STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	R-C 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 From 07/28/2026 to 08/13/2026, the bureau of assisted living southern regional office conducted a standard survey, verification visit and 2 complaint investigations at Brookdale Madison West AL/MC a CBRF located in Madison, WI. As a result of the survey, 10 violations of DHS Chapter 83 and 1 violation from DHS Chapter 50 were idenitified. One of 2 complaints were substantiated. Two of 4 violations from previous statement of deficiency (SOD) J30X11 dated 02/20/2026 were corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 30	{N 000}		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. From 07/28/2026 to 08/13/2026, Surveyors identified 10 violations of DHS Chapter 83 and 1 violation of DHS Chapter 50. Three violations identified were repeats from previous statements	{N 196}		

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

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{N 196}	Continued From page 1 of deficiency (SOD). This is a repeat violation from previous SOD RRI411 dated 10/07/2021 and SOD J30X11 dated 02/20/2026. FINDINGS INCLUDE: Facility has a Class CNA non-ambulatory license with a capacity of 42 residents and serves advanced aged, irreversible dementia & Alzheimer's. From 07/28/2026, Surveyor arrived at the facility for a standard survey, verification visit and 2 complaint investigations. From 07/28/2026 to 08/13/2026, Surveyors identified 10 violations of DHS Chapter 83, 1 violation of DHS Chapter 50 and 1 complaint was substantiated. The violations identified were as follows: 1.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 2.) 83.17(2)(a) Employees Screened For Communicable Disease 3.) 83.32(3)(i) Rights Of Residents: Adequate Treatment 4.) 83.37(1)(j) Proof-Of-Use Record 5.) 83.37(2)(d) Documentation Of Medication Administration 6.) 83.37(2)(e) Other Administration Given Or Delegated By Rn 7.) 83.38(1)(i) Behavior Management 8.) 83.43(1) Environment Safe, Clean, And Comfortable 9.) 83.45(3) Toxic Substances 10.) 83.47(2)(e) Other Evacuation Drills 11.) 50.09(1)(L) Care	{N 196}		

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{N 196}	Continued From page 2 From 07/28/2026 to 08/13/2026, The following were identified as repeat violations: 1.) 83.14(2)(a) Licensee Ensures Facility Complies With Laws 2.) 83.32(3)(i) Rights Of Residents: Adequate Treatment 6.) 83.45(3) Toxic Substances INTERVIEWS: On 07/28/2026 at 4:10 PM, Surveyors discussed concerns identified with Administrator M and Regional Nurse N. Administrator M acknowledged Caregiver R's record did not include a tuberculosis (TB) test. Administrator M and Regional Nurse N reported they could not locate Caregiver R's RN delegation for administration of injectable medications. Administrator M and Regional Nurse N acknowledged residents required scheduled subcutaneous insulin injections and as needed (PRN) intramuscular (IM) epinephrine injection. Administrator M acknowledged the provider did not have evidence of semi-annual other emergency drills. Administrator M and Regional Nurse N acknowledged Surveyor observed multiple environmental concerns which included but not limited to, a strong urine-like smell coming from Resident 6's room, several nails sticking out from damaged door trim, dust covered sprinkler head in laundry room, gross amount of lint buildup behind the 3 clothes dryers, food-like debris on kitchenette stove, and when Surveyor met Resident 2 in the provider's common area Surveyor observed under Resident 2's chair a bundle of multi-colored wires protruding directing from the floor. Surveyor observed Resident 2 playing with the wires which forced Surveyor to alert staff. Administrator M and Regional Nurse N acknowledged laundry room door handle was	{N 196}		

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{N 196}	Continued From page 3	{N 196}		

broken leaving the room unlocked leaving multiple cleaning supplies with toxic ingredients unsecured. Administrator M and Regional Nurse N acknowledged multiple cleaning supplies with toxic ingredients were stored in an unsecured cabinet in resident kitchenette. Administrator M stated 1:1 agency staff were added to Resident 2's care for his/her safety because s/he would continuously attempt to elope from the facility. Administrator M stated the 1:1 duty was to redirect Resident 2 from setting off door alarms and attempted elopements. Administrator M stated the facility staff were to follow the individualized service plan (ISP) and perform the personal care which included but not limited to showers, laundry, and housekeeping. Administrator M acknowledged Resident 2 was paying for facility to perform personal care and basic care services. Administrator M acknowledged Surveyor interviewed current caregivers and it was reported the 1:1 agency staff were tasked with laundry, showers, and housekeeping, followed by the 1:1 agency staff report to Surveyor that laundry, showers and housekeeping were facility staff responsibility. Administrator M acknowledged Resident 2's ISP wasn't being implemented as written by staff.

On 08/04/2026 at 1:30 PM, Surveyor discussed the above concerns with Administrator M and Regional Nurse O. Regional Nurse O stated that on 06/01/2026 and 06/02/2026, agency didn't send a staff to be Resident 2's 1:1 and acknowledged Resident 2 had eloped from facility both days. Administrator M acknowledged on 04/22/2026 Resident 2 was diagnosed with a right inguinal hernia and was previously prescribed the PRN medication hydrocodone for pain. Administrator M and Regional Nurse O acknowledged Resident 2 had Alzheimer's

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{N 196}	Continued From page 4	{N 196}		

disease and difficulty reporting pain. Administrator M and Regional Nurse O acknowledged Resident 2 was sent to the local ER for pain management multiple times, even though facility hadn't administered the PRN hydrocodone available to them. Administrator M and Regional Nurse O stated they were not aware only 9 doses of hydrocodone were administered from diagnosis of the hernia in April until the hernia repair surgery in June. Administrator M and Regional Nurse O were not aware on 06/17/2025 Resident 2's physician diagnosed him/her with acute pain and discontinued the PRN hydrocodone and prescribed PRN oxycodone for pain. Administrator M and Regional Nurse O stated they were not aware facility didn't administer PRN oxycodone in response to reports of pain until approximately 10 days post-operation. Surveyor asked why on May 4th when Resident 2 was crying and verbally reporting pain, staff didn't administer his/her PRN hydrocodone, or on May 11th why facility sent him/her to ER for pain management without first attempting to administer his/her PRN hydrocodone. Administrator M and Regional Nurse O reported they were not aware of those specific incidents, or details of the other pain episodes. Administrator M reported since Resident 2's hernia repair surgery on 06/25/2026, his/her behaviors of elopement and verbal aggression had greatly decreased in frequency. Administrator M reported Resident 2's 1:1 agency supervision would likely be decreased soon. Administrator M and Regional Nurse O acknowledged Resident 2's pain was not adequately managed to meet his/her needs from 04/22/2026 to 06/26/2026. Administrator M and Regional Nurse N acknowledged Resident 2 had undergone several changes in needs including a return from a

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{N 196}	Continued From page 5 surgery without being provided a comprehensive assessment upon return to facility. On 08/12/2026 at 9:23 AM, Surveyor called Administrator M. Administrator M reported Coordinator V hadn't notified him/her of possible narcotic diversion discussed with Surveyor on 08/06/2026. Administrator M stated s/he wasn't aware of a discrepancy between Resident 2's proof-of-use record and MAR. Administrator M said as far as s/he aware proof-of-use record was signed by the staff when removing narcotic tablets from the cart.	{N 196}		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation was obtained from a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse indicating Caregiver R was screened for	N 220		

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N 220	Continued From page 6 clinically apparent communicable disease including tuberculosis (TB). Findings include: On 07/28/2026, Surveyor reviewed employee records and identified the following: -Caregiver R was hired 01/20/2026. His/her record did not include a TB test. On 07/28/2026 at 4:10 PM, Surveyors conducted an exit conference and shared findings with Administrator M and Regional Nurse N. Administrator M acknowledged Caregiver R's record did not include a TB test and shared all records had been provided for review. Administrator M did not provide further comment.	N 220		
{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 provider didn't ensure Resident 2 received prompt and adequate treatment to meet his/her needs. From 04/22/2026 to 06/26/2026, Provider did not adequately treat Resident 2's acute pain secondary to right inguinal hernia to meet his/her needs.	{N 353}		

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{N 353}	Continued From page 7 This is a repeat violation from previous statement of deficiency J30X11 dated 02/20/2026. FINDINGS INCLUDE: On 07/10/2026, the department received a complaint regarding facilities behavior management processes. On 07/28/2026, Surveyor arrived at the facility for a complaint investigation. RECORD REVIEW: FACILITY RECORD: On 07/28/2026, Surveyor reviewed Resident 2's facility facesheet. Resident 2 was admitted to the facility on 03/20/2023. Resident 2 had an activated power of attorney (APOA). At time of admission Resident 2's diagnosis list documented the following but not limited to: dementia, Alzheimer's disease, major depressive disorder, and anxiety disorder. On 01/30/2026, the diagnosis of, "INFECTION AND INFLAMMATORY REACTION DUE TO INDWELLING CATHETER, SEQUELA," was added to the diagnosis list. On 06/17/2026, the diagnosis of, "ACUTE PAIN, NOT ELSEWHERE CLASSIFIED," was added to the diagnosis list. On 07/28/2026, Surveyor reviewed Resident 2's individualized service plan (ISP) dated 02/23/2026. Under the subsection titled, "Medications," the following was documented, "Be alert for expressions of pain and pain behaviors ...[Resident 2] will receive physical assistance with taking medications as prescribed.	{N 353}		

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{N 353}	Continued From page 8 On 07/28/2026, Surveyor reviewed Resident 2's comprehensive assessments. The sole comprehensive assessment documented was the pre-admission assessment dated 03/15/2023. On 07/28/2026, Surveyor reviewed Resident 2's progress notes from 02/24/2026 to 07/28/2026: 1.) On 03/26/2026 at 8:32 PM, Coordinator V documented, "Resident was sitting in the dining room with [his/her] head down in [his/her] hands when asked what's wrong the resident stated [s/he] wanted to go to urgent care [s/he] was shaking [s/he] just finished eating breakfast..." 2.) On 04/22/2026 at 1:42 PM, Coordinator V documented s/he administered PRN Hydrocodone-Acetaminophen Oral Tablet 5-325 MG because, " ...Resident complained of abdominal pain" 3.) On 04/22/2026 at 5:18 PM, Coordinator V documented, "Resident complained of abdominal pain and was given a hydrocodone about a few hours ago that is helping to relieve pain at this time Resident currently in the dining room eating dinner. [Family Member T] was called to have [him/her] look at by [his/her] primarydoctor (sic.) in one to two days per ER visit. [Family Member T] stated [s/he] will take [him/her] to the doctor if they [s/he] (sic.) can get a appointment soon. [Name Of Home Health Agency] nurse was here and stated [s/he] see (sic.) a hernia and that's where the resident's pain in the abdomen is coming from [Family Member T] is aware and trying to get [him/her] an appointment soon ...The resident was diagnosed with a UTI and prescribed antibiotics for the next 10 days." 4.) On 04/24/2026 at 2:59 PM, Coordinator V	{N 353}		

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{N 353}	Continued From page 9	{N 353}		

documented, "[Family Member T] came and picked up resident up for an outing and will return in an hour ...Resident had been complaining of lower abdominal pain and receiving pain med that is managing pain."

5.) On 04/24/2026 at 5:53 PM, Coordinator V documented the Family Member T took Resident 2 to the ER because s/he was in a lot of pain.

6.) On 04/25/2026 at 8:42 PM, Caregiver Q documented s/he administered PRN Hydrocodone-Acetaminophen Oral Tablet 5-325 MG because, " ...aggressive...upset about pain and [spouse] headache"

7.) On 05/02/2026 at 2:42 AM, Med Tech X documented s/he administered PRN Hydrocodone-Acetaminophen Oral Tablet 5-325 MG because, " ...Resident is in a lot of pain"

8.) On 05/04/2026 at 5:21 PM, Coordinator V documented, " ...resident was crying and the writer asked what's wrong and [s/he] said i (sic.) need to go to urgent care I'm in pain I told [him/her] [s/he] just got [his/her] pain meds about an hour ago ... the caregiver redirected [him/her] to maybe go and rest in bed because [s/he] was in pain walking around. [S/He] followed the caregiver to [his/her] room and got in bed and rested ..."

9.) On 05/06/2026 at 6:57 PM, Coordinator V documented, "Resident went on the bus to go to the zoo and [s/he] started to feel pain from [his/her] hernia and they brought [him/her] back resident was taken to [his/her] room by [his/her] 1:1 and rested and woke up [s/he] is crying about where is [his/her] [spouse] ..."

