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 05/20/2025

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

(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 05/14/2025 to 05/20/2025, Surveyors conducted 2 complaint investigations, standard survey, and verification visit at Cottages of Madison Elmwood. Eight deficiencies were identified. Six of 8 deficiencies were repeat violations. See Statements of Deficiencies (SODs) 88ZV14 dated 03/20/2024, SOD 88ZV12, dated 01/26/2023, SOD 77FZ12, dated 07/07/2021, SOD 77FZ11 dated 02/25/2021, and SOD EGFK12 dated 12/17/2020. One violation from previous SOD 88ZV16, dated 11/13/2024 was corrected. One complaint was substantiated. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed. Census: 14	{N 000}		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.	N 381		

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

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not assess Resident 10' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there was a change in needs, abilities or condition, which included all areas listed under par. (c).

Resident 10 was not provided a comprehensive assessment prior to admission.

On 04/07/2025, staff observed Resident 10 slurring his/her words and sent him/her to an emergency room (ER). While in the ER Resident 10 was treated for an elevated blood alcohol level secondary to ingestion of hand sanitizer. Facility did not perform a comprehensive assessment related to Resident 10's ER visit.

This is a repeat violation of previous statement of deficiency (SOD) 77FZ11 dated 02/25/2021 and SOD 88ZV14 dated 03/20/2024.
.
FINDINGS INCLUDE:

The facility was a class CNA (non-ambulatory) CBRF (community based residential facility) with a maximum capacity of 16 residents, and served the following client groups: advanced aged, emotionally disturbed, mental illness, irreversible dementia, Alzheimer's, and physically disabled.

On 05/14/2025, Surveyor arrived at facility for a complaint investigation and standard survey.

On 05/14/2025 at 9:00 AM, Surveyor observed

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Caregiver HH administering medication for the facility medication cart. Surveyor did not see where Caregiver HH kept his/her hand sanitizer. Caregiver HH showed Surveyor s/he kept the hand sanitizer locked up in the bottom drawer of the medication cart. Caregiver HH reported facility kept all hand sanitizer locked up because Resident 10 had a history of drinking the hand sanitizer.

On 05/14/2025, Surveyor reviewed Resident 10's facility record.

On 05/14/2025, Surveyor reviewed Resident 10's facility face sheet. Resident 10 was admitted to the facility on 12/23/2024. Resident 10 had an activated health care power of attorney. Resident 10 was diagnosed with but not limited to: alcohol dependence.

On 05/14/2025, Surveyor reviewed Resident 10's progress notes from 03/01/2025 to 05/14/2025. The following was documented:

1.) On 04/07/2024 at 1:30 PM, Caregiver JJ documented the following, "resident was slurring [his/her] words and not acting at baseline. resident (sic.) was sent to [Name Of Hospital]."

2.) On 04/07/2025 at 6:15 PM, Caregiver LL documented the following, "RT (resident) returned from hospital, RT had a blood alcohol level of 158, RT had a bottle of hand sanitizer hidden in [his/her] room, Staff (sic.) needs to make sure any Hand (sic.) sanitizer is behind locked doors and out of reach. POA was concerned to even have RT returned to facility since this was not the first time this has happened."

3.) On 04/16/2025 at 7:00 PM, Caregiver HH

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documented the following, "Resident was putting hand sanitizer in [his/her] mouth when I walked in the room ..."

4.) On 04/25/25 at 4:30 PM, Manager A documented the following, "Reached out to [Name of Medical Provider] to up [his/her] meds for depression [Resident 10] stated [s/he] is struggling with depression and wanting to drink. [Resident 10] will start crying out of frustration. [Resident 10] would also like [his/her] loraz (lorazepam) to be available for [him/her] more than 2x a day to help [him/her] irritation. Currently waiting for them to call or email me back."

