 11:30AM, Surveyor requested facility emergency protocol binder from Caregiver O. Caregiver O acknowledged facility staff utilized	N 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 480	Continued From page 14	N 480		

emergency protocol binder to store printed copies of resident's facesheet, code status and legal status for emergency situations. Caregiver O retrieved the emergency protocol binder from facilities locked medication room.

On 09/03/2026, Surveyor reviewed facility emergency protocol binder and did not see any documentation for Resident 4 maintained in the binder.

On 09/03/2026 at 12:00PM, Surveyor interviewed Nurse I. Nurse I reported s/he wasn't covering the triage phone line for facility staff the evening of 08/20/2026. Nurse I reported facility caregivers do not have access to a printer connected to the new electronic health record on evenings and weekends. Nurse I reviewed the emergency protocol binder and acknowledged Resident 4's documentation hadn't been added to the binder.

On 09/03/2026 at 12:30 PM, Surveyor interviewed Director B. Director B stated s/he was the one to answer the triage line the evening of 08/20/2026. Director B reported s/he was speaking with emergency medical technicians (EMTs) over the phone. Director B reported s/he didn't have access to Resident 4's facility records during the conversation. Director B stated s/he spoke with the EMTs while in his/her care and didn't have access to his/her laptop. Director B reported s/he supplied information to EMTs from his/her memory.

On 09/03/2026 at 3:00 PM, Surveyor discussed the above concerns with Administrator A, Director B, Nurse I, Regional J, and Regional K. Administrator A, Director B, Nurse I, Regional J, and Regional K acknowledged staff didn't have a means to print off information from the computer

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N 480	Continued From page 15 nor was documentation available for staff in the emergency protocol binder. Administrator A, Director B, Nurse I, Regional J, and Regional K acknowledged employees in charge of the 08/20/2026 evening shift didn't have a means to access Resident 4's records to provide EMTs with Resident 4's information. CROSS REFERENCE: N0352 83.32(3)(h) Rights Of Residents: Receive Medication CROSS REFERENCE: N0431 83.38(1)(g) Health Monitoring	N 480		