STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 06/03/2026, with information gathered through 06/09/2026, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey and complaint investigation at Heritage Assisted Living located at 700 Welsh Road in Watertown, WI. Four citations of noncompliance were issued. The complaint was unsubstantiated. Census: 37	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that an injury experienced by Resident 1, which could not be adequately explained by him/her, was investigated with documentation maintained of the investigation. There was no documentation of actions taken to investigate a "big" right hip bruise observed on Resident 1 by caregiving staff on 05/05/2026. Findings include: On 06/03/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider	N 161		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

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N 161	Continued From page 1	N 161		

on 06/16/2025 with diagnoses including unspecified dementia with behavioral disturbance. Resident 1's current individual service plan (ISP), last dated as reviewed 01/07/2026, documented that s/he was unable to make his/her needs known and that s/he required questions to be phrased in "simple yes/no" answers to communicate. Surveyor reviewed Resident 1's observation notes from 04/01/2026 - 06/03/2026 and observed an entry dated 05/05/2026 (10:15 a.m.), which documented, "Yesterday while getting resident up for the day, I noticed that there was quite a big bruise on [his/her] right hip. I talked to [Executive Director A] and let [him/her] know. There was no follow up information within the observation notes regarding Resident 1's right hip bruise.

At approximately 4:03 p.m., Surveyor interviewed Vice President of Assisted Living B regarding any documentation of the above bruise. Vice President of Assisted Living B reported that Executive Director A had notified Resident 1's hospice agency and that a hospice agency staff member assessed Resident 1 on 05/07/2026 but found no markings. Vice President of Assisted Living B then provided Surveyor the hospice visit note from that day. In reviewing the note, Surveyor did not observe any evidence that hospice staff were aware of the "big bruise" on Resident 1's right hip or that they assessed for it. When asked if there was any reconciliation done based on the note's contents to ensure that hospice staff were aware of and specifically assessed Resident 1's right hip, Vice President of Assisted Living B replied that s/he was not sure.

At approximately 4:15 p.m., Surveyor interviewed Executive Director A about the course of actions taken upon discovery of Resident 1's right hip

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 161	Continued From page 2 bruise. Executive Director A reported s/he called Resident 1's hospice agency upon being notified of the bruise but wasn't sure who s/he specifically spoke with. Executive Director A confirmed s/he wasn't made aware of the bruise until approximately 1 day after it was first observed by caregiving staff. S/he reported that on the same day s/he was made aware of the bruise, s/he him/herself looked at it and to him/her it looked more like discoloration than a bruise, which s/he thought was due to Resident 1 sitting in his/her Broda chair. Executive Director A reported s/he did not document these actions as part of his/her investigation. Executive Director A confirmed s/he could not verify that hospice staff had assessed Resident 1's right hip specifically as part of their visit based on the contents of the note. Executive Director A reported understanding of Surveyor's concerns that there was no other documentation regarding Resident 1's right hip, including the appearance, scope, and specific location of Resident 1's alleged right hip bruise or follow-up investigation.	N 161		
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, record review, and interview, the provider did not ensure that 5 of 5 residents reviewed received all prescribed	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 352	Continued From page 3	N 352		

medications in the dosages and at intervals prescribed by their practitioners.

Staff initialed off on 95 of 95 potential administrations of Resident 2's polyethylene glycol from 03/01/2026 - 06/03/2026, an amount that would've equaled at least 3 full containers utilized in the sizes dispensed by his/her pharmacy. However, only approximately 1 and 2/3 containers were utilized during this period.

From 03/25/2026 - 06/03/2026, Resident 3 did not receive at least 40 daily doses of his/her polyethylene glycol that were initialed as administered (not accounting for the small amount of powder still observed covering his/her current use container that would indicate additional missed doses). Resident 3's record identified a diagnosis of constipation and that s/he required the administration of as needed (PRN) medication during Surveyor's review period to alleviate constipation episodes. Resident 3 also did not receive an additional 3 polyethylene glycol doses from 03/22/2026 through 03/24/2026 due to it being out.

From 05/19/2026 - 06/03/2026, Resident 4 did not receive at least 7 daily doses of his/her polyethylene glycol that were initialed as administered. Resident 4's record identified the administration of PRN medication during Surveyor's review period to alleviate constipation episodes.

