STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility did not ensure that the resident environment remains as free of accident hazards as is possible for 1 of 1 incident reviewed.RN C (Registered Nurse) burned sage in the facility and the facility did not verify that the sage was extinguished and did not provide education to the staff regarding safety.Evidenced by:Surveyor requested policy related to fire safety / flames in building. No policy provided.Facility email from RN D to NHA A (Nursing Home Administrator) and DON B (Director of Nursing), dated 7/18/25, states, in part: .came into work today, 7/17/25.at about 11:30 PM, smelled marijuana so strong, so I started to walk through all the units, but the smell remained at the atrium.asked RN C about the smell and RN C admitted stating it is me don't say nothing please I am burning sage the smell will go away. Then she demanded for me to give her the narcotic box key stating want to count.I walked away.RN C came back to me erratic requesting the narcotic box key the second time then I became suspicious that she is impaired at this time and will not give her the narcotic box key. I called DON B but was unable to reach then decided to call NHA A to notify about the incident. On 7/29/25 at 11:14 AM, Surveyor called RN D with message left requesting return call. RN D did not return Surveyor's call.On 7/29/25 at 11:52 AM, Surveyor interviewed RN E who stated that, a few nights previous, RN D had called RN E asking for RN E to come to RN D's side of the building because RN D thought someone was smoking marijuana in the building. RN E indicated that on arrival to that area, RN E was not certain about marijuana, but noted there was something smoky in the air; haze and smoky smell. RN E indicated that on arrival, RN D was in the center of the lounge and RN C came out of one of the unit hallways and asked RN D to come and count narcotics with RN C. RN E stated that RN D refused, saying that RN D thought it was not a normal task at that time of night. RN E stated that a few words were exchanged and RN C went into the office. RN E stated that RN C's eyes looked a little red and RN C seemed nervous / wouldn't look at RN E. Surveyor asked if the facility had asked RN E about the incident. RN E stated that RN D had asked RN E to write a statement, but there was not contact from anyone else from the facility. RN E indicated uncertainty about the origin of the smoke but stated that the smoky haze appeared to be in the lounge, near the office.On 7/29/25 at 3:33 PM, Surveyor interviewed NHA A who indicated getting a frantic call around midnight from RN D stating that RN C was smoking in the office. NHA A indicated that RN C had been working, at that time, on a concern related to narcotic medications. NHA A indicated then speaking with RN C on the phone, regarding the allegation and that RN C denied smoking marijuana and indicated that RN C had been burning sage in the office. NHA A indicated that NHA A ordered RN C to leave the building and told RN D that statements would be needed. NHA A stated that RN D told NHA A that the smell was dissipating. NHA A indicated that the next morning, RN C came to the facility and showed NHA A the sage on a dish in the office and voluntarily completed a drug test which was negative. NHA A stated RN C made a mistake and there was no reason to believe that RN C was under the influence at work. Surveyor asked if anyone had gone into the office. NHA A stated I don't think so, I think staff may have stepped in / near and smelled the smell. NHA A stated they confirmed the next day that there was no drug paraphernalia. Surveyor asked if anyone looked into the allegation that night. NHA A stated no, RN C was told to leave. Surveyor asked if anyone walked RN C out. NHA A indicated no, they were able to verify the next day on camera. Surveyor asked if there was any education provided following the incident. NHA A stated that RN C was educated; there is no facility policy on not burning sage, but that facility refers to federal regulation and educated on not burning anything in the facility. Surveyor asked if facility staff were educated. NHA A stated no.On 7/29/25 at 4:04 PM, Surveyor interviewed RN C and asked if smoking or burning of substances is allowed on facility premises. RN C stated no. Surveyor asked about incident. RN C indicated RN C did not smoke anything. We grow sage in my mother's garden; I took a bit and burned it to try to curb the bad energy. RN C stated it was an error in judgement. Surveyor asked what happened to the sage after it had been lit. RN C stated it sat in a meal tray cover (hard plastic covering for a dinner plate). RN C indicated that it remained there until the next morning. RN C indicated speaking to NHA A on the phone and NHA A asking RN C to write a statement. RN C expressed exhaustion and NHA A indicated that the statement could be written in the AM. RN C stated that RN C did not recall if NHA A told RN C to leave the building. RN C stated that RN C did not recall if RN C finished up some tasks prior to leaving or just went home. RN C indicated returning to work the next day and meeting with NHA A and DON B, at which time RN C wrote a statement and completed a drug test that RN C brought along to the building.On 7/29/25 at 5:20 PM, Surveyor asked NHA A if anyone in the building was asked to