STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017701	A. BUILDING: _____ B. WING _____	R-C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON ELMWOOD	5575 BURKE RD MADISON, WI 53718

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{N 000}	Initial Comments On 09/26/2023, The Bureau of Assisted Living, Southern Regional Office conducted an verification visit & complaint investigation at Cottages of Madison Elmwood, a CBRF located in Madison, WI. As a result of this survey, 3 violations of Chapter DHS 83 were issued. 2 violations from previous statement of deficiency (SOD) # 88ZV12 dated 01/26/2023 were re-issued. 4 violations from previous statement of deficiency (SOD) # 88ZV12 dated 01/26/2023 were corrected. Complaint was substantiated. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed. Census: 14	{N 000}		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by:	N 348		

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

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Based on record review and interview, the provider did not ensure all residents were free from financial misappropriation.

On 08/25/2023, it was discovered that Former Director C had made a total of $1,100.86 in unauthorized purchases on Resident 3's credit card.

FINDINGS INCLUDE:

The facility provides services to the following client groups: emotionally disturbed, mentally ill, irreversible dementia, Alzheimer's, advanced aged and physically disabled.

On 09/26/2023, Surveyors arrived at facility for a complaint investigation and verification visit.

RECORD REVIEW:

On 09/26/2023, Surveyor reviewed Resident 3's facility facesheet. Resident 3 was admitted to the facility on 12/13/2017; and was discharged from the facility on 09/19/2023.

On 09/26/2023, Surveyor reviewed the "Misconduct Incident Report," that was filled out by Administrator F on 09/08/2023. Administrator F documented the following, "... [Former Director C], took a resident's credit card and spent another resident's cash. Family have credit card statements as proof...Resident lost some of [his/her] funds that [s/he] could have spent on [himself/herself] or family. Family upset that their loved one was taken advantage of...Affected Person [Resident 3]...Accused Person [Former Director C]."

On 09/26/2023, Surveyor reviewed the facility's

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investigation related to the misappropriation of Resident 3's funds. On 09/08/2023 at 12:55 PM, Manager A documented, "08/30/2023 at 3:55 PM...[Resident 3's] family came to pick up [Resident 3]. I explained to them [s/he] was to spend down that [Former Director C] was helping [him/her] with that. I asked if all items were in [his/her] room they said they didn't have that information they saw the computer [s/he] bought [him/her] and took it because [s/he] does not know how to use it." On 09/08/2023 at 1:20 PM, Manager A documented,"08/25/2023 at 1:20PM... After [Former Director C] quit I went to clean out [his/her] office and found [Resident 3's] card I notified family that happened to be here at the facility that I have it. They mentioned unauthorized transactions on statement. I asked if they want to press charges, they stated NO."

On 09/26/2023, Surveyor reviewed Former Director C's record. A form in the record stated the following, "[Former Director C] self-terminated on 08/28/2023 Date of hire was 12/23/2022 [his/her] last day of work was 08/21/2023..."

On 09/26/2023, Surveyor reviewed an email sent from Case Manager E. In the form attached to the email Case Manager E documented that Family Member D reported Resident 3's bank issued him/her 2 credit cards from 12/06/2022 to 08/25/2023. Family Member D reported both of Resident 3's credit cards were held by the facility. Case Manager E documented the following, "...The July purchases were made in store at Walmart Superstore at [store address] and Hy-Vee at [store address] ... We spoke with [Manager A] on 08/25/23 in [his/her] office [S/he] had the card and found (and or got) it when [s/he] cleaned out the [Facility Name] office. [S/he] volunteered that the card had been used for

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unauthorized purchases. We again saw [Manager A] on 08/30 walking to the [Facility Names] building and asked [him/her] about the unauthorized purchases. [S/he] volunteered that it was [Former Director C] that placed those orders and asked if we were going to press charges...Per [Family Member D] and [Family Member G], [Resident 3] has never had a functional cell phone or computer. [Resident 3] never saw either of the cards. [Resident 3] didn't go to Walmart or Hy-Vee in July."

On 09/26/2023, Surveyor reviewed an email sent from Resident 3's financial institution to Family Member D. The email is to Family Member D and Family Member G and stated the financial institution had completed its own investigation into disputed claims on the credit card. The financial institution found there was sufficient evidence to support the crediting back of $1,100.86. The following unauthorized purchases were credited back to Resident 3's credit card:
1.) 07/05/2023 Hy Vee - $54.53
2.) 07/05/2023 Hy Vee - $9.42
3.) 07/02/2023 Wal-Mart - $103.05
4.) 07/02/2023 Wal-Mart - $933.86

INTERVIEW:

On 09/26/2023, Surveyor discussed the above concern with Manager A. Manager A stated the issue was discovered when Resident 3's family came to take him/her shopping and asked for his/her credit card. Manager A stated s/he went into the office to retrieve the credit card, but it wasn't there. Manager A stated s/he called Former Director C and Former Director C told Manager A that s/he had Resident 3's credit card with him/her. Manager A stated that Former Director C was not working that day. Former