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{N 353}	Continued From page 10 10.) On 05/06/2026 at 9:05 PM, Med Tech Y documented s/he administered PRN Hydrocodone-Acetaminophen Oral Tablet 5-325 MG because, " ...Having Serious Pain from Hernia" 11.) On 05/09/2026 at 8:22 AM, Med Tech Z documented s/he administered PRN Hydrocodone-Acetaminophen Oral Tablet 5-325 MG because, " ...resident in visible extreme pain" 12.) On 05/11/2026 at 2:54 PM, Coordinator V documented, "[Family Member T] is here taking resident to ER because of [his/her] hernia pain. Resident was crying holding [his/her] stomach saying [s/he] is in a lot of pain. POA called and [s/he] came after work to take [him/her] to the ER to get [his/her] hernia checked out and will keep thecommunity (sic.) informed on what the hospital decides to do for [his/her] hernia." 13.) On 05/11/2026 at 6:34 PM, Coordinator V documented, "[Family Member T] took [him/her] to the ER and when [s/he] came back after dinner, [s/he] started asking to go to urgent care and [Family Member T] already taken [him/her] to see the doctor and the emergency room resident is walking around crying saying [s/he] is in pain and [s/he] has a hernia. Resident currently at the front door setting the door alarm off twice saying [s/he] needs to go to urgent care [s/he] doesn't remember going to the ER. Staff redirected [him/her] to go to [his/her] room to rest instead of walking around in pain and resident went to [his/her] room." 14.) On 05/12/2026 at 10:30 AM, Previous Manager E documented, "Writer would like to add that the Resident didn't have a 1:1 person with [him/her] yesterday and ended up at the ER	{N 353}		

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{N 353}	Continued From page 11 possibly due to lack of personalized attention." 15.) On 05/12/2026 at 4:22 PM, Coordinator V documented, "Resident returned from the ER yesterday with [Family Member T] with a binder on [his/her] stomach for the resident hernia to help relieve the pain until [s/he] goes to [his/her] office visit on June 15 consult for surgery. [Family Member T] took [him/her] out on an appointment to see [his/her] oncology doctor today and they drew [his/her] labs [Family Member T] just brought resident back from [his/her] appointment and when [s/he] stopped in the office to give me the paperwork resident was behind [him/her] and crying and [s/he] said [Resident 2] I'm take you to your room to lay down Resident currently does not have a 1:1 today this morning [s/he] was wandering around crying about [his/her] [spouse] ..." 16.) 05/21/2026 at 5:42 PM, Coordinator V documented, "Resident currently with [his/her] 1:1 and was complaining of pain with [his/her] hernia and the med passer gave [him/her] a pain pill and the resident is currently having no complaints of pain or discomfort he has his stomach binder on. Resident currently reading his newspaper in the dining room." 20.) On 06/03/2026 at 5:17 PM, Coordinator V documented, "[Name of Home Health Agency] visit VS taken at 1323 t98.0 p65 r16 118/68bp L arm sitting SPO2 98% pt verbally denied pain but objectively this writer observed pt wincing and holding Abd/groin area where pt has hernia ...." 23.) On 06/05/2026 at 8:06 PM, Caregiver R documented s/he administered PRN Hydrocodone-Acetaminophen Oral Tablet 5-325 MG.	{N 353}		

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{N 353}	Continued From page 12 24.) On 06/07/2026 at 7:50 PM, Caregiver R documented s/he administered PRN Hydrocodone-Acetaminophen Oral Tablet 5-325 MG because, " ...resident is having bad hernia pain level 6" 25.) On 06/12/2026 at 12:00 PM, Caregiver R documented s/he administered PRN Hydrocodone-Acetaminophen Oral Tablet 5-325 MG because, " ...pain level 5" 26.) On 06/17/2026 at 6:39 PM, Coordinator V documented, "Resident was crying in pain earlier the 1:1 caregiver stated [s/he] said it comes from [his/her] catheter [his/her] home health was called and they were coming for a visit today when the writer went to see resident [s/he] was crying in pain to get on [his/her] bed to lay down and when asked where is the pain [s/he] pointed to [his/her] hernia [s/he] has the white binder on and we gave [him/her] a warm cloth to put over [his/her] hernia and [s/he] was fine and rested until the home health nurse arrived the home health nurse got in touch with the resident doctornurse (sic.) to see can they get him some pain med schedule to deal with the pain until [s/he] has [his/her] hernia surgery and they will get back to us tomorrow and let the writer know if they will prescribe anything resident at his baseline no complaints of pain or discomfort behavior has been better today no exit seeking today" 27.) On 06/18/2026 at 6:09 PM, Coordinator V documented, "Resident complained of pain and can't walk this morning [s/he] was given breakfast close to [his/her] room [s/he] said [s/he] couldn't walk to the dining room [s/he] was in too much pain and [s/he] was just given [his/her] Tylenol dose resident ate [his/her] breakfast and there	{N 353}		

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were no complaints of pain for the rest of the day [s/he] has a 1:1 caregiver for both shifts and [s/he] has been doing activities with [him/her] and taking [him/her] outside for walks and [s/he] have not been exit seeking while having [his/her] 1:1 caregiver."

28.) On 06/19/2026 at 6:02 AM, Med Tech AA documented s/he administered his/her scheduled dose of Acetaminophen (Tylenol) 500 mg and , "resident was in extreme pain, nurse was contacted."

29.) On 06/25/2026 at 6:06 PM, Coordinator V documented Resident 2 left with Family Member T for his/her hernia repair surgery. Resident 2 stayed at hospital overnight for observation.

30.) On 06/26/2026 at 4:11 PM, Coordinator V documented, "Arrival Date/Time: 6/26/26 3pm ...Arrived From: Meriter Hospital ...Mode of Arrival: [Family Member T] by car ...Accompanied By: [Family Member T] Observations/Notes: : bp 138/60 p 78 t 97.7 r22 O2 97% Resident confused don't (sic.) understand [s/he] just had surgery resident complained of pain was put in bed by caregiver to rest"

31.) On 07/01/2026 at 3:59 PM, Coordinator V documented, " [Name of Home Health Agency] note foley catheter changed draining clean dark yellow urine with procedure wounds assessed no signs of infection or symptoms noted site painful activity abdominal bruising"

On 07/28/2026, Surveyor reviewed Resident 2's medication administration record (MAR) for April 2026:
1.) "Acetaminophen (Tylenol) Oral Tablet 500 MG ...Give 2 tablet by mouth three times a day

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{N 353}	Continued From page 14 (scheduled) for pain" - 4 doses were documented as "HELD" and 86 doses were documented as administered. 2.) "HYDROcodone-Acetaminophen (APAP) Oral Tablet 5-325 MG ...Give 1 tablet by mouth every 24 hours as needed (PRN) for Pain if this medication is given, [his/her] next acetaminophen dose should be cut down to 500mg instead of 1,000mg (1 Tab instead of 2 Tabs of Acetaminophen)-Start Date- 01/02/2026 1345 (1:45 PM) ...-Hold Date- from 04/24/2026 1555 (3:55 PM) to 04/25/2026 1218 (12:18 PM) -D/C Date 06/19/2026 1014 (10:14AM) - The following doses were administered: - On 04/22/2026 at 1:42 PM, Hydrocodone-APAP PRN dose was administered for 8/10 level of pain, was documented as effective in reducing pain. - On 04/23/2026 at 8:46 PM, Hydrocodone-APAP PRN dose was administered for 10/10 level of pain, was documented as effective in reducing pain. - On 04/25/2026 at 8:42 PM, Hydrocodone-APAP PRN dose was administered for 8/10 level of pain, was documented as effective in reducing pain. On 07/28/2026, Surveyor reviewed Resident 2's May 2026 MAR: 1.) "Acetaminophen (Tylenol) Oral Tablet 500 MG ...Give 2 tablet by mouth three times a day (scheduled) for pain" - All scheduled doses were administered. 2.) "HYDROcodone-Acetaminophen (APAP) Oral Tablet 5-325 MG ...Give 1 tablet by mouth every 24 hours as needed (PRN) for Pain if this medication is given, [his/her] next acetaminophen dose should be cut down to 500mg instead of	{N 353}		

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{N 353}	Continued From page 15 1,000mg (1 Tab instead of 2 Tabs of Acetaminophen)-Start Date- 01/02/2026 1345 (1:45 PM) ...-D/C Date 06/19/2026 1014 (10:14AM) - The following doses were administered: - On 05/02/2026 at 2:42 AM, Hydrocodone-APAP PRN dose was administered for 10/10 level of pain, was documented as effective in reducing pain. - On 05/06/2026 at 9:05 PM, Hydrocodone-APAP PRN dose was administered for 10/10 level of pain, was documented as effective in reducing pain. - On 05/09/2026 at 8:22 AM, Hydrocodone-APAP PRN dose was administered for 9/10 level of pain, was documented as effective in reducing pain. On 07/28/2026, Surveyor reviewed Resident 2's June 2026 MAR: 1.) "Acetaminophen (Tylenol) Oral Tablet 500 MG ...Give 2 tablet by mouth three times a day (scheduled) for pain" - 4 doses documented as "HELD," and 86 doses were documented as administered. 2.) "HYDROcodone-Acetaminophen (APAP) Oral Tablet 5-325 MG ...Give 1 tablet by mouth every 24 hours as needed (PRN) for Pain if this medication is given, [his/her] next acetaminophen dose should be cut down to 500mg instead of 1,000mg (1 Tab instead of 2 Tabs of Acetaminophen)-Start Date- 01/02/2026 1345 (1:45 PM) ... -Hold Date- from 06/17/2026 1907 (7:07 PM) to 06/19/2026 1014 (10:14 AM) ...-D/C Date 06/19/2026 1014 (10:14AM) - The following doses were administered: - On 06/05/2026 at 8:06 PM, Hydrocodone-APAP PRN dose was administered for 6/10 level of pain, was documented as effective in reducing	{N 353}		

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{N 353}	Continued From page 16 pain. - On 06/07/2026 at 7:50 PM, Hydrocodone-APAP PRN dose was administered for 6/10 level of pain, was documented as effective in reducing pain. - On 06/12/2026 at 12:00 PM, Hydrocodone-APAP PRN dose was administered for 5/10 level of pain, was documented as effective in reducing pain. 3.) "oxyCODONE HCl Oral Tablet 5 MG ...Give 1 tablet by mouth every 24 hours as needed (PRN) for Pain related to ACUTE PAIN, NOT ELSEWHERE CLASSIFIED ...-Start Date - 06/17/2026 1915 (7:15 PM) ...-Hold Date- from 06/26/2026 0841 (8:41 AM) to 06/26/2026 1511 (3:11 PM) - Zero, doses were administered. 4.) "ibuprofen Oral Tablet 200 MG ...Give 2 tablet by mouth every 8 hours as needed (PRN) for pain ...-Start Date- 06/26/2026 1945 (7:45 PM) - The following doses were administered: -On 06/27/2026 at 1:40 PM, ibuprofen dose administered for 7/10 level of pain, was documented as effective in reducing pain. -On 06/29/2026 at 5:48 PM, ibuprofen dose administered for 10/10 level of pain was documented as effective in reducing pain. On 08/01/2026, Surveyor reviewed Resident 2 home health record. The following entries were documented: 1.) On 06/03/2026 at 2:16 PM, Home Health Nurse EE documented, " ...Patient verbally denied pain; however, objectively, this writer observed the patient wincing and holding [his/her] lower abdominal/groin area where [his/her] hernia is. Reported this to [Coordinator V] prior to my departure ..."	{N 353}		

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{N 353}	Continued From page 17 2.) On 06/17/2026 at 12:01 PM, Home Health Nurse EE documented the following, "Patient verbally denied pain to this writer; however, patient was in [his/her] bed lying down for the duration of our visit. At the end of the visit, patient went to stand up to pull up [his/her] pants, and immediately grabbed the area of the hernia, winced and made an audible groan. When inquiring patient about if [s/he] was experiencing pain there, [s/he] said 'yeah, something is going on right there.' Due to patient's cognitive deficits, [s/he] doesn't recall having a hernia and that being the source for [his/her] pain. Patient was reminded about this and reminded how the hernia does not seem to cause [him/her] any pain or discomfort when [s/he] is lying down, only when first changing positions from sitting to standing and then consistently with ambulation ...Assessment findings regarding patient's pain reported to [Coordinator V]. [Coordinator V] informed this writer about lack of options for this patient for pain control and to keep [him/her] comfortable until [his/her] surgical consult in August. Plan for this writer to reach out to PCP and surgeon's office to request patient's medication list to be reviewed and explore alternatives for adequate pain control and to follow up with [Coordinator V] ...." 2.) Surveyor reviewed a document titled, "Summary of Care Rendered in Past Certification Period," signed by Home Health Nurse PP on 07/01/2026 at 11:49 PM, " ...Development of a large right inguinal hernia was discovered in April causing the patient significant pain, mainly with ambulation. Pain was being well-controlled with hydrocodone once daily, but in recent weeks, pain control has been inadequate with current medications prescribed. Inadequate pain control has been a challenge this certification period.	{N 353}		

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{N 353}	Continued From page 18 Patient takes 1,000 mg acetaminophen scheduled three times daily and if hydrocodone is given, patient's next acetaminophen dose is cut in half to keep patient under the recommended daily maximum for acetaminophen. [Coordinator V], ALF Health and Wellness Coordinator, and [Family Member T], continue to have difficulty obtaining any additional measures/changes in medications from providers to reach adequate pain control and has been told 'if patient is in that much pain, [s/he] needs to go to the ER. This patient has had several trips to the ER for inadequate pain control (not this certification period) but [s/he] is not given anything additional in the ER and not discharged back to ALF with any new medications as patient's memory is a barrier to receiving pain medications in the ER. This is what happens: pain is uncontrolled with present therapies at the ALF, patient is sent to ER after ALF staff denied additional medications to treat pain. Patient is lying on the stretcher/lying in the bed when hospital staff inquire about pain. [Resident 2] will always say no, even when staff says something to the effect of 'I was told you were having right groin/lower abdominal pain and that's what brought you here,' [Resident 2] will chuckle and say something like 'well, I don't know anything about that' or 'there doesn't seem to be any pain.' [Resident 2] will always deny pain when asked in these settings: [s/he] is sitting or lying down. [Resident 2] experiences intense pain with ambulation. If ER staff stood [Resident 2] up and had [him/her] walk 5-10 feet, they would see the visual cues of [him/her] wincing, audible cues, of [him/her] groaning, and physical cues of [him/her] grabbing the area of the hernia and if they asked at that time about pain, [s/he] will tell you because [s/he] has it in that moment; due to [his/her] dementia, if you ask about pain when [s/he] is not experiencing pain at the moment, [s/he] will say	{N 353}		

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no every time as [s/he] cannot recall previously being in pain, only what [s/he] feels in the present. On 6/17/26, This writer contacted PCP, [Doctor CC's] office, PCP, and ... surgeon, to paint this clinical picture and describe the challenges [his/her] cognitive deficits present for [him/her] receiving adequate pain control after which, hydrocodone was discontinued and oxycodone was prescribed the same day, allowing patient to receive the PRN oxycodone without reducing his scheduled acetaminophen doses. An office visit was scheduled for 6/24 to reexamine [Resident 2] on 6/24. During that visit, the decision was made to move [his/her] hernia repair surgery up from August to the next day 6/25 ..."

