STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011119	A. BUILDING: _____ B. WING _____	C 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 06/03/2026, the bureau of assisted living southern regional office conducted a standard survey and 2 complaint investigations of Oakwood Meadows a CBRF located in Madison, WI. As a result of this survey, 3 violations of DHS 83 were issued. Two of 2 complaints were substantiated. Census: 18	N 000		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 caregivers reviewed that required continuing education had at least 15 hours of continuing education annually. Caregiver E did not receive 15 hours of continuing education in 2025 and Caregiver C did not receive 15 hours of continuing education in	N 277		

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

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N 277	Continued From page 1 2025. Findings include: On 06/03/2026 at approximately 10:00 a.m., Surveyor reviewed Caregiver E's record. Caregiver E was hired on 09/17/2024. Caregiver E's record did not include any continuing education for 2025. In the records provided Surveyor noted a column on the 2025 training documents that stated the training was assigned but 'not started'. On 06/03/2026 at approximately 10:00 a.m., Surveyor reviewed Caregiver C's record. Caregiver C was hired on 08/19/2024. Caregiver C's record did not include any continuing education for 2025. In the records provided Surveyor noted a column on the 2025 training documents that stated the training was assigned but 'not started'. On 06/03/2026 at 11:50am Surveyor interviewed Administrator A who confirmed that the continuing education training was not completed for either of the caregivers reviewed. Administrator A pointed to the documents provided and showed Surveyor the area on the document that read 'not started' and stated the statement was accurate and the training was not done.	N 277		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication	N 352		

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N 352	Continued From page 2 is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure each resident received all prescribed medications in the dosage and at intervals prescribed by a practitioner. From 03/01/2026 to 06/02/2026, Resident 2 wasn't administered his/her prescribed daily dose of Polyethylene-Glycol 70 times. Resident 2 wasn't administered his/her Divalproex Sodium one time. From 03/01/2026 to 06/02/2026, Resident 3 wasn't administered his/her prescribed daily dose of Polyethylene-Glycol 70 times. On 05/30/2026 and 06/02/2026, Resident 4 wasn't administered his/her Carbidopa-Levodopa tablets as prescribed. FINDINGS INCLUDE: On 04/28/2026, the Department received a complaint regarding medication administration practices at facility. On 06/03/2026, Surveyor arrived at facility for a complaint investigation and standard survey. OBSERVATION: On 06/03/2026 at approximately 9:30 AM, Surveyor observed the contents of the medication cart with Administrator A. Administrator A stated facility has a pharmacy on the first floor which supplies the medications for the residents. Administrator A stated staff passing medications	N 352		

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were expected to remove pills from the slot numbered according to the dated (EX: 6/3/26 - 3rd slot).

Surveyor pulled up Resident 2's blister packs for his/her noon dose of Divalproex Sodium 125mg capsules. Administrator A explained Resident 2's noon dose of Divalproex Sodium was 625mg, and facility pharmacy had created 5 blister packs of 125mg capsules to supply the dose. Surveyor observed the 5 blister packs of Divalproex Sodium and found capsules had been removed from the #2 slot on 4 of the 5 blister packs (Picture 3). Administrator A reviewed Resident 2's June medication administration record (MAR) and found the full dose of Divalproex Sodium at noon had been documented as administered on 06/02/2026.

Surveyor pulled up Resident 2's bottle of Polyethylene Glycol. The pharmacy label documented a once daily scheduled order for administration of 17gm at bedtime and a dispense by date of 08/12/2025 (Picture 4). Administrator A looked over medication carts and stated Surveyor had the only bottle of Polyethylene-Glycol labeled for Resident 2. Administrator A reviewed the prescription label and acknowledged if Polyethylene-Glycol been administered as prescribed the bottle would have been replaced 30 days later (09/12/2025). Surveyor with Administrator A observed the bottle to be approximately 50% full (~15 doses remained). Administrator A and Surveyor reviewed Resident 2's MAR from March 2026 to present day, more than 75% of administrations of Polyethylene-Glycol were documented as "administered" by staff. Administrator A acknowledged Resident 2 had not been administered his/her Polyethylene-Glycol as