On 05/14/2025, Surveyor reviewed Resident 10's March 2025 medication administration record (MAR). Resident 10 was prescribed the following psychotropic medications:
1.) Buspirone 5 mg tablet - TID (3 times daily)

2.) Hydroxyzine 50 mg tablet - once daily - Indication: anxiety

3.) Venlafaxine 70 mg ER (extended release) capsule - once daily - Indication: depression

4.) Lorazepam 0.5 mg tablet - PRN (as needed) up to 2 times daily - Indication: anxiety

On 05/14/2025 at 10:15 AM, Surveyor provided Administrator FF and Manager A a list of documentation to request for Resident 10. Surveyor requested Resident 10's pre-admission assessment, and all assessments completed since Resident 10's admission to the facility.

On 05/14/2025, Surveyor reviewed all of the Resident 10's assessments:
1.) On 01/02/2025, a targeted assessment of

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N 381	Continued From page 4 Resident 10's skin had been completed. 2.) On 04/15/2025, a review of Resident 10's psychotropics had been completed. On 05/14/2025 at 3:30 PM, Surveyor discussed the above concerns with Administrator FF, Manager A, and Consultant GG. Administrator FF stated Resident 10's pre-admission assessment was documented on his/her temporary individualized service plan (ISP). Surveyor reviewed Resident 10's temporary ISP with Administrator FF. Administrator FF acknowledged Resident 10's diagnoses, medications, and durable medical equipment (DME) were not documented on Resident 10's temporary ISP. Administrator FF stated the temporary ISP was usually maintained alongside the medical records from a resident PCP (primary care clinic) for a complete comprehensive pre-admission assessment. Administrator FF and Manager A acknowledged Resident 10's record did not contain documentation from Resident 10's PCP prior to his/her admission on 12/23/2024. Administrator FF stated s/he was not the administrator during December 2024. Administrator FF stated if s/he found documentation of Resident 10's completed pre-admission assessment s/he would email it to Surveyor within the next 24 hours. Administrator FF, Manager A, and Consultant GG acknowledged on 04/07/2025 Resident 10 was sent to an emergency room where s/he was treated for an elevated blood alcohol level secondary to ingestion of hand sanitizer. Administrator FF, Manager A, and Consultant GG denied prior knowledge of Resident 10's behavior of imbibing ethanol-based products in a controlled setting. Administrator FF, Manager A, and Consultant GG acknowledged Resident 10	N 381		

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N 381	Continued From page 5 experienced a change in condition on 04/07/2025 and was not provided a comprehensive assessment. Administrator FF stated if s/he found any more assessments on record for Resident 10, s/he would email then to Surveyor within the next 24 hours. On 05/16/2025 at 8:00 AM, Surveyor reviewed his/her email. Administrator FF had not emailed Surveyor documentation for Resident 10. CROSS REFERENCE: N0389 DHS Chapter 83.35(3)(d) Service Plans Updated Annually Or Upon Changes	N 381		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure when there was a change in Resident 10's needs, abilities, physical and/or mental condition, the individual service plan (ISP)	N 389		

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was reviewed and revised based on the assessment under sub. (1), and then signed by Resident 10 and his/her legal representative signed the ISP, acknowledging their involvement in, understanding of and agreement with the ISP.

This is a repeat violation from previous statement of deficiency (SOD) EGFK12 dated 12/17/2020 and SOD 88ZV14 dated 03/20/2024.

FINDINGS INCLUDE:

On 05/14/2025, Surveyor arrived at facility for a complaint investigation and standard survey.

On 05/14/2025 at 9:00 AM, Surveyor observed Caregiver HH administering medication for the facility medication cart. Surveyor did not see where Caregiver HH kept his/her hand sanitizer. Caregiver HH showed Surveyor that s/he kept the hand sanitizer locked up in the bottom drawer of the medication cart. Caregiver HH reported facility kept all hand sanitizer locked up because Resident 10 had a history of drinking the hand sanitizer.