On 08/01/2026, Surveyor reviewed Resident 2's hospital record. On 06/08/2026, Nurse Practitioner DD documented," Assessment & Plan ...Chronic disorder with persistent behavioral disturbance including agitation and sundowning. Symptoms appeared multifactorial with contribution from inguinal hernia pain and facility stressors ...Agitation due to dementia (HCC) Persistent agitation with limited redirectability. Prior Trazodone dose reduction improved drowsiness but agitation persisted. Pain from inguinal hernia and facility stressors likely exacerbated symptoms ..."

INTERVIEW:

On 08/04/2026 at 1:30 PM, Surveyor discussed the above concerns with Administrator M and Regional Nurse O. Regional Nurse O stated that on 06/01/2026 and 06/02/2026, agency didn't send a staff to be Resident 2's 1:1 and acknowledged Resident 2 had eloped from facility both days. Administrator M acknowledged on

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{N 353}	Continued From page 20 04/22/2026 Resident 2 was diagnosed with a right inguinal hernia and was previously prescribed the PRN medication hydrocodone for pain. Administrator M and Regional Nurse O acknowledged Resident 2 had Alzheimer's disease and difficulty reporting pain. Administrator M and Regional Nurse O acknowledged Resident 2 was sent to the local ER for pain management multiple times, even though facility hadn't administered the PRN hydrocodone available to them. Administrator M and Regional Nurse O stated they were not aware from diagnosis on 04/22/2026 until his/her hernia repair surgery on 06/25/2026, facility staff hadn't administered PRN hydrocodone in response to reports of pain. Administrator M and Regional Nurse O stated they were not aware only 9 doses of hydrocodone were administered by facility between diagnosis of the hernia in April and the hernia repair surgery in June. Administrator M and Regional Nurse O were not aware on 06/17/2025 Resident 2's physician diagnosed him/her with acute pain and discontinued the PRN hydrocodone and prescribed PRN oxycodone for pain. Administrator M and Regional Nurse O stated they were not aware facility didn't administer PRN oxycodone in response to reports of pain until approximately 10 days post-operation. Surveyor asked why on May 4th when Resident 2 was crying and verbally reporting pain, staff didn't administer his/her PRN hydrocodone, or on May 11th why facility sent him/her to ER for pain management without first attempting to administer his/her PRN hydrocodone. Administrator M and Regional Nurse O reported they were not aware of those specific incidents, or details of the other pain episodes. Administrator M reported since Resident 2's hernia repair surgery on 06/25/2026, his/her	{N 353}		

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{N 353}	Continued From page 21 behaviors of elopement and verbal aggression had greatly decreased in frequency. Administrator M reported that Resident 2's 1:1 agency supervision would likely be decreased soon. Administrator M and Regional Nurse O acknowledged Resident 2's pain was not adequately managed to meet his/her needs from 04/22/2026 to 06/26/2026. Administrator M and Regional Nurse N acknowledged Resident 2 had been sent to the ER several times and returned from a surgery without being provided a comprehensive assessment. On 08/05/2026 at 2:00 PM, Surveyor spoke with Family Member T over the phone. Family Member T stated s/he wasn't aware Resident 2 had only been administered his/her PRN Hydrocodone 9 times from diagnosis of the hernia in April until his/her hernia repair surgery on 06/25/2026. Family Member T reported facility had told him/her that Resident 2's pain was out of control and sent him/her to the ER multiple times, but then Resident 2 would forget his/her pain while at the ER. Family Member T reported s/he had assumed facility had tried all their pain relief abilities before sending him/her to the ER. Family Member T stated Resident 2's behaviors were so out of control, and s/he knew some of them were pain related. Family Member T stated the hospital wanted to wait until August for the hernia repair, but during his/her appointment in June Family Member T advocated that Resident 2 couldn't wait any longer. Family Member T recalled one of Resident 2's doctors being confused about his/her description of Resident 2 unmanageable pain, and asked Family Member T why s/he wasn't getting more pain medication. Family Member T stated s/he didn't have any answers. Family Member T reported that since the hernia repair surgery when s/he checks in with the 1:1	{N 353}		

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{N 353}	Continued From page 22 agency staff they don't have any notable behavioral incidents to report. On 08/06/2026 at 5:00 PM, Home Health Nurse EE called Surveyor. Home Health Nurse EE denied knowledge Resident 2 had been administered his/her PRN hydrocodone 9 times from diagnosis of hernia until his/her hernia repair surgery. Home Health Nurse EE stated s/he reported Resident 2 was having pain related to his/her hernia multiple times to facility, and was told they had been administering the PRN hydrocodone. Home Health Nurse EE reported s/he didn't have any access to facility records or medication cart. Home Health Nurse EE reported things weren't "adding up," with Resident 2's pain. Home Health Nurse EE reported every time s/he visited Resident 2 they were in notable pain. Home Health Nurse EE stated Resident 2 had a very difficult time verbalizing pain. Home Health Nurse EE stated s/he knew Resident 2 was in pain from the hernia because s/he would wince and guard the area over the hernia upon ambulation. Home Health Nurse EE stated s/he would ask facility staff, mostly Coordinator V, if Resident 2 had received his/her PRN hydrocodone and every time s/he would be told Resident 2 had received the PRN hydrocodone. Home Health Nurse EE assumed the PRN hydrocodone was ineffective for pain and would call Resident 2's primary doctor begging for a different form of pain medication. Home Health Nurse EE didn't understand why the primary doctor wouldn't provide different pain medication orders. Home Health Nurse EE asked if the doses of PRN hydrocodone on the MAR were documented as effective. Surveyor verified the 9 of 9 doses on the MAR were documented as effective. Home Health Nurse EE stated being highly frustrated with local ER because when	{N 353}		

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facility would send Resident 2 to ER for pain crisis, the ER would return him/her without new pain orders. Home Health Nurse EE stated Resident 2's hernia pain was movement based, and most prevalent upon ambulation. Home Health Nurse EE reported s/he finally got the doctor to replace the PRN hydrocodone with PRN oxycodone but was not aware Resident 2 didn't receive PRN oxycodone in response to reports of pain until July. Home Health Nurse EE reported that didn't make any sense, facility had been reporting the PRN hydrocodone wasn't effective so why refrain from administering the new PRN oxycodone when made available.

On 08/12/2026 at 4:03 PM, Surveyor called the pharmacy contracted to dispense Resident 2's medications to facility. Surveyor spoke with Pharmacist II. Pharmacist II reported that pharmacy doesn't have access to facility MARs or EHR (electronic health record). Pharmacist II reported facility delivered 7 tablet quantities of PRN hydrocodone to facility on the following dates: 12/31/2025, 03/18/2026, 04/30/2026 and 06/05/2026. Pharmacist II reported that account manager (Account Manager JJ) of the facility wasn't at the pharmacy.

On 08/13/2026 at 9:17 AM, Surveyor called the pharmacy and was connected to Account Manager JJ. Account Manager JJ reported s/he does on-site reviews of facility medication rooms. Account Manager JJ reported s/he has never been allowed access to the resident MARs or facility EHR during his/her on-site reviews.

CROSS REFERENCE: N0409 DHS CHAPTER 83.37 (1)(j) Proof-Of-Use Record
CROSS REFERENCE: N0415 DHS CHAPTER 83.37(2)(d) Documentation Of Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	R-C 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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 353}	Continued From page 24 Administration CROSS REFERENCE: N0433 DHS CHAPTER 83.38(1)(i) Behavior Management CROSS REFERENCE: Y3244 DHS CHAPTER 50.09(1)(L) Care	{N 353}		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the administrator or designee audited, signed, and dated the proof-of-use records on a daily basis. From 03/19/2026 to 07/27/2026, the administrator nor designee signed Resident 2's proof-of-use record on a daily basis. FINDINGS INCLUDE: On 07/10/2026, the department received a complaint regarding facilities behavior management processes. On 07/28/2026, Surveyor arrived at the facility for a complaint investigation.	N 409		

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N 409	Continued From page 25 RECORD REVIEW: On 07/28/2026, Surveyor reviewed Resident 2's facility facesheet. Resident 2 was admitted to the facility on 03/20/2023. Resident 2 had an APOA (Family Member T). At time of admission Resident 2's diagnosis list documented the following but not limited to: dementia, Alzheimer's disease, major depressive disorder, and anxiety disorder. On 06/17/2026, the diagnosis of, "ACUTE PAIN, NOT ELSEWHERE CLASSIFIED," was added to the diagnosis list. On 07/28/2026, Surveyor reviewed Resident 2's individualized service plan (ISP) dated 02/23/2026. Under the subsection titled, "Medications," the following was documented, "Be alert for expressions of pain and pain behaviors ... [Resident 2] will receive physical assistance with taking medications as prescribed. On 03/19/2026, the "INDIVIDUAL NARCOTIC COUNT LOG," was started for PRN hydrocodone-acetaminophen (APAP) 5-325mg oral tablets, RX#8078167. The "initial quantity received," was documented as "7." There were zero signatures from an administrator or designee to document daily audit of the proof-of-use record. The following tablets were documented as removed from the blister pack: 1. On 03/20/2026 at 12:55 PM, Med Tech KK 2. On 03/26/2026 at 11:53 AM, Med Tech HH 3. On 03/30/2026 at 7:03 PM, Med Tech HH 4. On 04/22/2026 at 1:35 PM, Coordinator V 5. On 04/23/2026 at 8:00 PM, Med Tech GG 6. On 04/25/2026 at 8:30, Caregiver Q 7. On 04/26/2026 at 4:00 PM, Med Tech GG On 04/30/2026, the "INDIVIDUAL NARCOTIC	N 409		

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N 409	Continued From page 26	N 409		

COUNT LOG," was started for PRN hydrocodone-APAP 5-325 mg oral tablets, RX#8149848. The "initial quantity received," was documented as 7. There were zero signatures from an administrator or designee to document daily audit of the proof-of-use record. The following tablets were documented as removed from the blister pack:
1. On 05/02/2026 at 2:45 AM, Med Tech LL
2. On 05/06/2026 at 8:00 PM, Med Tech Y
3. On 05/07/2026 at 4:00 PM, Med Tech GG
4. On 05/09/2026 at 8:00 AM, Med Tech MM
5. On 05/12/2026 at 8:22 PM, Caregiver Q
6. On 05/21/2026 at 4:00 PM, Med Tech GG
7. On 05/24/2026 at 8:00 PM, Med Tech GG

On 06/05/2026, the "INDIVIDUAL NARCOTIC COUNT LOG," was started for PRN hydrocodone-APAP 5-325 mg oral tablets, RX#8207663. The "initial quantity received," was documented as 7. There were zero signatures from an administrator or designee to document daily audit of the proof-of-use record. The following tablets were documented as removed from the blister pack:
1. On 06/05/2026 at 8:05 PM, Caregiver R
2. On 06/07/2026 at 7:50 PM, Caregiver R
3. On 06/09/2026 at 12:00 PM, Med Tech HH
4. On 06/12/2026 at 12:00 PM, Caregiver R
5. On 06/16/2026 at 7:37, Med Tech NN
6. On 06/18/2026 at 6:30 PM, Med Tech GG
7. "68-3/26" at 8:00 PM, Med Tech FF

On 06/17/2026, a "INDIVIDUAL NARCOTIC COUNT LOG," was started for PRN oxycodone 5 mg oral tablets, RX#8227001. The "initial quantity received," was documented as 7. There were zero signatures from an administrator or designee to document daily audit of the proof-of-use record. The following tablets were