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N 352	Continued From page 4 prescribed. Surveyor pulled up Resident 3's bottle of Polyethylene-Glycol. The pharmacy label documented order for administration once daily and a dispense by date of 04/08/2025 (Picture 5). Administrator A identified the bottle of Polyethylene-Glycol as the only bottle for Resident 3. Administrator A reviewed the prescription label and acknowledged if Polyethylene-Glycol had been administered as prescribed the bottle would have been replaced 30 days later (05/08/2025). Surveyor with Administrator A observed the bottle to be approximately 25% full (~10 doses remained). Administrator A and Surveyor reviewed Resident 3's MAR from March to present day, more than 75% of administrations of Polyethylene-Glycol were documented as administered. Surveyor pulled up Resident 4's blister pack of carbidopa-levodopa 25-100mg tablets. The prescription label documented a dispense by date of 05/28/2026. Surveyor and Administrator A observed tablets remained in the #29 and #2 slots (Picture 2). Administrator A reported Resident 4 was still in process to moving-in the unit on 05/29/2026 and that was why the tablets remained in the #29 slot. Administrator A stated the tablets in the #2 slot were not administered as prescribed and s/he was actively investigating the medication error. RECORD REVIEW: EXAMPLE 1: Resident 2 On 06/03/2026, Surveyor reviewed Resident 2's facility facesheet. Resident 2 was admitted to the facility on 06/17/2021. Resident 2 had an	N 352		

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activated power of attorney. Resident 2 was diagnosed with but not limited to: Alzheimer's disease with early onset.

On 06/03/2026, Surveyor reviewed Resident 2's March 2026 MAR:
1.) "Polyethylene 3350 Powder (Polyethylene Glycol 3350 (Bulk)) Give 17 gram by mouth at bedtime for constipation ...Start Date 08/12/2025 ..." 30 out of 31 prescribed intervals were documented as administered.

On 06/03/2026, Surveyor reviewed Resident 2's April 2026 MAR:
1.) "Polyethylene 3350 Powder (Polyethylene Glycol 3350 (Bulk)) Give 17 gram by mouth at bedtime for constipation ...Start Date 08/12/2025 ..." 26 out of 30 prescribed intervals were documented as administered.

On 06/03/2026, Surveyor reviewed Resident 2's May 2026 MAR:
1.) "Polyethylene 3350 Powder (Polyethylene Glycol 3350 (Bulk)) Give 17 gram by mouth at bedtime for constipation ...Start Date 08/12/2025 ..." 29 out of 30 prescribed intervals were documented as administered.

On 06/03/2026, Surveyor reviewed Resident 2's June 2026 MAR:
1.) "Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 MG ... Give 5 capsules by mouth two times a day for Behaviors open Sprinkle Capsule and place in applesauce or pudding ...Start Date 09/23/2025." The afternoon dose on 06/02/2026 was documented as administered.

2.) "Polyethylene 3350 Powder (Polyethylene Glycol 3350 (Bulk)) Give 17 gram by mouth at

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N 352	Continued From page 6 bedtime for constipation ...Start Date 08/12/2025 ..." Two of 2 prescribed intervals were documented as administered. EXAMPLE 2: Resident 3 On 06/03/2026, Surveyor reviewed Resident 3's facility facesheet. Resident 3 was admitted to the facility on 04/08/2025. Resident 3's had an activated power of attorney. Resident 3 was diagnosed with but not limited to: Parkinson's disease, depression and constipation. On 06/03/2026, Surveyor reviewed Resident 3's March 2026 MAR: 1.) "MiraLax Oral Powder 17GM/SCOOP (Polyethylene-Glycol 3350) Give 1 scoop by mouth in the morning for constipation ...Start Date ...04/27/2026 ..." 30 out of 31 prescribed intervals were documented as administered. On 06/03/2026, Surveyor reviewed Resident 3's April 2026 MAR: 1.) "MiraLax Oral Powder 17GM/SCOOP (Polyethylene-Glycol 3350) Give 1 scoop by mouth in the morning for constipation ...Start Date ...04/27/2026 ..." 29 out of 30 prescribed intervals were documented as administered. On 06/03/2026, Surveyor reviewed Resident 3's May 2026 MAR: 1.) "MiraLax Oral Powder 17GM/SCOOP (Polyethylene-Glycol 3350) Give 1 scoop by mouth in the morning for constipation ...Start Date ...04/27/2026 ..." 28 out of 31 prescribed intervals were documented as administered. On 06/03/2026, Surveyor reviewed Resident 3's June 2026 MAR: 1.) "MiraLax Oral Powder 17GM/SCOOP	N 352		