From 05/06/2026 - 06/03/2026, Resident 5 did not receive approximately 15 daily doses of his/her polyethylene glycol that were initialed as administered.

From 04/18/2026 - 06/03/2026, Resident 6 did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 352	Continued From page 4 not receive at least 15 daily doses of his/her polyethylene glycol that were initialed as administered (not accounting for the small layer of powder still observed in his/her current use container that would indicate additional missed doses). Resident 6's record identified the administration of PRN medication during Surveyor's review period to alleviate constipation episodes, including 5 suppository administrations. Findings include: Example 1 - Resident 2's polyethylene glycol On 06/03/2026, at approximately 10:46 a.m., Surveyor observed the medication cart with Caregiver G, who confirmed s/he was the medication passer that day for the memory care unit. Surveyor observed the following 2 containers of polyethylene glycol prescribed to Resident 2: 1. Container of "GaviLAX" that appeared approximately 1/3 full. The manufacturer's label on the container identified that it contained 30 once-daily doses. The pharmacy label on the container identified that it was prescribed to Resident 2, dispensed on 04/15/2026, and contained instructions to, "Mix 17g[rams] (1 capful) with 4-8 oz liquid and drink once daily." There were no annotations identifying when the container was opened (Photos 5 and 6). 2. Container of polyethylene glycol that had its seal still intact. The manufacturer's label on the container identified that it contained 30 once-daily doses. The pharmacy label on the container identified that it was prescribed to Resident 2, dispensed on 05/31/2026, and contained the same instructions as the previously observed container (Photos 7, 8, and 9).	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 352	Continued From page 5	N 352		

No other containers of polyethylene glycol were observed for Resident 2.

On 06/03/2026, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 11/13/2025. There was no information regarding Resident 2's diagnoses within his/her electronic record. Resident 2's prescriptions showed his/her polyethylene glycol powder prescription with the same instructions as observed earlier, active as of at least 01/06/2026. Resident 2's medication administration records (MARs), reviewed from 03/01/2026 through 06/03/2026, showed that staff initialed off on 95 of 95 potential administrations of his/her polyethylene glycol powder (49 of which occurred from 04/16/2026, the day after his/her current-use observed container was dispensed, through 06/03/2026).

On 06/08/2026, at approximately 1:45 p.m., Surveyor interviewed Pharmacy Manager H from the pharmacy that dispensed Resident 2's medications. Pharmacy Manager H reported that 510-gram containers (the same size as observed by Surveyor on site) were dispensed, 1 each, on 01/06/2026, 02/09/2026, 04/15/2026, and 05/31/2026.

In reconciling the container open date, prescription, and MARs, Surveyor noted that even if administered daily as prescribed since 01/06/2026, the periods between each container's dispensing was greater than 30 days (the maximum number of doses contained within each container) - most notably the approximate 63-day period between 02/09/2026 - 04/15/2026. Surveyor noted that the current container of Resident 2's polyethylene glycol in use,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 352	Continued From page 6	N 352		

dispensed on 04/15/2026, and administered as initialed by staff should have been out after at least the 05/15/2026 administration, which was inconsistent with the approximate 1/3-full container observed by Surveyor onsite. Surveyor noted that 95 administrations of Resident 2's polyethylene glycol since 03/01/2026, as signed off by staff, would have amounted to 3 full containers and a small amount of a fourth container used. This was inconsistent with only approximately 1 and 2/3 containers used (the one that would have been used from 02/09/2026, and the approximate 2/3-empty container from 04/15/2026 observed by Surveyor).

Example 2 - Resident 3's polyethylene glycol

On 06/03/2026, at approximately 10:46 a.m., Surveyor observed the medication cart with Caregiver G, who confirmed s/he was the medication passer that day for the memory care unit. Surveyor observed the following 2 containers of polyethylene glycol prescribed to Resident 3:

1. Container of polyethylene glycol powder that had an approximate thin layer of remaining powder enough to cover the bottom of the container. The manufacturer's label on the container identified that it contained 30 once-daily doses. The pharmacy label on the container identified that it was prescribed to Resident 3, dispensed on 03/24/2026, and contained instructions to, "Mix 1 capful (17g[rams]) in 4-6 oz of apple juice and drink once daily." A handwritten annotation in marker near the top of the container identified that it was opened on 03/25/2026 with Caregiver G's initials (Photos 10, 11, and 12). Caregiver G confirmed s/he typically wrote a date of opening when s/he opened a new container or bottle of medication for a resident and that this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 352	Continued From page 7 was an expectation for staff. 2. Container of polyethylene glycol that had its seal still intact. The manufacturer's label on the container identified that it contained 30 once-daily doses. The pharmacy label on the container identified that it was prescribed to Resident 3, dispensed on 05/31/2026, and contained the same instructions as the previously observed container (Photos 13 and 14). No other containers of polyethylene glycol were observed for Resident 3. On 06/03/2026, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 03/31/2025 with diagnoses including Alzheimer's disease and constipation. Resident 3's prescriptions showed his/her polyethylene glycol powder prescription with the same instructions as observed earlier, active as of at least 01/26/2026. Resident 3's MARs, reviewed from 03/01/2026 through 06/03/2026 documented that s/he did not receive his/her polyethylene glycol on 03/22/2026, 03/23/2026, and 03/24/2026 due to it having run out. The annotation on 03/24/2025 documented, "reordered 3/24." Surveyor noted this was 2 days after it was already marked as being out. From 03/25/2026, the day his/her container in current use was marked as being opened, through 06/03/2026, staff initialed off on 70 of 71 potential administrations of his/her polyethylene glycol powder. In reconciling the container open date, prescription, and MARs, Surveyor noted that the current container of Resident 3's polyethylene glycol in use, opened on 03/25/2026, when administered as initialed by staff (including the	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 352	Continued From page 8	N 352		

sole non-administration entry, which was a refusal documented on 04/05/2026), should have been out after the 04/23/2026 administration. As a result, Resident 3 did not receive at least 40 doses of his/her polyethylene glycol that were initialed as administered (not accounting for the small amount of powder still observed covering his/her current use container that would indicate additional missed doses).

Of note, in reviewing the MARs Surveyor observed 6 occasions that staff administered Resident 3's PRN senna 8.6 mg tablets or milk of magnesia 400 mg/5 mL oral suspension during Surveyor's review period - both of which were prescribed for constipation - including 05/01/2026, 05/02/2026, 05/03/2026 (3 administrations), and 06/02/2026. For the first 5 administrations, staff documented that Resident 3 experienced no relief.

On 06/08/2026, at approximately 1:45 p.m., Surveyor interviewed Pharmacy Manager H from the pharmacy that dispensed Resident 3's medications. Pharmacy Manager H reported that 510-gram containers (the same size as observed by Surveyor on site) were dispensed, 1 each, on 01/23/2026, 03/24/2026, and 05/31/2026.

In reconciling the prescription and dispense dates, Surveyor noted that even if administered daily as prescribed since 01/26/2026, the periods between each container's dispensing was greater than 30 days (the maximum number of doses contained within each container), including the approximate 60 days between the first and second containers dispensed and approximate 68 days between the second and third containers.