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N 409	Continued From page 27 documented as removed from the blister pack: 1. On 07/05/2026 at 5:00 PM, Med Tech FF 2. On 07/07/2026 at 4:00 PM, Caregiver Q 3. On 07/08/2026 at 8:00 PM, Med Tech FF 4. On 07/10/2026 at 10:15 PM, Med Tech AA 5. On 07/21/2026 at 8:00 PM, Caregiver Q 6. On 07/22/2026 at 4:50 PM, Med Tech GG 7. On 07/27/2026 at 4:32 PM, Med Tech FF INTERVIEWS: On 08/06/2026 at 9:50 AM, Surveyor called Coordinator V. Coordinator V stated s/he had been the unit wellness coordinator since March 2026. Coordinator V reported facility would be dispensed 7 doses of Resident 2's PRN hydrocodone at a time. Coordinator V wasn't aware of instances Resident 2's verbal and non-verbal signs of pain weren't assessed and/or treated. Coordinator V acknowledged Resident 2 had been sent to ER for pain crisis but didn't know why the PRN hydrocodone hadn't been administered prior. Coordinator V didn't know why after PRN oxycodone was ordered on 06/17/2026, zero doses were administered during incidents of documented pain until 07/07/2026. Coordinator V did not know why Resident 2 wasn't administered pain medication in response to report of pain upon return from hernia repair surgery on 06/26/2026. On 08/06/2026 at 4:00 PM, Coordinator V called Surveyor. Coordinator V reported Resident 2 received his/her hydrocodone PRN when in pain because it was signed out on the proof-of-use record (narcotic count). Coordinator V acknowledged the proof-of-use record indicated staff had removed hydrocodone tablets from the blister packs. Coordinator V acknowledged only documentation on the MAR indicated the	N 409		

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 409	Continued From page 28	N 409		

hydrocodone was administered. Coordinator V acknowledged s/he didn't know if Resident 2's narcotic medication had been diverted by staff or not. Coordinator V couldn't explain why on so many occasions it was documented in Resident 2's progress notes that s/he was in pain, without any mention of having been administered a PRN hydrocodone that was ineffective. Coordinator V acknowledged the 9 times the PRN hydrocodone was documented as administered on the MAR it was assessed as effective for all 9 doses. Coordinator V stated s/he would need to do further investigation into possible diversion of narcotics.

On 08/06/2026 at 6:35 PM, Surveyor emailed Administrator M and requested Resident 2's narcotic count records from 02/01/2026 to present.

On 08/07/2026 at 5:06 PM, Coordinator V emailed Resident 2's narcotic count records from 02/01/2026 to present.

On 08/12/2026 at 9:23 AM, Surveyor called Administrator M. Administrator M reported Coordinator V hadn't notified him/her of possible narcotic diversion discussed with Surveyor on 08/06/2026. Administrator M stated s/he wasn't aware of a discrepancy between Resident 2's proof-of-use record and MAR. Administrator M said as far as s/he aware proof-of-use record was signed by the staff when removing narcotic tablets from the cart.

CROSS REFERENCE: N0353 DHS CHAPTER 83.32(3)(i) Rights Of Residents: Adequate Treatment
CROSS REFERENCE: N0415 DHS CHAPTER 83.37(2)(d) Documentation Of Medication

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N 409	Continued From page 29 Administration	N 409		
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 ensure 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 and that any side effects observed by the employee or symptoms reported by the resident were documented, the need for any PRN (as needed) medication and the resident ' s response were documented. From 04/26/2026 to 07/22/2026, Provider did not document the administration and response to 12 doses of PRN schedule II narcotic tablets on Resident 2's medication administration record (MAR).	N 415		

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N 415	Continued From page 30 FINDINGS INCLUDE: On 07/10/2026, the department received a complaint regarding facilities behavior management processes. On 07/28/2026, Surveyor arrived at the facility for a complaint investigation. RECORD REVIEW: On 07/28/2026, Surveyor reviewed Resident 2's facility facesheet. Resident 2 was admitted to the facility on 03/20/2023. Resident 2 had an APOA (Family Member T). At time of admission Resident 2's diagnosis list documented the following but not limited to: dementia, Alzheimer's disease, major depressive disorder, and anxiety disorder. On 06/17/2026, the diagnosis of, "ACUTE PAIN, NOT ELSEWHERE CLASSIFIED," was added to the diagnosis list. On 07/28/2026, Surveyor reviewed Resident 2's individualized service plan (ISP) dated 02/23/2026. Under the subsection titled, "Medications," the following was documented, "Be alert for expressions of pain and pain behaviors ...[Resident 2] will receive physical assistance with taking medications as prescribed. On 08/12/2026, Surveyor reviewed Resident 2's "INDIVIDUAL NARCOTIC COUNT LOGS: -On 03/19/2026, the "INDIVIDUAL NARCOTIC COUNT LOG," was started for PRN hydrocodone-acetaminophen (APAP) 5-325mg oral tablets, RX#8078167. The "initial quantity received," was documented as "7." On 04/26/2026 at 4:00 PM, Med Tech GG documented removal of a tablet from the blister	N 415		

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pack.

-On 04/30/2026, the "INDIVIDUAL NARCOTIC COUNT LOG," was started for PRN hydrocodone-APAP 5-325 mg oral tablets, RX#8149848. The "initial quantity received," was documented as 7. The following tablets were documented as removed from the blister pack:
1. On 05/07/2026 at 4:00 PM, Med Tech GG
2. On 05/12/2026 at 8:22 PM, Caregiver Q
3. On 05/21/2026 at 4:00 PM, Med Tech GG
4. On 05/24/2026 at 8:00 PM, Med Tech GG

-On 06/05/2026, the "INDIVIDUAL NARCOTIC COUNT LOG," was started for PRN hydrocodone-APAP 5-325 mg oral tablets, RX#8207663. The "initial quantity received," was documented as 7. The following tablets were documented as removed from the blister pack:
1. On 06/09/2026 at 12:00 PM, Med Tech HH
2. On 06/16/2026 at 7:37, Med Tech NN
3. On 06/18/2026 at 6:30 PM, Med Tech GG
4. "68-3/26" at 8:00 PM, Med Tech FF

-On 06/17/2026, a "INDIVIDUAL NARCOTIC COUNT LOG," was started for PRN oxycodone 5 mg oral tablets, RX#8227001. The "initial quantity received," was documented as 7. The following tablets were documented as removed from the blister pack:
1. On 07/05/2026 at 5:00 PM, Med Tech FF
2. On 07/08/2026 at 8:00 PM, Med Tech FF
3. On 07/22/2026 at 4:50 PM, Med Tech GG

On 07/28/2026, Surveyor reviewed Resident 2's medication administration record (MAR) for April 2026:
1.) "HYDROcodone-Acetaminophen (APAP) Oral Tablet 5-325 MG ...Give 1 tablet by mouth every 24 hours as needed (PRN) for Pain if this

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medication is given, [his/her] next acetaminophen dose should be cut down to 500mg instead of 1,000mg (1 Tab instead of 2 Tabs of Acetaminophen)-Start Date- 01/02/2026 1345 (1:45 PM) ...-Hold Date- from 04/24/2026 1555 (3:55 PM) to 04/25/2026 1218 (12:18 PM) -D/C Date 06/19/2026 1014 (10:14AM)" The MAR did not contain documentation of the tablet removed from blister pack on 04/26/2026 at 4:00 PM.

On 07/28/2026, Surveyor reviewed Resident 2's May 2026 MAR:
1.) "HYDROcodone-Acetaminophen (APAP) Oral Tablet 5-325 MG ...Give 1 tablet by mouth every 24 hours as needed (PRN) for Pain if this medication is given, [his/her] next acetaminophen dose should be cut down to 500mg instead of 1,000mg (1 Tab instead of 2 Tabs of Acetaminophen)-Start Date- 01/02/2026 1345 (1:45 PM) ...-D/C Date 06/19/2026 1014 (10:14AM)..." The MAR did not contain documentation of the tablets removed from the blister pack on 05/07/2026 at 4:00 PM, 05/12/2026 at 8:22 PM, 05/21/2026 at 4:00 PM, and 05/24/2026 at 8:00 PM.

On 07/28/2026, Surveyor reviewed Resident 2's June 2026 MAR:
1.) "HYDROcodone-Acetaminophen (APAP) Oral Tablet 5-325 MG ...Give 1 tablet by mouth every 24 hours as needed (PRN) for Pain if this medication is given, [his/her] next acetaminophen dose should be cut down to 500mg instead of 1,000mg (1 Tab instead of 2 Tabs of Acetaminophen)-Start Date- 01/02/2026 1345 (1:45 PM) ... -Hold Date- from 06/17/2026 1907 (7:07 PM) to 06/19/2026 1014 (10:14 AM) ...-D/C Date 06/19/2026 1014 (10:14AM)..." The MAR did not contain documentation of the tablets removed from the blister pack on 06/09/2026 at

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12:00 PM, 06/16/2026 at 7:37, 06/18/2026 at 6:30 PM, and "68-3/26" at 8:00 PM.

On 07/28/2026, Surveyor reviewed Resident 2's July 2026 MAR from 07/01/2026 to 07/27/2026: 1.) "oxyCODONE HCl Oral Tablet 5 MG ...Give 1 tablet by mouth every 24 hours as needed (PRN) for Pain related to ACUTE PAIN, NOT ELSEWHERE CLASSIFIED ...-Start Date - 06/17/2026 1915 (7:15 PM) ...-Hold Date- from 07/20/2026 0900 (9:00AM) to 07/20/2026 1132 (11:32AM)..." The MAR did not contain documentation of the tablets removed from the blister pack on 07/05/2026 at 5:00 PM, 07/08/2026 at 8:00 PM, and 07/22/2026 at 4:50 PM.

On 08/01/2026, Surveyor reviewed Resident 2's clinical record. On 04/30/2026, Doctor CC documented the following, "History...Inguinal hernia- recent ED visits with no concern for incarceration/strangulation. Benefitted from warm compress. Norco (hydrocodone) 5-325mg daily PRN #7 was started in ED (emergency department) at the end of 2025. Refills of this have been continued (21 total tablets since 12/2025). [Family Member T] is unclear how often this is being used...."

INTERVIEWS:

On 08/06/2026 at 9:50 AM, Surveyor called Coordinator V. Coordinator V stated s/he had been the unit wellness coordinator since March 2026. Coordinator V reported facility would be dispensed 7 doses of Resident 2's PRN hydrocodone at a time. Coordinator V wasn't aware of instances Resident 2's verbal and non-verbal signs of pain weren't assessed and/or treated. Coordinator V acknowledged Resident 2

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N 415	Continued From page 34 had been sent to ER for pain crisis but didn't know why the PRN hydrocodone hadn't been administered prior. Coordinator V didn't know why after PRN oxycodone was ordered on 06/17/2026, zero doses were administered during incidents of documented pain until 07/07/2026. Coordinator V did not know why Resident 2 wasn't administered pain medication in response to report of pain upon return from hernia repair surgery on 06/26/2026. On 08/06/2026 at 4:00 PM, Coordinator V called Surveyor. Coordinator V reported Resident 2 received his/her hydrocodone PRN when in pain because it was signed out on the proof-of-use record (narcotic count). Coordinator V acknowledged the proof-of-use record indicated staff had removed hydrocodone tablets from the blister packs. Coordinator V acknowledged only documentation on the MAR indicated the hydrocodone was administered. Coordinator V acknowledged s/he didn't know if Resident 2's narcotic medication had been diverted by staff or not. Coordinator V couldn't explain why on so many occasions it was documented in Resident 2's progress notes that s/he was in pain, without any mention of having been administered a PRN hydrocodone that was ineffective. Coordinator V acknowledged the 9 times the PRN hydrocodone was documented as administered on the MAR it was assessed as effective for all 9 doses. Coordinator V stated s/he would need to do further investigation into possible diversion of narcotics. On 08/06/2026 at 6:35 PM, Surveyor emailed Administrator M and requested Resident 2's narcotic count records from 02/01/2026 to present.	N 415		

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N 415	Continued From page 35 On 08/07/2026 at 5:06 PM, Coordinator V emailed Resident 2's narcotic count records from 02/01/2026 to present. On 08/12/2026 at 9:23 AM, Surveyor called Administrator M. Administrator M reported Coordinator V hadn't notified him/her of possible narcotic diversion discussed with Surveyor on 08/06/2026. Surveyor explained since phone conversation with Coordinator V. The Surveyor had cross referenced Resident 2's narcotic count record (proof-of-use record) received via e-mail from Coordinator V on 08/07/2026 with Resident 2's MARs. Surveyor explained on 04/26/2026, Med Tech GG documented s/he removed a PRN hydrocodone tablet on the narcotic count but didn't document administration of the PRN hydrocodone on the MAR. Surveyor explained on 04/27/2026 Resident 2 was sent to the local emergency room (ER) for pain crisis. Surveyor explained Med Tech GG documented removal of hydrocodone tablet(s) on the narcotic count the following days: 05/07/2026, 05/21/2026, 05/24/2026 and 06/18/2026 but didn't document administrations of the PRN hydrocodone on the MAR. Surveyor identified for Administrator M on 05/12/2026 Caregiver Q documented s/he removed a PRN hydrocodone tablet on the narcotic count but didn't document administration of the PRN hydrocodone on the MAR. Surveyor identified for Administrator M on 06/09/2026 Med Tech HH documented s/he removed a PRN hydrocodone tablet on the narcotic count but didn't document administration of the PRN hydrocodone on the MAR. Administrator M stated s/he would investigate the discrepancy between narcotic counts and MARs. On 08/12/2026 at 4:03 PM, Surveyor called the pharmacy contracted to dispense Resident 2's	N 415		

