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	0019533	A. BUILDING: _____ B. WING _____	R-C 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MEADOWS SENIOR LIVING	2800 N CALHOUN RD BROOKFIELD, WI 53005

(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 05/13/2026 to 05/26/2026, Surveyors conducted a complaint investigation, standard survey, and verification visit at Sunrise Meadows Senior Living. Five deficiencies were identified. One of 5 deficiencies was a repeat violation. See Statement of Deficiency (SOD) YXPQ11 dated 02/08/2024. The previous deficiencies from SOD DM7012, dated 12/23/2025 were substantially corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed. Census: 45	{N 000}		
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 observation, interview and record review, the provider did not ensure the resident right to receive all medications in the dosage and intervals prescribed by the practitioner. Staff documented administration of Resident 3's	N 352		

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

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physician ordered polyethylene glycol when it was not administered.

This is a repeat violation. See Statement of Deficiency (SOD) YXPQ11 dated 02/08/2024.

Findings include:
The facility is licensed as a CLASS CNA (nonambulatory CBRF) able to serve up to 52 residents within the client groups of developmentally disabled, advanced aged, emotionally disturbed/mental illness and irreversible dementia/Alzheimer's.

On 05/13/2026 at 9:38 AM while inspecting the medication carts with Med Tech Q, Surveyor observed 1 nearly empty bottle of polyethylene glycol in the medication cart for Resident 3.
Pharmacy label identified (Photo 1):
Polyethylene Glycol 3350, dissolve 1 capful (17 grams) in 8 ounces water or juice and drink once daily for constipation.
Dispensed from pharmacy 12/08/2025.
Quantity 510 grams (30 doses)

On 05/13/2026, Surveyor reviewed Resident 3's record. S/he was admitted 07/09/2025.
Physician orders included polyethylene glycol powder 3350 dissolve 1 capful in 8 ounces of water or juice and drink once daily for constipation (order date 07/08/2025).

Medication Administration record (MAR) dated 12/08/2026-05/13/2026:
From 01/01/2026-05/13/2026, staff documented administration of polyethylene glycol 132 times.

On 05/13/2026 at 9:40 AM, Surveyor interviewed Med Tech Q and Med Tech R. Med Tech Q stated approximately 1 dose remained in the bottle. Med

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N 352	Continued From page 2 Tech R stated it was the only bottle of polyethylene glycol at facility for Resident 3. Med Tech R stated pharmacy only dispensed 1 bottle at a time and facility staff needed to reorder it from pharmacy. On 05/13/2026 at 3:18 PM, Surveyors discussed concern regarding staffs documentation of 132 doses of Resident 3's polyethylene glycol 3350 from a 30-dose bottle with Interim Executive Director M, RN N, Marketing Lead O and Operations Manager P. RN N stated s/he would check if additional bottles of polyethylene glycol were dispensed from a different pharmacy since 12/08/2026 and update Surveyor by noon on 05/14/2026. On 05/15/2026 at 8:41 AM, Surveyor interviewed Pharmacy Tech S who stated prior to 05/14/2026, Resident 3's poly glycol was last filled on 12/08/2026 and facility staff needed to contact pharmacy for refills. As of 3:15 PM on 05/15/2026, no additional information was received from provider regarding Resident 3's polyethylene glycol 3350.	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the	N 353		

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provider did not provide prompt and adequate treatment appropriate to Resident 4's needs.

Resident 4 experienced a fall and remained on the floor for approximately 7 hours.

Findings include:

On 03/10/2026, the Department received a complaint alleging concerns with a resident's fall.

On 05/13/2026, Surveyor conducted a complaint investigation and reviewed Resident 4's record and found the following:

Record Review:

Resident 4 was admitted to the facility on 12/09/2024 with a diagnosis of vascular dementia and Alzheimer's disease. Resident 4 had an activated healthcare power of attorney. Resident 4's individual service plan (ISP) dated 02/05/2025 documented: "Personal Safety r/t Cognitive Impairment: all medications, and chemicals are locked and inaccessible to the resident for their safety, frequent checks, resident is visually checked on frequently through the day and night to promote safety and to encourage participation in activities, frequent safety checks visual safety checks. Mobility: ambulates with assist with cane, encourage participation in activities that will increase strength and mobility, transfers self independently, encourage proper footwear, keep pathways in room clear of clutter, escorts to meals and activities. Wellness/Safety: two times bed safety check/assistance per night, call light nearby."