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(Polyethylene-Glycol 3350) Give 1 scoop by mouth in the morning for constipation ...Start Date ...04/27/2026 ..." Three of the 3 prescribed intervals were documented as administered.

EXAMPLE 3: Resident 4

On 06/03/2026, Surveyor reviewed Resident 4's facility facesheet. Resident 4 was admitted to the facility on 05/28/2026. Resident 4 had an activated power of attorney. Resident 4 was diagnosed with but not limited to: Parkinson's disease with dyskinesia.

On 06/03/2026, Surveyor reviewed Resident 4's May 2026 MAR. Resident 4 was documented as starting to receive medication by facility staff after 5:00 PM on 05/29/2026. On 05/30/2026, Resident 4's 7:00 AM dose of carbidopa-levodopa 25-100mg was documented as "Other-See Progress Notes."

On 06/03/2026, Surveyor reviewed Resident 4's June 2026 MAR. On 06/02/2026, Resident 6's 11:00 AM dose of carbidopa-levodopa 25-100mg was documented as "Other-See Progress Notes."

On 06/03/2026, Surveyor reviewed Resident 4's progress notes:
1.) On 05/30/2026 at 8:27 AM, Caregiver C documented, " ...Was not aware I was supposed to give a 7AM carbidopa- Helped with gets ups & didn't start left side meds until around 8AM. It was too late to give medication ..."

2.) On 06/02/2026 at 12:13 PM, Caregiver D documented, " ...Previous medication given too close to this dose ..."

INTERVIEW:

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N 352	Continued From page 8 On 06/03/2026 at 1:00 PM, Surveyor discussed the above concerns with Administrator A and Executive Director B. Administrator A acknowledged Resident 2 didn't receive his/her complete noon dose of divalproex sodium on 06/02/2026. Administrator A acknowledged Resident 2 didn't receive his/her prescribed dose of polyethylene-glycol as prescribed from approximately 08/12/2025 to 06/02/2026. Administrator A acknowledged Resident 3 didn't receive his/her scheduled daily dose of polyethylene-glycol as prescribed from approximately 04/08/2025 until 06/02/2026. Administrator A acknowledged Resident 4 didn't receive his/her prescribed dose of carbidopa-levodopa 2 times since his/her admission to the facility on 05/29/2026.	N 352		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider didn't implement and follow the individualized service plan I(SP) as written. On 05/01/2026, Resident 1 developed a bruise under his/her left eye. Caregiver G was the first to observe the bruise immediately after Resident 1's shower. Two staff witnessed Caregiver G to leave Resident 1 unattended in the bathroom to notify LPN J of the bruise. During LPN J's post-injury assessment Caregiver G couldn't identify the origin of Resident 1's bruise.	N 388		

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From 05/01/2026 to 05/08/2026, Administrator A conducted an investigation into Resident 1's injury of unknown origin. The conclusion of the investigation was Caregiver G hadn't provided Resident 1 with the full assistance s/he required during the shower. Otherwise, Caregiver G would have been aware of how Resident 1 obtained the injury below his/her left eye.

Provider terminated Caregiver G's employment on 05/12/2026.