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N 415	Continued From page 36 medications to facility. Surveyor spoke with Pharmacist II. Pharmacist II reported that pharmacy doesn't have access to facility MARs or EHR (electronic health record). Pharmacist II reported facility delivered 7 tablet quantities of PRN hydrocodone to facility on the following dates: 12/31/2025, 03/18/2026, 04/30/2026 and 06/05/2026. Pharmacist II reported that account manager (Account Manager JJ) of the facility wasn't at the pharmacy. On 08/13/2026 at 9:17 AM, Surveyor called the pharmacy and was connected to Account Manager JJ. Account Manager JJ reported s/he does on-site reviews of facility medication rooms. Account Manager JJ reported s/he has never been allowed access to the resident MARs or facility EHR during his/her on-site reviews. CROSS REFERENCE: N0353 DHS CHAPTER 83.32(3)(i) Rights Of Residents: Adequate Treatment CROSS REFERENCE: N0409 DHS CHAPTER 83.37 (1)(j) Proof-Of-Use Record	N 415		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the	N 416		

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provider did not ensure injectable medications were delegated by a Registered Nurse (RN) pursuant to the Nurse Practice Act [s. N 6.03(3)] and in accordance with accepted standards of practice for 1 of 3 unlicensed caregivers (Caregiver R) reviewed who administered insulin injections.

Findings include:

On 07/28/2026, Surveyor reviewed employee records and identified the following:

Caregiver R was hired 01/20/2026. Caregiver R's file did not contain evidence of receiving RN delegation for administration of injectable medications.

On 07/28/2026, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 05/06/2026 with a diagnosis of type 2 diabetes. Resident 4's individual service plan (ISP) dated 07/17/2026 indicated staff administer his/her medications. Resident 4's physician orders indicated Resident 4 was prescribed insulin glargine 32 units to be administered at bedtime and insulin lispro 8 units to be administered with meals.

Resident 4's medication administration record (MARs) for June and July 2026, indicated Caregiver R administered Resident 4's insulin injections on the following dates:
June:
-Insulin glargine 32 units: 06/03, 06/05, 06/06, 06/07, 06/12, 06/13, 06/17, 06/23, and 06/27.

-Insulin lispro 8 units: 06/02 (8am, 12pm, and 5pm), 06/03 (5pm), 06/05 (8am, 12pm, and 5pm), 06/07 (8am, 12pm, and 5pm), 06/10 (8am and

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N 416	Continued From page 38 12pm), 06/12 (8am, 12pm, and 5pm), 06/13 (5pm), 06/15 (8am and 12pm), 06/17 (5pm), 06/20 (8am and 12pm), 06/21 (8am and 12pm), 06/23 (5pm), 06/25 (8am and 12pm), 06/26 (8am and 12pm), 06/27 (5pm), 06/30 (8am and 12pm). July: -Insulin glargine 32 units: 07/17 Insulin lispro 8 units: 07/03 (8am and 12pm), 07/05 (8am and 12pm), 07/09 (8am and 12pm), 07/17 (5pm), 07/18 (8am and 12pm), 07/19 (8am and 12pm), 07/23 (5pm), 07/25 (5pm), 07/26 (5pm), 07/28 (8am and 12pm.) On 07/28/2026 at 4:10 PM, Surveyors conducted an exit conference and shared findings with Administrator M and Regional Nurse N. The management team acknowledged the above concerns. The management team reported all records had been provided and they could not locate Caregiver R's RN delegation for administering injectable medications. On 07/28/2026, Surveyor reviewed Resident 7's facility record. Resident 7 was diagnosed with but not limited to vascular dementia and mild cognitive impairment. Surveyor reviewed Resident 7's MAR and observed order the as needed (PRN) order for Epinepherine 0.3MG/0.3ML IM injection documented it was to be used for, " ...allergic reaction."	N 416		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents	N 433		

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N 433	Continued From page 39 the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure Resident 2 was provided adequate behavior management for his/her behaviors that may be harmful to themselves or others to meet his/her needs. On 06/01/2026 and 06/03/2026, Resident 2 eloped from the facility both days. On 07/28/2026, Surveyor reviewed Resident 2's facility record. Resident 2's individualized service plan (ISP) didn't have a behavioral management plan comprehensive to his/her needs. FINDINGS INCLUDE: On 07/10/2026, the department received a complaint regarding facilities behavior management processes. On 07/28/2026, Surveyor arrived at the facility for a complaint investigation. OBSERVATION: On 07/28/2026 at 10:00 AM, Surveyor observed Resident 2 sitting in the dining room. S/he was quietly reading a newspaper. Resident 2's 1:1	N 433		

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N 433	Continued From page 40 (Agency Staff P) was sitting a few feet behind Resident 2. RECORD REVIEW: On 07/28/2026, Surveyor reviewed Resident 2's facility facesheet. Resident 2 was admitted to the facility on 03/20/2023. Resident 2 had an activated power of attorney (APOA). At time of admission Resident 2's diagnosis list documented the following but not limited to: dementia, Alzheimer's disease, major depressive disorder, and anxiety disorder. On 07/28/2026, Surveyor reviewed Resident 2's individualized service plan (ISP) dated 02/23/2026: 1.) Under the subsection titled "Medications," the following was documented,"... [Resident 2] is also prescribed Bupropion and Vortioxetine to help manage [his/her] diagnosis of Major Depressive Disorder..." 2.) Under the subsection titled, "Behavior Management," the following was documented, "Resident attempts to exit building without needed supervision ...Redirect resident away from exit using a gentle voice and offer preferred activities ... Comments: [Resident 2] exhibits anxious, disruptive and obsessive behavior when [s/he] verbalizes [his/her] vehicle being stolen by [his/her] [Family Member] and needing to call the police. [Resident 2] is forgetful and fixes on the need to visit [his/her] [spouse] and becomes tearful anxious. [Resident 2] requires additional time and one on one with reassurance in moments of anxiety. Care staff call community nurse or designee when [Resident 2] is exhibiting anxiety behavior. [Resident 2] is redirectable but requires additional time to be redirected.	N 433		

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[Resident 2] had an attempted elopement on March 6, 2025, where [s/he] beached (sic.) the second floor secured door. On June 26, 2025, and October 7,2025[Resident 2] (sic.) eloped from the community and was returned safely without physical harm. [Resident 2] is often obsessed with [his/her] indwelling catheter and opens the end, allowing the urine to flow from the bag. To assist with this, staff has scheduled times to check and empty the leg bag. Staff to monitor [Resident 2's] location during awake hours and offer stimulation activities to distract. When [Resident 2] has increased anxiety, perseverating on [his/her] vehicle of [his/her] [spouse], notify nurse to assess resident and r/o (rule out) potential UTI. Resident has [Name of Home Health Agency] to obtain sample ..."

On 07/28/2026, Surveyor reviewed Resident 2's progress notes:
1.) On 02/26/2026 at 5:49 PM, Facility Nurse B documented that on 02/25/2026 s/he was moved from the second floor to the first floor of the memory care unit due to increase in disruptive behaviors and repeated attempts to go down the stairway.

2.) On 03/18/2026 at 1:49 PM, Facility Nurse B documented, "Resident with an elopement from the community today. Staff responded to the side door alarm closest to the resident's apartment and was able to follow the resident from the building to the sidewalk and re-direct [him/her] back to community ..."

3.) On 03/20/2026 at 4:07 PM, Facility Nurse B documented, " ...Resident was very difficult to re-direct and calm and only became more aggressive striking at care staff. 911 was called and the situation was explained. EMS felt best to

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send police and the resident was aggressive in nature. During the policemen visit to the community, Resident calmed significantly ..."

4.) On 03/21/2026 at 1:14 PM, Facility Nurse B documented that 1:1 staff was assigned to Resident 2 due to, " ...quite combative and aggressive with staff and toward others as [s/he] seeks to exit the building to get to [his/her] spouse ..."

5.) On 03/24/2026 at 4:11 PM, Facility Nurse B documented, "Received new orders for Trazodone 50mg twice daily as needed (PRN) for agitation and aggression. Resident is to also discontinue the use of Wellbutrin (bupropion) use. Staff will monitor for effectiveness of the medication ..."

6.) On 03/27/2026 at 4:51 PM, Coordinator W documented, "Resident having an episode of unwanted behavior: [S/He] left the community, followed closely by associates, and walked into the bank lobby that is near the community. [S/He] was able to be redirected back to the community; (sic.) however, [s/he] is threatening, banging, yelling that [s/he] had been separated from [his/her] [spouse]. Resident was taken to see [his/her] [spouse] by [Family Member T] this morning, but, does not remember it. [S/He] is also asking police be called. Attempts to talk to resident go without success and [s/he] continues to yell atstaff (sic.) and invade personal space. [Coordinator W] intervened @ this time to give PRN medication."

7.) On 03/30/2026 at 12:22PM, Facility Nurse B documented that the PRN Trazodone 25mg was discontinued. An order for scheduled Trazodone 25 mg was started.

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N 433	Continued From page 43 8.) On 06/01/2026 at 6:30 PM, Coordinator V documented, "LATE ENTRY ...Resident eloped from the back exit and proceeded east on mineral point road and refused to respond to verbal cues to turn around called nurse and AED and the police to assist with return of the resident the police and myself eventually convinced [him/her] to return to the facility via police transport we were outside for about a half an hour before [s/he] returned to the community" 9.) On 06/03/2026 at 11:28 AM, Coordinator V documented, "Resident got out of the building to the business next door would not come back to the community for 20 minutes after we advise [him/her] that [his/her] [spouse] was on the phone then the resident proceeded to come back to the building with staff." 10.) On 06/03/2026 at 5:23 PM, Coordinator V documented, "Resident have (sic.) eloped two times within the last three days resident did not have a 1:1 person Monday (06/01/2026) or Tuesday (06/03/2026) when resident eloped. Resident currently have (sic.) a 1:1 caregiver today and [s/he] has been very content no behaviors today 1:1 has been sitting with [him/her] taking [him/her] outside and doing activities with [him/her] today resident currently in the dining room eating dinner." 11.) On 06/04/2026 at 5:09 PM, Coordinator V documented, "Resident eloped yesterday night and when the staff found [him/her] [s/he] was walking down the street and refusing to come back to the community the resident was physical and verbally aggressive toward the staff when the staff called the writer [s/he] was yelling at them telling them [s/he] is not going back [s/he] needs	N 433		

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to see [his/her] [spouse] the writer told staff to tell [him/her] [his/her] [spouse] is on the phone in the community and that's when [s/he] started walking back to the community with staff after a few minutes of redirection the writer called the doctor today and informed them of the elopement and to ask the doctor to adjust [his/her] meds because of the aggressive behaviors and something for pain for [his/her] hernia the nurse took my message and will call me back and let me know what the doctor will do"

On 07/28/2026, Surveyor reviewed Resident 2's comprehensive assessments. The sole comprehensive assessment documented was the pre-admission assessment dated 03/15/2023.

On 08/01/2026, Surveyor reviewed Resident 2's clinical record. On 06/08/2026, Nurse Practitioner DD documented, " ...06/2025: bupropion 150mg XL started for MDD (major depressive disorder) ...03/2026: bupropion discontinued out of concern for iatrogenic (treatment induced) agitation ..."

On 08/01/2026, Surveyor reviewed Resident 2's hospital record. The following entries were documented:
1.) On 03/18/2026, Resident 2 was sent to local ER for aggressive behaviors. Resident 2 was diagnosed with a UTI and prescribed antibiotic treatment. Resident 2 was sent back to the facility from ER. The following was documented on the after-visit summary, "You were seen in the Emergency Department for: altered mental status and agitation ...We found evidence of a urinary tract infection, but no other signs of infection or trauma. We have prescribed you a course of linezolid to treat this infection, based on culture results from past UTIs. The culture from this urine sample will not be available for several days--if it

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reveals that a different organism that would not be treated by linezolid is growing in your urine, our pharmacy staff will contact you with further recommendations ...What to expect and do at home ...Please take your prescribed linezolid twice a day for the next seven days ... Please follow up with your primary care doctor in the next few days for follow-up as well as discussion of whether prophylactic antibiotics would be helpful for your recurrent urinary tract infections ...Reasons to return to the Emergency Department: Any new or concerning symptoms ..."

