STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019837	A. BUILDING: _____ B. WING _____	R-C 06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE MEADOWS LAKE GENEVA	6722 STATE ROAD 50 LAKE GENEVA, WI 53147

(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 06/17/2026, Surveyor conducted a verification visit at Sage Meadows of Lake Geneva. Four (4) deficiencies were identified; two (2) are repeat deficiencies from statement of deficiency (SOD) 308912, dated 01/21/2026. Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed. Census: 27	{N 000}		
N 351	83.32(3)(g) Rights of Residents: Physical restraints In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from physical restraints. Be free from physical restraints except upon prior review and approval by the department upon written authorization from the resident ' s primary physician or advanced practice nurse prescriber as defined in s. N 8.02(2). The department may place conditions on the use of a restraint to protect the health, safety, welfare and rights of the resident. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 8 and Resident 9 were free from restraint. Resident 8 and Resident 9 had bed rails added to their beds to prevent them from falling out. Findings include:	N 351		

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

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N 351	Continued From page 1 On 06/17/2026, Surveyor conducted a verification visit. The provider was issued a license as a non-ambulatory community based residential facility (CBRF) on 08/01/2024 with the ability to serve up to 42 residents within the client groups of irreversible dementia/Alzheimer's, terminally ill, and advanced age. Example 1 - Resident 8 Surveyor reviewed Resident 8's record. Resident 8 was admitted on 08/21/2024 with diagnoses that included cerebral infarction. Surveyor reviewed Resident 8's progress notes. An entry on 05/19/2026 documented, "Staff to ensure all fall precautions are in place.r repeat every few hours. Added 'Extensive Fall Prevention Program - Adaptive Device' [Resident 8] has a half side rail to prevent falls out of [his/her] bed." On 06/17/2026 at 11:08 a.m., Surveyor interviewed Caregiver K regarding Resident 8's bed rails. Caregiver K stated that Resident 8 has half rails on both sides of his/her bed so that s/he doesn't roll out of bed. On 06/17/2026 at 12:22 p.m., Surveyor observed Resident 8 in bed with a half rail on both sides of his/her bed. Assistant Executive Director F stated that the rails were on Resident 8's bed because s/he kept falling and rolling out of bed and on the floor. Assistant Executive Director F stated that s/he did a safety assessment for Resident 8's bed rails on 04/15/2026 but did not submit a waiver to the department. Example 2 - Resident 9	N 351		

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N 351	Continued From page 2 Surveyor reviewed Resident 9's record. Resident 9 was admitted on 09/01/2022 with diagnoses that included anxiety, Parkinson's disease, and mild cognitive impairment. Surveyor reviewed Resident 9's current individualized service plan (ISP), no date noted, that documented that Resident 8 had bed rails. On 06/17/2026 at 11:08 a.m., Surveyor interviewed Caregiver K regarding Resident 9's bed rails. Caregiver K stated that s/he wasn't sure why Resident 9 had side rails, but it was probably because s/he is anxious about sliding out of bed. On 06/17/2026 at 12:22 p.m., Surveyor observed Resident 9 in bed with a half rail on both sides of his/her bed. Assistant Executive Director F stated that the rails were on Resident 9's bed when s/he started working for the provider and that they were placed on the bed because Resident 9 was terrified of falling out of bed. Assistant Executive Director F stated that s/he did not complete a safety assessment for Resident 9's side rails or submit a waiver to the department. On 06/17/2026 at 1:00 p.m., Surveyor reviewed the facility's electronic file and did not see that a waiver had been submitted to the department for Resident 8 or Resident 9's bed rails. On 06/17/2026 at 1:08 p.m., Surveyor shared the above concerns with Regional Operations J. Regional Operations J stated that s/he was unaware that bedrails were being used as fall prevention and stated s/he understands that it would be a restraint. Regional Operations J stated that s/he was unaware if a waiver had been submitted for Resident 8 or Resident 9's	N 351		

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N 351	Continued From page 3 bedrails but that Administrator I should know. On 06/18/2026 at 8:17 a.m., Surveyor received an email from Administrator I stating that no waiver has been submitted for either resident's side rails. The email also included Resident 8 and Resident 9's bedrail assessments. Resident 8's bedrail assessment, dated 04/15/2026, documented: -Resident 8 would be at risk for falling out of bed if bed rails were not used. -Resident 8 would be at risk of injury if safety rails were not supplied. -Clinical reasoning for decision; Resident has had numerous falls while asleep out of his/her bed. -Further recommendations; Bolstered mattress considered if side rails do not improve fall rate. Resident 9's bedrail assessment, dated 11/19/2025, documented: -Resident 9 is not able to get out of bed independently. -Resident 9 would be at risk for falling out of bed if bed rails were not used. -Resident 9 would be at risk of injury if safety rails were not supplied. -Clinical reasoning for decision; Resident would be a good candidate for bed rails as s/he is not a risk for entrapment or climbing over, and the bed rails will assist in providing the feeling of safety to the resident.	N 351		
{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	{N 352}		

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{N 352}	Continued From page 4	{N 352}		

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 Resident 11 received his/her fentanyl patch every 72 hours as prescribed.