Example 3 - Resident 4's polyethylene glycol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 352	Continued From page 9 On 06/03/2026, at approximately 10:46 a.m., Surveyor observed the medication cart with Caregiver G, who confirmed s/he was the medication passer that day for the memory care unit. Surveyor observed the following 2 containers of polyethylene glycol prescribed to Resident 4: 1. Container of polyethylene glycol powder that appeared approximately 1/2 full. The manufacturer's label on the container identified that it contained 14 once-daily doses. The pharmacy label on the container identified that it was prescribed to Resident 4, dispensed on 05/19/2026, and contained instructions to, "Mix 1 capful (17grams) in 4-6 oz of liquid and drink once daily for bowel regimen." There were no annotations identifying when the container was opened (Photos 15, 16, 17, and 18). 2. Container of polyethylene glycol that had its seal still intact. The manufacturer's label on the container identified that it contained 14 once-daily doses. The pharmacy label on the container identified that it was prescribed to Resident 4, dispensed on 05/31/2026, and contained the same instructions as the previously observed container (Photos 19, 20, 21, and 22). No other containers of polyethylene glycol were observed for Resident 4. On 06/03/2026, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 03/31/2025 with diagnoses including dehydration, "senile degeneration of brain," and abnormal weight loss. Resident 4's prescriptions showed his/her polyethylene glycol powder prescription with the same instructions as observed earlier, active as of at least 02/26/2026.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 352	Continued From page 10 Resident 4's MARs, reviewed from 04/01/2026 through 06/03/2026, showed that staff initialed off on 64 of 64 potential administrations of his/her polyethylene glycol powder (15 of which occurred from 05/20/2026, the day after his/her current-use container was dispensed, through 06/03/2026). On 06/08/2026, at approximately 1:45 p.m., Surveyor interviewed Pharmacy Manager H from the pharmacy that dispensed Resident 4's medications. Pharmacy Manager H reported that 238-gram containers (the same size as observed by Surveyor on site) were dispensed, 1 each, on 01/19/2026, 03/08/2026, 04/08/2026, 04/30/2026, 05/19/2026, and 05/31/2026. In reconciling the prescription and dispense dates, Surveyor noted that even if administered daily as prescribed since 02/26/2026, the periods between each container's dispensing was greater than 14 days (the maximum number of doses contained within each container). In reconciling the container open date, prescription, and MARs, Surveyor noted that the current container of Resident 4's polyethylene glycol in use, dispensed on 05/19/2026, when administered as documented by staff should have been out after at least the 06/02/2026 administration, which was inconsistent with the approximate half-full container observed by Surveyor onsite. As a result, Resident 4 did not receive at least 7 doses of his/her polyethylene glycol that were initialed as administered. Of note, in reviewing the MARs Surveyor observed 2 occasions that staff administered Resident 4's PRN senna 8.6 mg tablets, which were prescribed for constipation during Surveyor's review period - including 04/07/2026 and 05/10/2026. For the 04/07/2026	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 352	Continued From page 11	N 352		

administration, staff documented that Resident 3 experienced no relief.

Example 4 - Resident 5's polyethylene glycol

On 06/03/2026, at approximately 10:46 a.m., Surveyor observed the medication cart with Caregiver G, who confirmed s/he was the medication passer that day for the memory care unit. Surveyor observed 1 container of polyethylene glycol prescribed to Resident 5 that appeared approximately 1/2 full. The manufacturer's label on the container identified that it contained 30 once-daily doses. The pharmacy label on the container identified that it was prescribed to Resident 5, dispensed on 05/04/2026, and contained instructions to, "Mix 17g[rams] (1 capful) in 4-6 oz liquid and drink once daily with breakfast for constipati[on]." A handwritten annotation in marker near the top of the container identified that it was opened on 05/06/2026 (Photos 23, 24, and 25).

No other containers of polyethylene glycol were observed for Resident 5.

On 06/03/2026, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 12/09/2024 with diagnoses including Alzheimer's disease. Resident 5's prescriptions showed his/her polyethylene glycol powder prescription with the same instructions as observed earlier, active as of at least 05/05/2026. Resident 5's MARs, reviewed from 05/01/2026 through 06/03/2026 showed his/her polyethylene glycol having started to be initialed off by staff on 05/06/2026 (consistent with it having been dispensed the day prior according to the pharmacy label). From 05/06/2026, the day his/her container in current use was marked as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

(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 352	Continued From page 12 being opened, through 06/03/2026, staff initialed off on 29 of 29 potential administrations of his/her polyethylene glycol powder. In reconciling the container open date, prescription, and MARs, Surveyor noted that the current container of Resident 5's polyethylene glycol in use, opened on 05/06/2026, would have been nearly out with only 1 dose (1 capful of powder) remaining if administered as staff documented. This was inconsistent with the container observed onsite having been approximately 1/2 full. As a result, Resident 5 did not receive approximately 15 doses of his/her polyethylene glycol that were initialed as administered. On 06/08/2026, at approximately 1:45 p.m., Surveyor interviewed Pharmacy Manager H from the pharmacy that dispensed Resident 5's medications. Pharmacy Manager H reported that a single 510-gram container was dispensed on 05/04/2026. Surveyor noted this was the same container observed earlier onsite. Example 5 - Resident 6's polyethylene glycol On 06/03/2026, at approximately 10:46 a.m., Surveyor observed the medication cart with Caregiver G, who confirmed s/he was the medication passer that day for the memory care unit. Surveyor observed the following 2 containers of polyethylene glycol prescribed to Resident 6: 1. Container of polyethylene glycol powder that had an approximate small layer of remaining powder on the bottom of the container. The manufacturer's label on the container identified that it contained 30 once-daily doses. The pharmacy label on the container identified that it	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ASSISTED LIVING	700 WELSH RD WATERTOWN, WI 53098

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N 352	Continued From page 13	N 352		

was prescribed to Resident 6, dispensed on 04/07/2026, and contained instructions to, "Mix 17g[rams] (1 capful) with 4-6 ox coffee and drink once daily for bowel regime[n]." A handwritten annotation in marker near the top of the container identified that it was opened on 04/18/2026 (Photos 26 and 27).