Resident 4's incident reports documented: "-02/06/2026 @ 6:36 unwitnessed fall: caregiver

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went to check on resident and get [him/her] dressed and observed resident laying in the middle of the bathroom floor laying on [his/her] right side with the shower curtain under [his/her] head. No apparent injuries. Res was checked for injury, none noted and assisted off the floor. VS checked. Res assisted back to couch. What interventions were added to the service plan, if any? Preventing Fall Signage posted in resident room for staff.
-02/09/2026 @ 1230 unwitnessed fall: the wellness coordinator was rounding on the resident around 11am and found [him/her] lying on the floor on [his/her] right side with [his/her] blanket rolled under [his/her] head. The resident had been observed a couple hours earlier by staff resting on [his/her] couch. The wellness coordinator notified clinical director. The clinical director immediately responded and assessed the resident and noted significant edema and bruising to [Resident 4's] right ankle and foot. The area was painful to palpation. The resident was informed that [s/he] would be sent to the ER for further evaluation and treatment. Pain, bruising, and swelling observed to resident right ankle. Res sent out to hospital. Res admitted with a right ankle fracture. An appropriate intervention will be implemented upon resident readmission and ISP will be updated."

Resident 4's monthly wellness note dated 01/13/2026 documented: "res dementia is progressing. [Resident 4] has been resistive with cares, striking out, requiring total assist with cares and dressing, and wandering into peers' rooms near [his/hers]. Documented reported behaviors: dementia progressing."

Resident 4's hospital records dated 02/09/2026 documented:

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"History of Present Illness: ...[fe/male] with Alzheimer and vascular dementia lives in assisted living [s/he] fell Friday and at that time [s/he] was able to get up and the staff at the assisted living felt that [s/he] was doing fairly well. Today [s/he] slid out off the couch [s/he] has a camera in [his/her] room and [his/her] children were able to review. [S/he] did not seem to have any chest pain or shortness of breath [s/he] did not lose consciousness. Patient is unable to give us any history. [His/her] [son/daughter] was able to help. Patient had significant right ankle swelling. Podiatry has seen the patient in ER [s/he] has a splint. Planning surgery tomorrow."

Resident 4's care task report documented:
"-2/5/2026 21:07 Wellness/Safety Check call light nearby, Frequent Safety Checks/visual safety checks? Response: Yes Documented by: [Caregiver T].
-2/6/2026 03:26 Wellness/Safety Check call light nearby? Response: Yes Documented by: [Caregiver T]."

Interviews:

On 05/13/2026 at 3:25 PM, Surveyors conducted an exit conference and shared findings with Interim Executive Director M, RN N, Marketing Lead O and Operations Manager P. Surveyor shared Resident 4's record only included 1 safety check on 3rd shift from 02/05 to 02/06 and his/her ISP noted 2 checks per night were supposed to be completed. Marketing Lead O reported s/he was aware of Resident 4's fall and concerns related to overnight supervision. Marketing Lead O reported Former Administrator U had quit on 02/09 and s/he was supposed to complete an investigation into Resident 4's fall from 2/6, after Legal Representative V had come forward with

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concerns of the fall and staff not checking on Resident 4. Marketing Lead O stated Resident 4's family was nice to work with, and they provided a copy of a video footage showing Resident 4 falling in his/her bathroom on 02/05 and staff not finding Resident 4 until the morning of 02/06. Marketing Lead O verbally confirmed s/he observed the video and acknowledged staff did not perform safety checks on Resident 4 during the night of 2/5 into 2/6, even though staff had documented checking on Resident 4. Marketing Lead O stated s/he remembers approving Caregiver T's suspension pending our investigation. Marketing Lead O reported during the investigation Caregiver T had stated s/he checked on Resident 4 at approximately 3:00 AM and observed Resident 4 walking from his/her bathroom back to the couch. Marketing Lead O stated Caregiver T did not know we had reviewed the video footage showing s/he did not check on Resident 4, and Resident 4 remained on the floor for several hours. Surveyor requested the provider's investigation into Resident 4's fall and/or Caregiver T's termination notice. Marketing Lead O stated the provider was still looking for evidence of the investigation. Surveyor noted the above requests or any other evidence related to Resident 4's fall would need to be submitted by the end of day 05/14/2026.