This is a repeat deficiency from statement of deficiency (SOD) 308911, dated 09/10/2025 and SOD 308912, dated 01/21/2026.

Findings include:

On 06/17/2026, Surveyor reviewed the record of Resident 11. Resident 11 was admitted to the provider on 06/30/2025 with diagnoses including chronic kidney disease.
Surveyor reviewed Resident 11's physician order for FENTANYL 25 MCG/HR PATCH TO APPLY 1 PATCH TO SKIN EVERY 72 HOURS.

On 06/17/2026 at 11:38 a.m., Surveyor interviewed Resident 11 and asked where his/her fentanyl patch was placed. Resident 11 felt around on his/her back and stated that s/he did not have a patch on. Surveyor observed Resident 11's back and did not see a fentanyl patch.

Surveyor reviewed Resident 11's June 2026 medication administration record (MAR). The MAR documented that Resident 11 was to have his/her fentanyl patch removed at 8:00 a.m. then a new patch applied at 8:30 a.m. every 72 hours (06/01, 06/04, 06/07, 06/10, 06/13, and 06/16/2026). Resident 11's fentanyl patch was not documented as removed or administered on

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{N 352}	Continued From page 5 06/16/2026. On 06/17/2026 at 11:43 a.m., Surveyor interviewed Caregiver L, who was administering medications. Caregiver L stated that s/he did not administer or remove Resident 11's fentanyl patch today and that the patch should have been removed and administered yesterday, on 06/16/2026. Caregiver L stated that the provider's wifi has been down for 2 days so there might be some medications documented in the electronic MAR and some might be on a paper copy of the MAR. Caregiver L confirmed s/he could not find a fentanyl patch and stated it might have fallen off. At 11:57 a.m., Caregiver L confirmed that the administration of Resident 11's fentanyl was not documented on the electronic or paper MAR. Caregiver L reviewed the narcotic counts and proof of use record and stated that there was 3 fentanyl patches left after the administration of Resident 11's fentanyl patch on 06/13/2026. Surveyor and Caregiver L observed Resident 11 had 3 remaining fentanyl patches, Caregiver L stated it does not appear that Resident 11 was administered his/her fentanyl patch as ordered on 06/16/2026. On 06/17/2026 at 12:11 p.m., Surveyor interviewed Assistant Executive Director F who confirmed Resident 11's fentanyl patch was not administered on 06/16/2026 or 06/17/2026. Assistant Executive Director F stated that the provider was switching from one electronic MAR to another and the order did not transfer correctly so it was not scheduled in the MAR for 06/16/2026 or 06/17/2026, so it was not administered as ordered. On 06/18/2026 at 8:17 a.m., Administrator I stated, "Both ECP (previous electronic MAR) and	{N 352}		

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{N 352}	Continued From page 6 ALIS (current electronic MAR) were available during the transition period. Oversight was provided to ensure resident information remained accessible and medication administration records could be reviewed as needed. Staff had access to resident information throughout the process and continuity of medication administration was maintained through ongoing communication with leadership, pharmacy providers, hospice providers, and staff."	{N 352}		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.	N 406		

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N 406	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the CBRF did not develop and implement a policy for disposing unused, medications in compliance with federal, state and local standards or laws. This is a repeat deficiency from statement of deficiency (SOD) 308911, dated 09/10/2025. Findings include: On 06/17/2026, Surveyor reviewed the record of Resident 11. Resident 11 was admitted to the provider on 06/30/2025 with diagnoses including chronic kidney disease. Surveyor reviewed Resident 11's physician order for FENTANYL 25 MCG/HR PATCH TO APPLY 1 PATCH TO SKIN EVERY 72 HOURS. On 06/17/2026 at 11:38 a.m., Surveyor interviewed Resident 11 and asked where his/her fentanyl patch was placed. Resident 11 felt around on his/her back and stated that s/he did not have a patch on. Surveyor observed Resident 11's back and did not see a fentanyl patch. Surveyor reviewed Resident 11's June 2026 medication administration record (MAR). The MAR documented that Resident 11 was to have his/her fentanyl patch removed at 8:00 a.m. then a new patch applied at 8:30 a.m. every 72 hours (06/01, 06/04, 06/07, 06/10, 06/13, and 06/16/2026). Resident 11's fentanyl patch was not documented as removed or administered on 06/16/2026. On 06/17/2026 at 12:02 p.m., Surveyor interviewed Caregiver L, who was administering medications. Caregiver L stated that the facility has a disposition record for when they destroy	N 406		

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N 406	Continued From page 8	N 406		

medications, but that the provider does not document on the disposition record each time Resident 11's fentanyl patch is removed and does not dispose of it any certain way, just that the caregivers click off in the electronic MAR when the fentanyl patch is removed.