2. Container of polyethylene glycol that had its seal still intact. The manufacturer's label on the container identified that it contained 30 once-daily doses. The pharmacy label on the container identified that it was prescribed to Resident 6, dispensed on 05/31/2026, and contained the same instructions as the previously observed container (Photos 28, 29, and 30).

No other containers of polyethylene glycol were observed for Resident 6.

On 06/03/2026, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 10/12/2023 with diagnoses including muscle weakness. Resident 6's prescriptions showed his/her polyethylene glycol powder prescription with the same instructions as observed earlier, active as of at least 12/02/2025. Resident 6's MARs, reviewed from 04/01/2026 through 06/03/2026, showed that staff initialed off on 63 of 64 potential administrations (45 of which occurred from 04/19/2026, the day after his/her current-use container was opened, through 06/03/2026).

In reconciling the container open date, prescription, and MARs, Surveyor noted that the current container of Resident 6's polyethylene glycol in use, opened on 04/18/2026, when administered as initialed by staff (including the sole non-administration entry, which was a refusal documented on 05/10/2026) should have

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N 352	Continued From page 14	N 352		

been out after the 05/19/2026 administration. As a result, Resident 6 did not receive at least 15 doses of his/her polyethylene glycol that were initialed as administered (not accounting for the small layer of powder still observed in his/her current use container that would indicate additional missed doses).

Of note, in reviewing the MARs Surveyor observed 9 occasions that staff administered Resident 6's PRN senna 8.6 mg tablets or milk of magnesia 1200 mg/15 mL oral suspension during Surveyor's review period - both of which were prescribed or administered for constipation - including 05/01/2026, 05/02/2026, 05/03/2026 (3 administrations), 05/07/2026, 05/14/2026, 05/26/2026, and 06/02/2026. For only 1 of these PRN administrations, 05/02/2026, staff documented Resident 6 experiencing relief. An administration of milk of magnesia on 05/26/2026 documented that it was being administered with the annotation, "no [bowel movement] since 5-22-26 ..." Resident 6 was also prescribed PRN bisacodyl 10 mg rectal suppositories, staff administered on 5 occasions during Surveyor's review period - 05/09/2026, 05/15/2026, 05/15/2026, 05/21/2026, and 05/22/2026. On only 2 of these occasions did staff document Resident 6 experiencing relief as a result of his/her suppository administration (05/15/2026 and 05/16/2026).

As part of Resident 6's record, Surveyor reviewed observation notes from 04/01/2026 - 06/03/2026, which appeared to mostly document his/her constipation concerns and suppository administrations. The sole entry on 05/15/2026 documented, "[Resident 6] was given a suppository at 2:30pm per hospice due to being constipated and unable to have a [bowel

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	0019479	A. BUILDING: _____ B. WING _____	C 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 352	Continued From page 15 movement (BM)]. [Resident 6] then had a large hard around 4pm. The BM was rock hard and was about the size of a softball. It was surrounded by loose and mucus like BM." On 06/08/2026, at approximately 1:45 p.m., Surveyor interviewed Pharmacy Manager H from the pharmacy that dispensed Resident 6's medications. Pharmacy Manager H reported that 510-gram containers (the same size as observed by Surveyor on site) were dispensed, 1 each, on 12/02/2025, 01/05/2026, 02/22/2026, 04/07/2026, and 05/31/2026. Surveyor noted that even if administered daily as prescribed since 12/02/2025, the periods between each container's dispensing was greater than 30 days (the maximum number of doses contained within each container). ADDITIONAL INTERVIEW: On 06/03/2026, at approximately 4:35 p.m., Surveyor interviewed Executive Director A, Vice President of Assisted Living B, and Clinical Nurse Director C. Surveyor reviewed the above findings that the number of polyethylene glycol powder administrations for each of the above residents appeared inconsistent with his/her observations of the powder amounts observed onsite. Surveyor shared the concern that these residents did not appear to be receiving their polyethylene glycol as documented by staff. All reported understanding of Surveyor's concern and denied having follow up questions. Clinical Nurse Director C reported s/he was approximately 80-90% done with conducting his/her own audit of residents' medications but had not yet discovered the issues Surveyor observed.	N 352		