FINDINGS INCLUDE:

On 05/05/2026, the Department received a complaint regarding program services at the facility.

On 06/03/2026, Surveyor arrived at facility for a complaint investigation.

RECORD REVIEW:

On 06/03/2026, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 03/10/2026. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to diabetes mellitus II, and Parkinson's disease.

On 06/03/2026, Surveyor reviewed the price rate documented on Resident 1's admission agreement. The following was documented, "MEADOWS ADVANCED ASSISTED LIVING ...Two person transfers or Hoyer lift ...24-hour staff availability ...basic health monitoring ..."

On 06/03/2026, Surveyor reviewed Resident 1's assessments. On 03/18/2026, Physical Therapist documented the following, " ...Limited speech

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answered yes/no questions. Currently Ax2 (assist times 2 staff) using sara lift. [Family Member F] reports [s/he] has a similar device as the sara steady at home where [s/he] was the main caregiver. [Resident 1] could benefit from ROW, strengthening of quads glutes for base of transfers - progressing to sara steady. Staff/education on technique, cues, safety/body mechanics ..."

On 06/03/2026, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 03/10/2026. Under the subsection titled, "BATHING," it was documented, " ...Will be able to meet bathing needs with assistance ... requires complete assistance ..." Under the subsection titled, "MOOD/BEHAVIOR," is was documented that Resident 1 could get agitated and had history of hallucinations/delusions.

On 06/03/2026, Surveyor reviewed Resident 1's "MISCONDUCT INCIDENT REPORT," sent to Department on 05/08/2026 by Administrator A. Administrator A reported, " ...Friday Morning May 1st at app 0715 [Caregiver G] and [Caregiver H] went into [Resident 1's] room to get [him/her] up for [his/her] shower. Apparently, [s/he] was weak, so they asked for the help of [Caregiver I] the Shift (sic.) coordinator. [Caregiver I] and [Caregiver H] use the lift to get [Resident 1] up and on the shower chair and [Caregiver I] leaves the room. [Caregiver G] proceeds to give [Resident 1] [his/her] shower while [Caregiver H] stays in the room to make the bed etc. Upon completion of the shower [Caregiver G] leaves the room to tell [LPN J] that [Resident 1] has a mark on [his/her] left cheek ..."

On 06/04/2026, Surveyor reviewed facility investigation notes for the injury of unknown

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origin reported on 06/05/2026. The conclusion was Caregiver G left Resident 1 unattended in the bathroom after the shower when the injury occurred. Caregiver G's employment was terminated on 05/12/2026. The reason for the corrective action was documented as follows, " ...Probation period, most recent investigation with resident skin concern and resident safety with leaving (sic) unattending (sic.) resident in bathroom alone ..."

INTERVIEW:

On 06/04/2026 at 9:30 AM, Surveyor discussed the above concerns with Administrator A via TEAMS video call. Administrator A reported facility is considered, "enhanced care," and all residents were 2 person transfers. Administrator A reported Resident 1 was a 2 person transfer and required full assistance with showers and bathing. Administrator A reported Caregiver G had given inconsistent reports during their investigation into Resident 1's bruised eye. Administrator A reported the other staff involved witnessed Caregiver G leave Resident 1 unattended, sitting on the toilet in the bathroom after his/her shower to report the bruised eye to LPN J. Administrator A reported the original injury was a "red mark" located by Resident 1's left eye and in the following day the red mark had darkened to a pink-lavender bruise. Caregiver H nor Caregiver I who assisted with Resident 1's transfer from bed to the wheelchair immediately before the shower both denied presence of a red mark below Resident 1's eye during the transfer. Administrator A determined Caregiver G was the individual charged with full assistance during Resident 1's shower and that didn't occur due to Caregiver G's lack of knowledge into how the injury developed. Administrator A acknowledged

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N 388	Continued From page 12 the Resident 1's ISP documented Resident 1 required full assistance while bathing. Administrator A acknowledged had Caregiver G implemented Resident 1's ISP as written s/he would have knowledge of the origin of injury.	N 388		