As of 05/15/2026, no additional documentation was received.

On 05/26/2026 at 10:43 AM, Surveyor interviewed Legal Representative V regarding Resident 4's fall on 2/5 into 2/6. Legal Representative V stated Former Administrator U had reached out proactively to obtain the video footage after his/her interview with staff had inconsistencies. Legal Representative V reported

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N 353	Continued From page 7 his/her [brother/sister] had provided a copy of the video footage to Former Administrator U and Marketing Lead O. Legal Representative V reported the video footage showed Resident 4 entering his/her bathroom at approximately 11:20 PM on 2/5, a thud can be heard from the bathroom, and Resident 4 did not exit the bathroom. Additionally, Legal Representative V reported the video footage showed an unknown dayshift staff member finding Resident 4 at approximately 7:20 AM on 2/6. Legal Representative V stated the video footage showed no staff checking on Resident 4 throughout the night even though Former Administrator U had reported staff performed a safety check at approximately 4:00 AM. Legal Representative V reported s/he had talked with Former Administrator U following the fall and s/he was going to complete an investigation. Legal Representative V stated s/he thinks Resident 4's fracture had occurred during the 2/5 fall vs 2/9 because the 2/9 fall was observed on camera and Resident 4 had slid off the couch. Legal Representative V stated the facility had a respiratory outbreak during this time and family was told Resident 4 had to isolate in his/her room. Legal Representative V reported Resident 4 was complaining s/he could not walk because his/her leg/foot was in pain prior to the fall on 2/9, but did not know the truth to this as Resident 4 was discharged to a skilled nursing facility following his/her fractured right ankle and Former Administrator U no longer worked at the facility.	N 353		
N 359	83.33(1)(a) Grievance procedure: information required A resident or any individual on behalf of the resident may file a grievance with the CBRF, the	N 359		

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N 359	Continued From page 8 department, the resident ' s case manager, if any, the board on aging and long term care, Disability Rights Wisconsin, Inc., or any other organization providing advocacy assistance. The resident and the resident ' s legal representative shall have the right to advocate throughout the grievance procedure. The written grievance procedure shall include the name, address and phone number of organizations providing advocacy for the client groups served, and the name, address and phone number of the department ' s regional office that licenses the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the posted grievance procedure included the correct address and phone number of the department's regional office that licensed the CBRF. The posted grievance procedure listed all 4 regional offices in Wisconsin but did not specify that the Southern Office licensed the CBRF, and the address and phone number for the Southern Office were incorrect. Findings include: The facility is licensed as a CLASS CNA (nonambulatory CBRF) able to serve up to 52 residents within the client groups of developmentally disabled, advanced aged, emotionally disturbed/mental illness and irreversible dementia/Alzheimer's. On 05/13/2026 at 10:36 AM, Surveyor observed the posted grievance procedure. The Bureau of	N 359		

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N 359	Continued From page 9 Assisted Living's Southern, Western, Northeastern, and Southeastern offices were listed on the procedure. The Southern office was not identified as the facility's regional office. The Southern office's phone number was listed as 1-608-266-9888 (correct phone number is 1-608-264-9888) and the address was listed as P.O. Box 7940 Madison, WI 53707-7940 (correct address is 201 E. Washington Ave Room E300 Madison, WI 53703) (Photo 3). On 05/15/2026 at 11:38 AM, Surveyor reviewed the posted grievance procedure with Interim Administrator M who stated s/he had not realized it was incorrect and would check if the posted grievance procedure was the current grievance procedure in use. On 05/13/2026 at 3:18 PM, Surveyors discussed concern regarding the posted grievance procedure with Interim Executive Director M, RN N, Marketing Lead O and Operations Manager P. Interim Executive Director M stated they would correct it right away.	N 359		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3.	N 452		