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N 389	Continued From page 16	N 389		
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 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 observation, interview, and record review, the provider did not ensure that the individual service plan (ISP) for Resident 1 was reviewed and revised when there were changes in his/her needs, abilities, and physical condition that reflected his/her use of a Broda chair for ambulation, Hoyer lift for transfers, and fall mat while sleeping. Findings include: On 06/03/2026, at approximately 8:55 a.m., Surveyor interviewed Caregiver D regarding resident needs. Caregiver D reported s/he was aware of only 2 residents who required a Hoyer lift for all transfers, one of whom was Resident 1. While interviewing Caregiver D, Surveyor observed Resident 1's room and observed a Hoyer lift within.	N 389		

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N 389	Continued From page 17 At approximately 9:10 a.m., Surveyor interviewed Certified Nursing Assistant (CNA) E, from a hospice agency that was involved in the care of most of the residents within the facility. CNA E reported that Resident 1 received hospice services and that s/he used a Hoyer lift for all transfers. At approximately 9:22 a.m., Surveyor observed Resident 1's room again. Resident 1 was sleeping in a hospital bed within his/her room. A fall mat was observed out alongside the bed. A Broda chair was observed in his/her room. At approximately 9:45 a.m., Surveyor interviewed Caregiver F. Caregiver F confirmed Resident 1 used a Hoyer lift for all transfers. On 06/03/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/16/2025 with diagnoses including unspecified dementia with behavioral disturbance. Resident 1's current individual service plan (ISP), last dated as reviewed 01/07/2026, documented that s/he used a sit-to-stand lift for all transfers and a wheelchair for all ambulation. The ISP did not identify any information regarding the use of a fall mat when Resident 1 was sleeping. At approximately 4:35 p.m., Surveyor interviewed Executive Director A, Vice President of Assisted Living B, and Clinical Nurse Director C. All reported understanding of Surveyor's concern that Resident 1's ISP was not updated to reflect his/her Broda chair use for ambulation, fall mat use, and Hoyer use for all transfers. Clinical Nurse Director C reported s/he was in the process of updating resident ISPs and had not	N 389		

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N 389	Continued From page 18 yet gotten to Resident 1's ISP.	N 389		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 1 of 2 doors for the enclosed laundry room, which was on a common level with all resident bedrooms, was normally kept closed. Findings include: On 06/03/2026, Surveyors conducted a complaint investigation and standard licensing survey. According to Department records for the provider, the provider is licensed to serve up to 46 residents within the client groups of traumatic brain injury, irreversible dementia/Alzheimer's, advanced aged, physically disabled, and terminally ill. At approximately 9:34 a.m., Surveyor observed the provider's enclosed laundry room, located on the main level with all resident bedrooms. The laundry room contained 4 dryers. One door from	N 640		

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N 640	Continued From page 19 the laundry room led to the provider's designated "memory care" area, while a second door led to the "assisted living" area. (Of note, both areas, while designated separately within the provider's floor plan, are under a single sole CBRF license.) The door separating the laundry room from the "assisted living" area was observed open with a cloth placed under the door to maintain it in an open position (Photo 1). At approximately 12:24 p.m., Surveyor observed the laundry room again. The door leading to the "assisted living" area was observed in the same position it was earlier (Photo 2). At approximately 2:32 p.m., Surveyor observed the laundry room again. The door leading to the "assisted living" area was observed in the same position it was earlier (Photo 3). At approximately 3:50 p.m., Surveyor observed the laundry room again. The door leading to the "assisted living" area was observed in the same position it was earlier (Photo 4). During the period Surveyors were on site, from approximately 8:07 a.m. until the exit conference at approximately 4:35 p.m., at least one of the provider's dryers could intermittently be heard running. At approximately 4:35 p.m., Surveyor discussed the concern with Executive Director A, Vice President of Assisted Living B, and Clinical Nurse Director C that 1 of 2 laundry room doors was not kept closed throughout the day. All reported understanding of Surveyor's concern.	N 640		