2.) On 04/11/2026, Resident 2 was sent to the local ER for aggressive behaviors and suspected abdominal pain. Resident 2 was diagnosed with a bladder infection and prescribed an antibiotic. Resident 2 was sent back facility from ER. The following was documented on the after-visit summary, "You were seen in the Emergency Department for: Lower abdominal pain. We found that you had a bladder infection, likely related to your indwelling foley. We changed out the foley and we will start you on antibiotics for your bladder infection ...What to expect and do at home: ...Continue to stay hydrated and take the Macrobid 2x a day for 7 days ...Please have your foley switched in a week to prevent infection growth ...Please follow up with your PCP for further management ...Reasons to return to the Emergency Department: For return of pain, fever, confusion, or for any other concerns ..."

3.) On 06/08/2026, Nurse Practitioner DD documented," Assessment & Plan ...Chronic disorder with persistent behavioral disturbance including agitation and sundowning. Symptoms appeared multifactorial with contribution from inguinal hernia pain and facility stressors

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N 433	Continued From page 46 ...Agitation due to dementia (HCC) Persistent agitation with limited redirectability. Prior Trazodone dose reduction improved drowsiness but agitation persisted. Pain from inguinal hernia and facility stressors likely exacerbated symptoms ..." On 08/01/2026, Surveyor reviewed Resident 2 home health record a document titled, "Summary of Care Rendered in Past Certification Period," the following was documented, " This patient has had two elopements from [his/her] memory care facility: 6/1 and 6/3." INTERVIEWS: On 07/28/2026 at 9:50 AM, Surveyor interviewed Caregiver Q on the first floor of the facility memory care unit. Caregiver Q stated Resident 2 was assigned to an agency staff as his/her 1:1. Caregiver Q stated Resident 2 was assigned the 1:1 staff because s/he started exit seeking and attempting to elope multiple times a day. Caregiver Q reported Resident 2 would put on his/her yellow jacket then wait by the door and would eventually push through the door triggering the alarm system. Caregiver Q reported that when staff would attempt to re-direct him/her away from the door, Resident 2 would yell and threaten them. Caregiver Q denied witnessing Resident 2 engage in physical violence towards staff. Caregiver Q described Resident 2's aggression as mostly verbal, yelling things like, "I'm calling 911!" "I want my (spouse)!". Caregiver Q stated there were times Resident 2 would lift his/her fist like s/he was going to hit staff, but denied witnessing episodes of punching, slapping or kicking staff. Caregiver Q reported the main concern had been Resident 2 attempted elopements from facility multiple times a day.	N 433		

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N 433	Continued From page 47 Caregiver Q reported since 1:1 agency staff have been assigned to Resident 2. Resident 2's behaviors had become manageable. On 07/28/2026 at 10:32 AM, Surveyor interviewed Caregiver R on the 2nd floor of the memory care unit. Caregiver R reported s/he had cared for Resident 2 prior to his/her move to the 1st floor. Caregiver R reported s/he knew of 3 instances Resident 2 had been physically violent with staff. Caregiver R described Resident 2's episodes of physical violence as punching, pushing and shoving staff. Caregiver R reported Resident 2 had been assigned an agency staff as 1:1 approximately 3 months ago. Caregiver R reported Resident 2 gets UTI's often but his/her increase in behaviors appeared to be related to his/her dementia. Caregiver R reported Resident 2 still had episodes of screaming on the unit, but the 1:1 staff was able to re-direct his/her behaviors with a walk or puzzle. Caregiver R stated when Resident 2 has eloped from the facility s/he can be re-directed back into the facility with verbal re-direction or offering a walk. Caregiver R denied Resident 2 getting violent with staff when outside of the facility, stated s/he had been violent because s/he felt trapped inside the facility. Caregiver R stated that with the 1:1 staff, Resident 2's behaviors had become manageable for them. On 07/28/2026 at 10:50 AM, Surveyor interview Agency Staff P in the dining room on the first floor on the memory care unit. Agency Staff P stated if Resident 2 is reading his/her newspaper s/he could answer questions while watching him/her. Agency Staff P identified himself/herself as Resident 2's assigned 1:1 staff, and that s/he was employed by [Name of Staffing Agency]. Agency Staff P stated it was his/her duty to watch	N 433		

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Resident 2 and offer re-direction if s/he attempted to elope from the facility. Agency Staff P described Resident 2 as mostly pleasant, re-directable and best with routine. Agency Staff P reported that when Resident 2 attempted to elope from facility, s/he could re-direct him/her with a walk outside, activity, or snack. Agency Staff P reported working with Resident 2 for approximately 2 months and denied any episodes of physical violence. Agency Staff P reported approximately 4-5 instances where Resident 2 didn't receive his/her medication at his/her routine time and described his/her behavior as more difficult. Agency Staff P reported that facility staff will watch Resident 2 during their lunch breaks and denied elopements occurring when facility staff were in the 1:1 position.

On 07/28/2026 at 2:00 PM, Surveyor requested all of Resident 2's comprehensive assessments for the year of 2026 from Regional Nurse N.

On 07/28/2026 at 2:30 PM, Regional Nurse N told Surveyor they had already been given all of Resident 2's comprehensive assessments for the year and pointed to the documents titled, "Personal Service Plan," dated 09/08/2025 and 02/23/2026. Surveyor asked if those were assessments or individual service plans (ISPs). Regional Nurse identified the "Personal Service Plans," as "ISPs" and stated that those were also the comprehensive assessments. Surveyor described to Regional Nurse N what a comprehensive assessment was per DHS Chapter 83. Regional Nurse N then repeated that facility and all sister facilities perform assessments by directly updating the ISP, "like if a resident had a fall we would update the fall risk section ..." Surveyor asked if there were any comprehensive assessments on file for Resident

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2 that were not an ISP. Regional Nurse N pointed out the document titled "Personal Service Assessment," dated 03/15/2023. Regional Nurse N stated that the pre-admission assessment on file.

On 07/29/2026 at 10:00 AM, Surveyor interviewed Ombudsman S. Ombudsman S reported s/he had been part of a care conference with Resident 2, Family Member T, County Dementia Specialist U and Previous Administrator A. Ombudsman S reported facility had moved Resident 2 from his/her original room on the 2nd floor to the first floor without permission from Family Member T or plan for therapeutic transition. Ombudsman S reported Previous Administrator A didn't provide any documentation of rationale for the move, or for necessity of the 1:1 agency staff. Ombudsman S stated County Dementia Specialist U asked Previous Administrator A what behavioral interventions facility had utilized prior to issuing a 30-day discharge or 1:1 agency assignment. Previous Administrator A didn't have an answer to County Dementia Specialist U's questions. Ombudsman S stated during his/her interactions with Resident 2 s/he didn't witness any behaviors that were beyond CBRF level of care.

On 07/29/2026 at 11:33 AM, Surveyor interviewed Family Member T over the phone. Family member T reported Resident 2 was moved from the 2nd floor to the 1st floor of the memory care unit without their permission. Family Member T stated s/he was Resident 2's APOA and s/he told facility not to move him/her because s/he was on vacation at the time. However, facility went forward with the move against his/her wishes. Family Member T stated facility reported Resident 2 needed to be moved to the first floor because

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there were more staff on the first floor to manage his/her elopement behaviors. Family Member T reported Resident 2 had a rough transition evidenced by him/her trying to elope back up the stairs to his/her previous room on the second floor. Family Member T stated Resident 2's attempts at elopement escalated after being moved to the first floor. Family Member T described an elopement where Resident 2 was found at a local credit union and police were called. Family Member T reported facility issued a 30-day discharge notice and implemented a 1:1 agency staff until his/her discharge. When Family Member T asked facility for documentation of what Resident 2's behaviors were that lead to this 30-day discharge s/he wasn't provided conclusive documentation by facility. Family Member T reported s/he didn't know what the contract with [Name of Staffing Agency] looked like because facility had already chosen the agency without consulting him/her. After a care conference with facility and Ombudsman S, Family Member T asked facility for a list of behaviors the 1:1 agency staff was managing for Resident 2. Family Member T wanted to know these behaviors when shopping for a 1:1 staff of their choice. Family Member T reported s/he wasn't provided any list of behaviors by facility. Family Member T reported Resident 2 had been dealing with pain related to UTIs and a right inguinal hernia during his/her transition to the 1st floor unit. Family Member T reported since Resident 2's hernia repair surgery there hadn't been reports of extreme behavioral disturbance from the facility. Family Member T reported when s/he would ask the 1:1 agency staff how Resident 2 was doing, there weren't reports of extreme behaviors. Family Member T reported some 1:1 agency staff described Resident 2 as very pleasant. Family Member T reported on a couple occasions the 1:1

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staff were witnessed helping with other residents while being 1:1 with Resident 2.

On 07/30/2026 at 11:46 AM, County Dementia Specialist U answered Surveyor's questions with the following email, " ...Hello [Surveyor], To answer your questions below ...It did not appear that [Resident 2] required a higher level of care than a CBRF Memory Care is designed to support. I offered to work with staff on communication strategies, de-escalation and approaches but the facility did not schedule this training. [Resident 2] had the one-on-one prior to my involvement. Based upon my understanding, the facility arranged this without the permission of the family. They set it up and stated that this is what was agreed upon in the contract. I met with the facility administrator, the family and the ombudsman and we discussed the need to try backing off on the one-on-one support and ways to go about supporting [Resident 2], but they did not seem interested in making this change. They continued to say that [Resident 2] required the 1:1 support and that they did not want to reduce this coverage despite the ombudsman suggesting that they should consider this. My role is as a consultant. I offered guidance and training, but this is a voluntary service. If the facility does not accept our services, we cannot force them. [Resident 2] was very pleasant and cooperative each time I saw [him/her]. [S/He] sat on the patio with me during my last interaction with [him/her] and [s/he] enjoyed watching the windmills spin. [Family Member T] has provided what the facility has requested in terms of supplies and activity items and supports. Thank you again for your involvement ..."

On 08/04/2026 at 1:30 PM, Surveyor discussed the above concerns with Administrator M and

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N 433	Continued From page 52 Regional Nurse O. Regional Nurse O stated that on 06/01/2026 and 06/02/2026, agency didn't send staff to be Resident 2's 1:1. Regional Nurse O acknowledged Resident 2 had eloped from facility both days. Administrator M and Regional Nurse O acknowledged Resident 2 had been moved from the 2nd floor to the 1st floor of the facility due to disruptive behaviors without being comprehensively assessed. Administrator M and Regional Nurse O acknowledged Resident 2 was assigned a 1:1 agency staff due to escalation of behaviors without being comprehensively assessed. Administrator M and Regional Nurse O acknowledged Resident 2 had eloped from the facility multiple times and wasn't comprehensively assessed upon return. Administrator M and Regional Nurse O acknowledged Resident 2's ISP didn't contain documentation of the 5 elopements which occurred after October 2025. Administrator M and Regional Nurse O acknowledged Resident 2's ISP didn't contain documentation of the 1:1 agency staff being assigned to Resident 2. Administrator M and Regional Nurse O acknowledged ISP didn't contain documentation of the rationale nor specific responsibilities of the 1:1 agency staff. Administrator M and Regional Nurse O acknowledged Resident 2's psychiatrist had identified the psychotropic medication bupropion as a medication that may have contributed to his/her aggressive behaviors and discontinued the medication, but the ISP still listed bupropion as an active medication. Administrator M and Regional Nurse O acknowledged Resident 2's ISP didn't contain a behavioral management plan that was comprehensive to his/her needs. Administrator M reported since Resident 2's hernia repair surgery on 06/25/2026, his/her behaviors of elopement and verbal aggression had greatly decreased in frequency. Administrator	N 433		

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N 433	Continued From page 53 M reported that Resident 2's 1:1 agency supervision would likely be decreased soon. On 08/06/2026 at 5:00 PM, Home Health Nurse EE called Surveyor... Home Health Nurse EE reported that due to Resident 2's dementia s/he would empty his/her urinary collection bag then forget to re-clamp it, so s/he would void on themselves afterwards. Home Health Nurse EE stated it was the responsibility of facility staff to empty the urinary collection bag, but it wasn't happening. Home Health Nurse EE stated during this time Resident 2's room always had a urine-like odor. Home Health Nurse EE reported s/he couldn't find any soap or shampoo in his/her bathroom, had no clue how Resident 2 was being washed. Facility told Home Health Nurse EE that Family Member T oversaw supplying Resident 2's toiletries, and facility didn't supply those items. Home Health Nurse EE reported s/he couldn't stand to think Resident 2 was being left cold and unclean. So, Home Health Nurse EE personally supplied Resident 2 with the AXE body spray deodorant, shampoo and soap that were being used in his/her room. Home Health Nurse EE stated every visit s/he would shower and dress Resident 2 in clean clothes prior to changing his/her urinary catheter. Home Health Nurse EE stated s/he didn't understand exactly why Resident 2 had been assigned a 1:1 staff. Home Health Nurse EE stated s/he never witnessed Resident 2 be combative. Home Health Nurse EE reported Resident 2's behaviors were possibly a result of being left in urine-soaked clothes. Home Health Nurse EE reported multiple occasions Resident 2 would ask about his/her spouse and Home Health Nurse EE would provide verbal therapeutic reassurance. Home Health Nurse EE reported that during these conversations s/he	N 433		