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N 348	Continued From page 4 Director C had to come over to the facility to bring Resident 3's family the credit card. Manager A stated it is against facility policy for staff to have access to a resident's credit card outside of working hours. Manager A stated Resident 3's family reported that unauthorized purchases had been made on Resident 3's credit card and that they would be pressing charges. Manager A stated Former Director C was the only staff member to have access to Resident 3's credit card before 08/25/2023. Manager A stated Former Director C quit when s/he was approached about the investigation and refused to participate in the investigation. Manager A acknowledged Resident 3's finances had been misappropriated by Former Director C in July 2023.	N 348		
{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 accurate documentation	{N 415}		

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{N 415}	Continued From page 5 in the Medication Administration Record (MAR) for Resident 4, Resident 5, or Resident 6. Resident 4, Resident 5 and Resident 6 had omissions in the MAR for the months of August 2023 and September 2023. This is a repeat violation from Statement of Deficiency (SOD) 88ZV12 dated 01/26/2023, SOD EGFK11 dated 06/26/2020 and SOD 88ZV11 dated 07/05/2022. Findings include: Example 1: Resident 4 On 09/26/2023 at 9:15 AM, Surveyor reviewed Resident 4's MAR for the months of August 2023 and September 2023. Documentation on the following dates was omitted in Resident 4's MAR for the month of September 2023. 09/02/2023 Senexon-S 8.6-50 milligram (mg) tablet (tab) Vitamin C 500 mg tab Quetiapine 300 mg tab 09/17/2023 Eliquis 5 mg tab Olanzapine 20 mg tab Olanzapine 5 mg tab Senexon-S 8.6-50 mg tab Vitamin C 500 mg tab Melatonin 3 mg tab Quetiapine 300 mg tab Example 2: Resident 5	{N 415}		

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{N 415}	Continued From page 6 On 09/26/2023 at 9:30 AM, Surveyor reviewed Resident 5's MAR for the months of August 2023 and September 2023. Documentation on the following dates was omitted in Resident 4's MAR for the month of September 2023: August 2023 08/02/2023 Anoro Ellipt 62.5-25 AER Triamcinolone .1% cream Mucus relief 600 mg extended release (ER) tab Multivitamin tab Omeprazole 40 mg cap Oxybutynin 5 mg tab Pot Chloride 10 MEQ ER tab Vitamin D-3 50 microgram (mcg) tab Escitalopram 5 mg tab Furosemide 20 mg tab Quetiapine 25 mg tab 08/09/2023 Tamsulosin .4 mg capsule (cap) Lurasidone HCL 80 mg tab Quetiapine 25 mg tab September 2023 09/04/2023 Quetiapine 25 mg tab 09/17/2023 Quetiapine 25 mg tab	{N 415}		

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{N 415}	Continued From page 7 09/20/2023 Triamcinolone .1% cream Oxybutynin 5 mg tab Trazadone 50 mg tab Atorvastatin 80 mg tab Divalproex 250 mg ER tab Divalproex 500 mg ER tab Melatonin 3 mg tab Quetiapine 300 mg tab 09/23/2023 Tamsulosin .4 mg cap Lurasidone HCL 80 mg tab Quetiapine 25 mg tab Example 3: Resident 6 On 09/26/2023 at 9:30 AM, Surveyor reviewed Resident 6's MAR for the months of August 2023 and September 2023. Documentation on the following dates was omitted in Resident 4's MAR for the month of September 2023: August 2023 08/08/2023 Carvedilol 6.25 mg tab Glipizide 5 mg tab September 2023 09/08/2023 Aspirin low 81 mg tab Haloperidol 5 mg tab	{N 415}		

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{N 415}	Continued From page 8 Melatonin 3 mg tab On 09/26/2023 at 11:00 AM, Surveyor discussed the above concern with Manager A. Manager A acknowledged that resident MAR must be documented accurately at the time of medication administration. Manager A confirmed that there were numerous omissions in resident's MARs for the months of August 2023 and September 2023.	{N 415}		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe, clean and comfortable environment appropriate for resident needs. The front entry door was damaged, the rear exit door was damaged. This is a repeat violation from previous Statement of Deficiency 88ZV12 dated 01/26/2023 and SOD 88ZV11 dated 07/05/2022. Findings include: On 09/26/2023 at 9:00 AM, Surveyor toured the physical environment. OBSERVATIONS:	{N 481}		

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{N 481}	Continued From page 9 The front exterior door is supposed to sound an alarm when exiting without using a code. The door alarm did not sound when Surveyor exited the facility. There were wires sticking out of the door mechanism, but not connected to anything. The sink in the laundry room was very dirty. The entire bottom of the sink was black with dirt. The color of the actual sink was white. The toilet seat in the bathroom across from Bedroom #14 was broken. There was a hole in the closet door next to the kitchen. The rear exit door was damaged due to being struck by resident assistive devices (wheelchairs, walkers). On 09/26/2023 at 11:00 AM, Surveyor discussed the above concern with Manager A. Manager A acknowledged that the front and rear facility doors need to be replaced. Manager A acknowledged there was a hole in the closet door and needs to be fixed or replaced.	{N 481}		