On 06/17/2026 at 12:11 p.m., Surveyor interviewed Assistant Executive Director F who confirmed that the provider does not keep a disposition record of when Resident 11's fentanyl patch is removed and stated s/he was unaware that would be required, but that it makes sense.

"Even after a patch is used, there is enough fentanyl left to cause illness, overdose or death in babies, children, pets and others who are accidentally exposed to the medicine in the patch. ... The FDA has included fentanyl patches on a list of medicines that should be flushed down a toilet because they could be especially harmful, and possibly fatal, in a single dose if used by someone other than the person for whom the medicine was prescribed." (Source: U.S. Food and Drug Administration, Fentanyl Patch Safety, June 2026)

On 06/17/2026 at 1:08 p.m., Regional Operations J stated s/he did not know there was fentanyl patches being used and that s/he is aware that a disposition record should have been maintained for the proper disposal of the fentanyl patches.

On 06/18/2026 at 8:17 a.m., Administrator I stated, "Staff were aware of the requirement to document the removal of fentanyl patches, this was taught by the RN (nurse). In this instance, the patch removal was completed and witnessed with nursing involvement. We will re-educated staff regarding documentation requirements for

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N 406	Continued From page 9 controlled substances and patch removal/destruction to ensure consistent documentation moving forward."	N 406		
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not document Resident 9's response after administering PRN (as needed) lorazepam, ibuprofen, acetaminophen or hydrocodone. Findings include: On 06/17/2026, Surveyor reviewed the record of Resident 11. Resident 11 was admitted to the provider on 06/30/2025 with diagnoses including chronic kidney disease. Surveyor reviewed Resident 11's physician's order for: -LORAZEPAM 0.5 MG TABLET TO TAKE 1 TO 2 TABLETS BY MOUTH EVERY 2 HOURS AS NEEDED FOR ANXIETY (1 TABLET FOR MILD,	{N 415}		

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{N 415}	Continued From page 10 2 TABLETS FOR MODERATE) -BACLOFEN 20 MG TABLET TO TAKE 1 TABLET BY MOUTH 2 TIMES DAILY WITH BREAKFAST AND LUNCH -BACLOFEN 20 MG TABLET TO TAKE 2 TABLETS BY MOUTH AT BEDTIME -GABAPENTIN 300 MG CAPSULE TO TAKE 1 CAPSULE BY MOUTH 3 TIMES DAILY -GABAPENTIN 300 MG CAPSULE TO TAKE 2 CAPSULES BY MOUTH AT BEDTIME Surveyor reviewed Resident 11's June 2026 medication administration record (MAR). Example 1: Resident 11's response after taking his/her as needed (PRN) lorazepam was not documented on the following dates: -06/09/2026 10:05 PM 1 TAB. Purpose: said his/her anxiety level was at a 5 was having some shakiness. Resident 11's response to the PRN lorazepam was not documented. -06/11/2026 8:18 AM 2 TABS. Purpose: very anxious. Resident 11's response to the PRN lorazepam was not documented. -06/13/2026 11:00 PM 2 TABS. Purpose: severe anxiety and restlessness. Resident 11's response to the PRN lorazepam was not documented. Example 2 Resident 11's baclofen and gabapentin were documented intermittently as administered and also as unavailable and waiting on pharmacy. -Resident 11's BACLOFEN 20 MG TABLET TO TAKE 1 TABLET BY MOUTH 2 TIMES DAILY WITH BREAKFAST AND LUNCH was documented 13 time as not administered due to waiting on pharmacy, and was documented as administered 19 times in June 2026. -BACLOFEN 20 MG TABLET TO TAKE 2	{N 415}		

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{N 415}	Continued From page 11 TABLETS BY MOUTH AT BEDTIME was documented 7 time as not administered due to waiting on pharmacy, and was documented as administered 8 times in June 2026. -GABAPENTIN 300 MG CAPSULE TO TAKE 1 CAPSULE BY MOUTH 3 TIMES DAILY was documented 21 time as not administered due to waiting on pharmacy, and was documented as administered 26 times in June 2026. -GABAPENTIN 300 MG CAPSULE TO TAKE 2 CAPSULES BY MOUTH AT BEDTIME was documented 7 time as not administered due to waiting on pharmacy, and was documented as administered 8 times in June 2026. On 06/17/2026 at 11:43 a.m., Surveyor interviewed Caregiver L, who was administering medications. Surveyor observed that Resident 11's baclofen and gabapentin were not available for administration and Caregiver L confirmed that Resident 11 had run out of baclofen and gabapentin and the provider was waiting for the medication to come in. On 06/18/2026 at 8:17 a.m., Administrator I stated that Assistant Executive Director F had contacted the pharmacy after staff identified that the medications were not available for administration. The pharmacy later reported the medications had been delivered; however, staff conducted a thorough search of all medication carts and storage areas and were unable to locate them. Administrator I confirmed that the medications were not available for administration.	{N 415}		