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N 433	Continued From page 54 learned that Resident 2 wouldn't recognize his/her spouse during the Friday visits and would be very confused when s/he would be dropped back off at the facility without his/her spouse. Home Health Nurse EE reported Resident 2 would consistently mention that his/her spouse was supposed to be living with him/her. Home Health Nurse EE would reassure Resident 2 that his/her spouse was being visited weekly by him/her and that would calm Resident 2 down. Home Health Nurse EE reported Resident 2 was being re-traumatized every visit and facility staff would be dealing with behaviors on Friday evening. Home Health Nurse EE stated from what s/he learned Resident 2's behaviors were re-directable with a phone call, reassurance, or activity. Home Health Nurse EE did report since the addition of the 1:1 staff because Resident 2 had been receiving more consistent showers and housekeeping from the 1:1 staff. CROSS REFERENCE: N0353 DHS CHAPTER 83.32(3)(i) Rights Of Residents: Adequate Treatment CROSS REFERENCE: Y50.09 DHS CHAPTER 50.09(1)(L) Care	N 433		
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:	N 481		

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N 481	Continued From page 55 Based on observation and interview, the provider did not ensure the living environment was safe, clean, comfortable, and homelike. Findings include: On 07/28/2026, Surveyor toured the facility and made the following observations: At 9:27 AM, Surveyor observed Resident 3's room. The toilet paper holder was damaged. At 3:30 PM, the same conditions were observed. At 9:31 AM, Surveyor observed Resident 4's room. Next to Resident 4's toilet, observed dirt and debris on the ground. At 3:30 PM, the same conditions were observed. At 9:36 AM, Surveyor observed the 1st floor laundry room. The door handle was loose. Behind all 3 dryers, observed a large amount of lint built up. The lint had stuck to furniture in the room. Moderate caked-on dust noted on sprinkler head directly above washer/dryer units, potentially causing a delay. At 9:40 AM, Surveyor observed mechanical room 2.1 (next to resident rooms). The left side door frame (towards the bottom) was damaged. There was an approximate 2 feet of wood that was damaged leaving several bent nails sticking out at sharp angles. At 9:41 AM, Surveyor toured the 2nd floor laundry room. Surveyor observed the door was missing a handle and could not be secured. At 9:47 AM, Surveyor toured the 2nd floor kitchenette. Surveyor observed 3 bananas cut in half on a small white plate that had been left next	N 481		

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N 481	Continued From page 56 to other snacks residents could take. The bananas appeared discolored and mushy. The stove was dirty with burnt food crumbs and appeared to have not been cleaned in a long time. At 9:58 AM, Surveyor toured Resident 5's room. The door entering his/her room exhibited heavy black scuff marks clustered along the bottom 12 inches of the surface, requiring surface cleaning and potential touch-up paint. At 10:26 AM, Surveyor toured the 1st floor kitchenette. The freezer had spilled food items stuck inside the door. At 10:15 AM, Surveyor toured Resident 6's room. The room had a strong odor of urine. At 3:30 PM, the same conditions were observed. At 3:58 PM, Surveyor met Resident 2 in the provider's common area where many other residents were sitting. Under Resident 2's chair, Surveyor observed a bundle of multi-colored wires protruding directing from the floor. The wires appeared they were coming from a floor receptacle. Resident 2 was observed playing with the wires until the Surveyor alerted staff. On 07/28/2026 at 4:10 PM, Surveyors conducted an exit conference and shared findings with Administrator M and Regional Nurse N. The management team acknowledged the above concerns and stated they would address the concerns with maintenance.	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that	N 499		

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N 499	Continued From page 57 cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds were securely stored in 2 of 2 areas. Cleaning compounds were not securely stored in a laundry room and kitchenette. This is a repeat deficiency. See Statement of Deficiency (SOD) 1KI812, dated 11/25/2020. Findings include: The facility is licensed to serve up to 42 residents in the following client groups: irreversible dementia/Alzheimer's and advanced age. On 07/28/2026 at 9:41 AM, Surveyor toured the 2nd floor laundry room. Surveyor observed the door was missing a handle and could not be secured. Surveyor entered the room by easily pushing on the door and observing the following: spray bottle of carpet and upholstery spotter cleaner and spray bottle of stainless steel cleaner and polish. On 07/28/2026 at 9:50 AM, Surveyor toured the 2nd floor kitchenette. In an unsecured cabinet above the microwave, Surveyor observed the following: 2 spray bottles of rapid multi surface disinfectant cleaner, spray bottle of bio-enzymatic odor eliminator, 2 spray bottles of scrub fee bathroom cleaner and disinfectant, and 1 bottle with all purpose sprayer (bottle was full, contents unknown.)	N 499		

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N 499	Continued From page 58 On 07/28/2026 at 4:10 PM, Surveyors conducted an exit conference and shared findings with Administrator M and Regional Nurse N. The management team confirmed the cleaning supplies were to be secured. Administrator M reported s/he would address the concern.	N 499		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure other emergency drills were conducted semi-annually for 2 of 2 years reviewed (2024 and 2025). Findings include: On 07/28/2026, Surveyor reviewed the provider's safety records and identified the following: Surveyor was unable to locate evidence of other evacuation drills for 2024 and 2025. On 07/28/2026 at 4:10 PM, Surveyors conducted an exit conference and shared findings with Administrator M and Regional Nurse N. Administrator M acknowledged the provider did not have evidence of semi-annually other emergency drills. Administrator M did not provide an answer on why other emergency drills were not completed for the above years.	N 526		
Y3244	50.09(1)(L) Care	Y3244		

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Y3244	Continued From page 59 (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 was provided adequate and appropriate care within the capacity of the facility. FINDINGS INCLUDE: Facility is a Class CNA non-ambulatory facility. Has a capacity of 42 residents and serves advanced aged, irreversible dementia & Alzheimer's. On 07/10/2026, the department received a complaint regarding facilities behavior management processes. On 07/28/2026, Surveyor arrived at the facility for a complaint investigation.	Y3244		

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Y3244	Continued From page 60 RECORD REVIEW: On 07/28/2026, Surveyor reviewed Resident 2's facility facesheet. Resident 2 was admitted to the facility on 03/20/2023. Resident 2 had an activated power or attorney (APOA). At time of admission Resident 2's diagnosis list documented the following but not limited to: dementia & Alzheimer's disease. On 07/28/2026, Surveyor reviewed Resident 2's individualized service plan (ISP) dated 02/23/2026. Under the subsection titled, "Showering or Bathing," the following was documented, "Resident is able to perform the following showering tasks with physical assistance as needed: Shampooing hair ...Washing upper body ...Washing lower body ...Outcome/Goal: [Resident 2] will have showering and bathing needs met through the end of the review period. [Resident 2] will receive a shower or bath assistance based on personal preference for frequency through the end of the review period. [Resident 2's] showers are scheduled for Monday and Thursday first shift. Family will provide preferred toiletry products. Staff should inform family when [Resident 2] needs additional supplies ... [Resident 2] requires assistance of one person with showering. [Resident 2] enjoys warm showers" It was documented that Resident 2 preferred laundry and housekeeping on Mondays and Thursdays. Under the subsection titled, "Bathroom Assistance," the following was documented, "Resident has an indwelling catheter ...Assist with pericare, catheter care and emptying the catheter bag, as needed ... [Resident 2] is continent of bowel. [Resident 2] has a chronic Foley Catheter in place managed by [Name of Home Health	Y3244		

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Agency] with Foley changed once monthly and weekly irrigation and patent checks. [Resident 2] needs assistance with emptying [his/her] catheter bag by Care Partners, monitored by [Name of Home Health Agency]. [Resident 2] wears regular underwear."

On 07/28/2026, Surveyor reviewed Resident 2's total finalized billing activity from 04/01/2026 through 06/30/2026:
1.) For April 2026, the total cost for basic service rate, personal service rate and 1:1 supervision totaled $20,147.30.
2.) For May 2026, the total cost for basic service rate, personal service rate, and 1:1 supervision totaled $18,979.10.
3.) For June 2026, the total cost for basic service rate, personal service rate, and 1:1 supervision totaled $21,105.80

On 07/28/2026, Surveyor reviewed Resident 2's [Name of Staffing Agency] behavioral log titled, "[Resident 2's] activities during scheduled 1:1," On 07/11/2026 at 7:37 AM, the entries were documented:
1.) On 07/11/2026 at 7:37 AM, "Cleaned up [Resident 2] in shower - covered in BM large amounts of BM, was up and about trying to dress [himself/herself] when I got in, was told [s/he] had a BM during report. [Resident 2] unable to follow basic instructions, wiping BM (feces) on [himself/herself], had to 1 assist wipe and help w/ cleaning. Used hibiclens to wash catheter. Cath output 300 ml yellow clear. [Resident 2] unaware [s/he] was covered in BM. Laundry not done, no boxers/briefs available but put pants/shirt ..."

2.) On 07/18/2026 at 4:00 PM, "Soiled pants, cath bag unscrewed washed up, cleaning supplies locked away [Resident 2] agitated, confused,

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uncooperative, demands to be wearing urine soaked items, can't find clean shoes trying to fight staff every step of help. Used wet wipes to clean up."

3.) On 07/25/2026 at 6:00 AM, staff documented a urine-like odor in Resident 2's room.

4.) On 07/27/2026 at 11:23 AM, "Visitation happening - [Resident 2] sleeping woke up ...toilet clogged, AC broken visitor said ..."

On 07/28/2026, Ombudsman S forwarded an email from Family Member T at 12:47 PM. The email stated, "Hi [Administrator M], ... I have recently learned some very upsetting news about the disregard for [Resident 2]. The on-the-floor staff are saying they have been told by management that they should not be entering [Resident 2's] room or do routine care - showers, laundry, making sure [his/her] room is clean and safe, etc. - because all of those duties should be done by the one-on-one staff. Routine care of [Resident 2] is part of what the base rate of care I am paying for, so it your facility staff is no longer doing these things I should not be paying for those services. Also, it does not seem that the one-on-one care staff are being communicated with that those are their responsibilities, and this care is not being done, and the facility staff do not notice or do not care that [his/her] comfort and well-being is being neglected ...Last Monday I took [Resident 2] in for surgery and helped [him/her] undress, then after it was determined that the surgery could not be performed, I took [him/her] to appointments on Friday with [his/her] oncology team, again I needed to help [him/her] undress so they could collect a urine sample. [S/he] was wearing the exact same clothes, down to [his/her] underwear. Which means ALL Week

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[s/he] was wearing the same clothes! [S/He] had not been showered, which I could tell because [s/he] had the same bandage on when [s/he] was released from the hospital on Monday after the surgery (sic.) cancelled! This is unacceptable negligence of [Resident 2's] health and hygiene on the part of the facility ...Last Sunday when [Family Member] and I went to visit we discovered that [his/her] room smelled and the floor was sticky with urine. [His/Her] toilet was clogged and that the A/C unit in [his/her] room was not functional; it was hot and stuffy in that room with the extreme heat we have been having ...When we reported this to the facility staff, we were told it was the one-on-one's job to report maintenance issues with the room. NO, the one-on-one staff are part-time, hourly outside vendors; it is not their job to see maintenance issues with YOUR facility that is your responsibility since the people in your care are not able to communicate maintenance issues ... My [Family Member] visited my [Resident 2] yesterday and the room A/C was still not working, and the toilet was still clogged ...[Family Member T]"

On 08/04/2026, Surveyor reviewed Resident 2's home health record. The following entries were documented:
1.) On 03/25/2026 at 11:32 AM, Home Health Nurse EE signed the following note," Note: At my first visit, patient was in [his/her] room with the door locked. I knocked, announced who I was and the patient said 'come in' but the door remained locked. Tried to explain this to the patient. [S/He] didn't unlock the door. Knocked on the door again, [s/he] asked 'who is it?' and I identified myself again and [s/he] told me to 'come in' again, but never unlocked the door so I told [him/her] the door was locked. Nothing. This went on for about 5 minutes until [s/he] came to

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Y3244	Continued From page 64 unlock the door. Upon entering, the patient was standing in [his/her] underwear barefoot with [his/her] foley leg bag hanging off of [him/her] pulling at [his/her] [genital area] and not safely secured to [his/her] leg. My shoes were sticking to the floor, there was puddles all over the floor, surrounding the bed, on the bed linens. The room smelled of urine. Asked the patient to sit down so I could help [him/her] with [his/her] foley. Patient was kind and agreeable. [S/He] was confused and said [s/he] just didn't understand what was going on around here, making reference to the wet linens and floor. I checked [his/her] foley bag and it was open. The patient had forgot to close it up again allowing urine to freely flow out of the bag into a puddle on the floor and once out of the bed while walking around [his/her] room, left a trail of urine all over. Spoke to ALF staff about my findings and concerns for safety as the urine on the hard wood flooring creates a slippery surface and patient was walking around with bare feet. There are several sharp corners in the patient's room as well creating an additional safety concern if patient were to have a fall. The fact patient locked [his/her] door and took so long to unlock it for me, this creates another safety concern that staff could not get to [him/her] in a timely manner if the patient needed help ... At this visit, patient was sitting in the dining room and as I was getting the patient to go back to [his/her] room one of the aides said 'it looks like [his/her] pants are wet, too.' Going to the patient's room, the strong urine scent starts several doors down before you reach [his/her] room. Once in [his/her] room, [his/her] bed was stripped, all the urine soaked bedding was in piles in the room. A urine-soaked blanket still laid on the bed and the patient laid on it when preparing for me to provide cares and change [his/her] Foley catheter. Several piles of urine-soaked clothes are in piles	Y3244		

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in [his/her] room. My shoes stuck to the floor. The patient was soaked so I assumed [s/he] had forgotten to close [his/her] Foley catheter leg bag again. [His/Her] pants, left sock, and left shoe were completed soaked with urine. [His/Her] leg bag was open so I closed it and cleaned the patient up. There is a shower in [his/her] room; however there is no shampoo, conditioner, body wash, bar soap, not even hand soap at the sink. There were no wipes of any kind. I used the antibacterial soap in my supply bag along with warm water to wash, rinse, and dry the patient. After irrigating and changing out [his/her] Foley catheter, I asked the patient to stand so I could help [him/her] pull up [his/her] pants. In doing so, I noticed the entire right side of [his/her] shirt was urine-soaked. I assisted the patient in removing [his/her] shirt. That's when I noticed the patient had a IV catheter in [his/her] left forearm presumably from [his/her] recent ER visit on 3/22. Asked patient to have a seat while I go get some help as I wanted a second set of eyes on what I found. An aide came back to the patient's room with me and said the patient dresses [himself/herself] so no one would see it. Patient also still had two hospital bands around [his/her] left wrist. They have sharp edges and can be problematic with fragile, loose skin like the patients. Contacted patient's PCP office to ask for an order to remove the IV."