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N 452	Continued From page 10 The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not seal food stored in the pantry and did not label or date leftovers in the refrigerator/freezer. Findings include: On 05/13/2026 at 9:31 AM, Surveyor conducted a standard survey and toured the facility with Interim Executive Director M. The following was found: Dry food storage: -2 ten-pound bags of bowtie noodles were wide open at the top, exposing the contents. -1 ten-pound bag of rotini noodles was wide open at the top, exposing the contents. -1 ten-pound bag of spaghetti noodles was wide open at the top, exposing the contents. -2 ten-pound bags of macaroni noodles were wide open at the top, exposing the contents. -Freezer #5 located inside the pantry had large ice built up on all 4 racks. -Produce refrigerator #3 located inside the pantry had the following concerns: 2 unsealed zip-top bags of tortillas that were open at the top-exposing the contents and not dated, 6 bags of celery that were not sealed and were open at the top. Many leaves inside the bags of celery	N 452		

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N 452	Continued From page 11 were turning brown, looked shriveled, and were slippery to the touch. 2 small bags of red cabbage were not dated. Refrigerator and freezer storage inside the kitchen: -2 short strawberry cakes not dated. -1 small carrot role note dated. -Large bag of frozen dinner rolls was wide open at the top, exposing the contents. On 05/13/2026 at 3:25 PM, Surveyors conducted an exit conference and shared findings with Interim Executive Director M, RN N, Marketing Lead O and Operations Manager P. The management team acknowledged the above concerns and stated they would address the concerns.	N 452		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the living environment was safe, clean, comfortable, and homelike. Findings include: On 05/13/2026, Surveyor toured the facility with Interim Executive Director M and made the	N 481		

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following observations:

At 9:18 AM, Surveyor observed Resident 5's room. Scattered across Resident 5's bedroom floor, observed debris and food particles. At 2:45 PM, the same conditions were observed.

At 9:21 AM, Surveyor observed Resident 6's room. Inside the bathroom, Surveyor observed the following cleaning compounds inside a doorless cabinet: 1 gallon of Clorox disinfecting bleach, 32 oz spray bottle of Clorox multi-surface cleaner/bleach, 24 oz bottle of Clorox clinging bleach gel, medium sized bottle of The Pink Stuff floor cleaner, and a 99 oz bottle of Mr. Clean Antibacterial multi-surface cleaner. Surveyor questioned if Resident 6's living environment was safe if s/he had free access to the above cleaning compounds. Interim Executive Director M stated Resident 6 had an activated healthcare power of attorney and acknowledged Resident 6 should not have unsecured chemicals in his/her room.

At 9:26 AM, Surveyor observed the provider's 2nd laundry room. The right side of the dryer was blowing lint into the air and lint had collected on the wall behind and above the dryer.

At 9:43 AM, Surveyor observed Resident 7's room. Resident 7 was missing a light switch cover upon immediately entering his/her room.

At 9:48 AM, Surveyor observed Resident 8's room. Resident 8 had a discolored heating pad on the right side of his/her bed. The decolorization resembled bowel movement and had an odor. At 2:45 PM, the same conditions were observed.

At 9:50 AM, Surveyor observed Resident 9's

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SUNRISE MEADOWS SENIOR LIVING	2800 N CALHOUN RD BROOKFIELD, WI 53005

(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 481	Continued From page 13 room. The entryway to Resident 9's room was missing trim along the left side of the doorway. Resident 9's mattress was missing a protector. Interim Executive Director M stated all residents should have a mattress protector. On 05/13/2026 at 3:25 PM, Surveyors conducted an exit conference and shared findings with Interim Executive Director M, RN N, Marketing Lead O and Operations Manager P. The management team acknowledged the above concerns and stated they would address the concerns.	N 481		