2.) On 04/23/2026 at 9:41 PM, Home Health Nurse EE documented, "The strong urine odor has returned. [Agency Staff FF] reported patient is able to empty [his/her] own foley bag. This writer informed [him/her] that [s/he] can, but [s/he] should not be allowed to do this unattended as the patient does not close the leg bag after emptying the urine which is what leads to everything being soaked with urine and urine

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spilling out onto the floor. [Agency Staff FF] reported [s/he] was unaware. [S/he] assisted the patient at the next foley emptying. The floor is sticky again ..."

INTERVIEWS:

On 07/28/2026 at 9:50 AM, Surveyor interviewed Caregiver Q on the first floor of the facility memory care unit. Caregiver Q stated Resident 2 was assigned to an agency staff as his/her 1:1. Caregiver Q stated Resident 2 was assigned the 1:1 staff because s/he started exit seeking and attempting to elope multiple times a day. Caregiver Q reported Resident 2 would put on his/her yellow jacket then wait by the door and would eventually push through the door triggering the alarm system. Caregiver Q reported that when staff would attempt to re-direct him/her away from the door, Resident 2 would yell and threaten them. Caregiver Q denied witnessing Resident 2 engage in physical violence towards staff. Caregiver Q described Resident 2's aggression as mostly verbal, yelling things like, "I'm calling 911!" "I want my (spouse)!". Caregiver Q stated there were times Resident 2 would lift his/her fist like s/he was going to hit staff, but denied witnessing episodes of punching, slapping or kicking staff. Caregiver Q reported the main concern had been Resident 2 attempted elopements from facility multiple times a day. Caregiver Q reported since 1:1 agency staff have been assigned to Resident 2. Resident 2's behaviors had become manageable. Caregiver Q reported Resident 2's family had visited over the weekend and were very upset because Resident 2 hadn't been showered, his/her laundry wasn't done, the air conditioner was broken, the toilet in his/her room was plugged and the room had a urine-like odor. Caregiver Q stated it was the 1:1

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Y3244	Continued From page 67 agency staffs job to take care of Resident 2's laundry, showers and housekeeping. Caregiver Q reported facility staff don't go in Resident 2's room because s/he has a 1:1 all day. Caregiver Q repeated the family was very upset this last weekend and s/he would like to know exactly what duties facility staff are responsible for versus what the 1:1 agency staff was responsible for. On 07/28/2026 at 10:32 AM, Surveyor interviewed Caregiver R on the 2nd floor of the memory care unit. Caregiver R reported s/he had cared for Resident 2 prior to his/her move to the 1st floor. Caregiver R reported s/he knew of 3 instances Resident 2 had been physically violent with staff. Caregiver R described Resident 2's episodes of physical violence as punching, pushing and shoving staff. Caregiver R reported Resident 2 had been assigned an agency staff as 1:1 approximately 3 months ago. Caregiver R reported the 1:1 staff was to do all personal cares, including laundry. Caregiver R stated facility staff will watch Resident 2 while the 1:1 does laundry or takes a break. Caregiver R reported Resident 2 gets UTI's often but his/her increase in behaviors appeared to be related to his/her dementia. Caregiver R reported Resident 2 still had episodes of screaming on the unit, but the 1:1 staff was able to re-direct his/her behaviors with a walk or puzzle. Caregiver R stated when Resident 2 has eloped from the facility s/he can be re-directed back into the facility with verbal re-direction or offering a walk. Caregiver R denied Resident 2 getting violent with staff when outside of the facility, stated s/he had been violent because s/he felt trapped inside the facility. Caregiver R stated that with the 1:1 staff, Resident 2's behaviors had become manageable for them.	Y3244		

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Y3244	Continued From page 68 On 07/28/2026 at 10:50 AM, Surveyor interview Agency Staff P in the dining room on the first floor on the memory care unit. Agency Staff P stated if Resident 2 is reading his/her newspaper s/he could answer questions while watching him/her. Agency Staff P identified himself/herself as Resident 2's assigned 1:1 staff, and that s/he was employed by [Name of Staffing Agency]. Agency Staff P stated it was his/her duty to watch Resident 2 and offer re-direction if s/he attempted to elope from the facility. Agency Staff P reported that is was facility staff's job to do Resident 2's laundry, showers and housekeeping. Agency Staff P denied working over the weekend but reported an instance s/he assisted Resident 2 with a shower because s/he "needed it." Agency Staff P reported s/he hadn't been instructed on doing laundry. Agency Staff P described Resident 2 as mostly pleasant, re-directable and best with routine. Agency Staff P reported that when Resident 2 attempted to elope from facility, s/he could re-direct him/her with a walk outside, activity, or snack. Agency Staff P reported working with Resident 2 for approximately 2 months and denied any episodes of physical violence. Agency Staff P reported approximately 4-5 instances where Resident 2 didn't receive his/her medication at his/her routine time and described his/her behavior as more difficult. Agency Staff P reported that facility staff will watch Resident 2 during their lunch breaks and denied elopements occurring when facility staff were in the 1:1 position. On 07/28/2026 at 10:40 AM, Surveyor asked Regional Nurse N and Manager BB. What the duties of the 1:1 was versus the facility staff. Regional Nurse N stated s/he was still becoming acquainted with facility and did not know. Manager BB stated the 1:1 duty was to verbally	Y3244		

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re-direct Resident 2, toileting, showers, laundry and emptying his/her urinary catheter. When asked what facility staff do for Resident 2 Manager BB mentioned medication administration.

On 07/28/2026 at 2:00 PM, Surveyor reviewed Resident 2's admission agreement and summary of the last 90 days of billing with Regional Nurse N. Surveyor asked if Resident 2 received a discount from paying facility for personal cares, since the 1:1 agency had been tasked with toileting, showers, laundry, housekeeping, and behavior management. Regional Nurse N denied any discount from what was agreed upon in the original admission agreement. Regional Nurse N stated the reasoning for this was because facility staff still administered medication and provided intermittent supervision while 1:1 staff were on breaks or unavailable. Regional Nurse N acknowledged Family Member T and Resident 2 signed an admission agreement to pay $11,044.00 monthly to facility for the, "Basic Service Rate," and "Personal Service Rate". Regional Nurse N acknowledged that the "Personal Service Rate," was for personal care services to be provided by facility. Regional Nurse N acknowledged that for April, Resident 2 had been charged an additional $9,103.30 for the 1:1 agency staff, and so the total cost of services for the month of April was $20,147.30. Regional Nurse N stated s/he had only been covering this facility for the past week but stated s/he agreed with how the charges were documented on the billing report. Regional Nurse N acknowledged that in May Resident 2 had been charged $18,979.10 and in June $21,105.80.

On 07/28/2026 at 4:10 PM, Surveyors discussed the above concerns with Administrator M and

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Y3244	Continued From page 70 Regional Nurse N. Administrator M stated 1:1 agency staff were added to Resident 2's care for his/her safety because s/he would continuously attempt to elope from the facility. Administrator M stated the 1:1 agency staff's duty was to redirect Resident 2 from setting off door alarms and attempted elopements. Administrator M stated the facility staff were to follow the ISP and perform personal care such as showers, laundry, and housekeeping. Administrator M acknowledged Resident 2 was paying for facility to perform personal care and basic care services. Administrator M stated s/he had not been made aware Resident 2's family was upset over the weekend to find s/he hadn't been showered, room had a urine-like odor, the room air conditioner was broken, and toilet to be plugged. Administrator M acknowledged Surveyor interviewed current caregivers and it was reported the 1:1 staff were tasked with laundry, showers, and housekeeping, followed by the 1:1 agency staff reporting laundry, showers and housekeeping were facility staff responsibility. Administrator M acknowledged that July 2026 facility progress notes documented Resident 2's behaviors as redirectable. Administrator M acknowledged the daily behavioral log provided [Name of Staffing Agency] for July 2026 described Resident 2 as being redirectable with phone calls to family, snacks, and walks outside. Administrator M acknowledged Resident 2's ISP wasn't being implemented as written by staff. On 08/06/2026 at 5:00 PM, Home Health Nurse EE called Surveyor... Home Health Nurse EE reported s/he has observed concerns related to the care provided by the facility. Home Health Nurse EE recalled an incident where s/he had found an IV-access port in Resident 2's arm,	Y3244		

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reported it had been multiple days since Resident 2 was discharged from the ER and facility hadn't intervened. Home Health Nurse EE reported s/he was assigned to perform routine urinary catheter appliance changes on Resident 2, but s/he never had a routine visit. Home Health Nurse EE reported prior to the 1:1 assigned staff, s/he would always find Resident 2 in urine-soaked clothing, at times walking in puddles of urine on his/her floor. Home Health Nurse EE reported that due to Resident 2's dementia s/he would empty his/her urinary collection bag then forget to re-clamp it, so s/he would void on themselves afterwards. Home Health Nurse EE stated it was the responsibility of facility staff to empty the urinary collection bag, but it wasn't happening. Home Health Nurse EE stated during this time Resident 2's room always had a urine-like odor. Home Health Nurse EE reported s/he couldn't find any soap or shampoo in his/her bathroom, had no clue how Resident 2 was being washed. Facility told Home Health Nurse EE that Family Member T oversaw supplying Resident 2's toiletries, and facility didn't supply those items. Home Health Nurse EE reported s/he couldn't stand to think Resident 2 was being left cold and unclean. So, Home Health Nurse EE personally supplied Resident 2 with the AXE body spray deodorant, shampoo and soap that were being used in his/her room. Home Health Nurse EE stated every visit s/he would shower and dress Resident 2 in clean clothes prior to changing his/her urinary catheter. Home Health Nurse EE stated s/he didn't understand exactly why Resident 2 had been assigned a 1:1 staff. Home Health Nurse EE stated s/he never witnessed Resident 2 be combative. Home Health Nurse EE reported Resident 2's behaviors were possibly a result of being left in urine-soaked clothes. Home Health Nurse EE reported multiple occasions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110331	A. BUILDING: _____ B. WING _____	R-C 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL/MC	413 S YELLOWSTONE DR MADISON, WI 53719

(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
Y3244	Continued From page 72 Resident 2 would ask about his/her spouse and Home Health Nurse EE would provide verbal therapeutic reassurance. Home Health Nurse EE reported that during these conversations s/he learned that Resident 2 wouldn't recognize his/her spouse during the Friday visits and would be very confused when s/he would be dropped back off at the facility without his/her spouse. Home Health Nurse EE reported Resident 2 would consistently mention that his/her spouse was supposed to be living with him/her. Home Health Nurse EE would reassure Resident 2 that his/her spouse was being visited weekly by him/her and that would calm Resident 2 down. Home Health Nurse EE reported Resident 2 was being re-traumatized every visit and facility staff would be dealing with behaviors on Friday evening. Home Health Nurse EE stated from what s/he learned Resident 2's behaviors were re-directable with a phone call, reassurance or activity. Home Health Nurse EE did report since the addition of the 1:1 staff because Resident 2 had been receiving more consistent showers and housekeeping from the 1:1 staff. CROSS REFERENCE: N0353 DHS CHAPTER 83.32(3)(i) Rights Of Residents: Adequate Treatment CROSS REFERENCE: N0433 DHS CHAPTER 83.38(1)(i) Behavior Management	Y3244		