On 05/14/2025 at 10:30 AM, Surveyor interviewed Resident 10. Resident 10 became tearful as s/he told Surveyor about his/her partners recent passing. Resident 10 was sitting in a wheelchair. Resident 10 reported s/he had a stroke that weakened his/her lower right extremity. So, s/he could not ambulate independently following the stroke. Resident 10 stated s/he required assistance from a staff member to transfer from bed to wheelchair, and back out of the wheelchair into the bed. Resident 10 stated s/he would like to speak with a therapist about his/her feelings. Resident 10 denied any current access to hand sanitizer. Surveyor did not

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N 389	Continued From page 7 observe any hand sanitizer and/or ethanol-based products in Resident 10's room. As Surveyor went to exit Resident 10's room. Surveyor observed a white door alarm installed on the top left corner of the door frame. The door alarm chimed once as Surveyor opened the door. Surveyor asked Resident 10 about the door alarm. Resident 10 stated s/he liked the door alarm because s/he was afraid of thieves entering his/her room. On 05/14/2025, Surveyor reviewed Resident 10's facility record. On 05/14/2025, Surveyor reviewed Resident 10's facility face sheet. On 05/14/2025, Surveyor reviewed Resident 10's progress notes from 03/01/2025 to 05/14/2025. The following was documented: 1.) On 04/07/2024 at 1:30 PM, Caregiver LL documented the following, "resident was slurring [his/her] words and not acting at baseline. resident (sic.) was sent to [Name Of Hospital]." 2.) On 04/07/2025 at 6:15 PM, Caregiver JJ documented the following, "RT (resident) returned from hospital, RT had a blood alcohol level of 158, RT had a bottle of hand sanitizer hidden in [his/her] room, Staff (sic.) needs to make sure any Hand (sic.) sanitizer is behind locked doors and out of reach. POA was concerned to even have RT returned to facility since this was not the first time this has happened." 3.) On 04/16/2025 at 7:00 PM, Caregiver HH documented the following, "Resident was putting hand sanitizer in [his/her] mouth when I walked in the room ..."	N 389		

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N 389	Continued From page 8 On 05/14/2025, Surveyor reviewed Resident 10's March 2025 medication administration record (MAR). Resident 10 was prescribed the following medications: 1.) Lorazepam 0.5 mg tablet - PRN (as needed) up to 2 times daily - Indication: anxiety 2.) Eliquis 5 mg tablet - twice daily - Indication: blood clot prevention On 05/14/2025, Surveyor reviewed Resident 10's individualized service plan (ISP). The ISP was not dated and/or signed by Resident 10 and his/her legal representative. The ISP documented the following subsections: diet, oral care, dressing, placing boot on right foot, bathing, toileting, and vision. The ISP did not have documentation of Resident 10's need for a wheelchair, transfer status, psychotropic PRN lorazepam, medical diagnoses, psychiatric diagnoses, anti-coagulant therapy, the door alarm installed in his/her room. The ISP did not contain a behavioral plan related to Resident 10's behavior of imbibing hand sanitizer with the plan to keep all hand sanitizer in the facility locked away from Resident 10. On 05/14/2025 at 2:50 PM, Surveyor asked Administrator FF and Manager A if s/he had been provided the complete ISP for Resident 10. Administrator FF reviewed the facility electronic health record (EHR), and verified Surveyor had reviewed the current ISP on file for Resident 10. On 05/14/2025 at 3:30 PM, Surveyor discussed the above concern with Administrator FF, Manager A and Consultant GG. Administrator FF, Manager A and Consultant GG acknowledged Resident 10's ISP had not been signed by himself/herself or Family Member E. Manager B acknowledged Resident 10 had a door alarm	N 389		

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N 389	Continued From page 9 installed in their room per their personal preference. Administrator A and Manager B acknowledged staff had been instructed to keep all hand sanitizer locked up to keep Resident 10 safe. Administrator A and Manager B acknowledged Resident 1 utilized a wheelchair for ambulation and required staff assistance for transfers. Administrator FF and Manager C acknowledged Resident 10's was taking PRN lorazepam for anxiety and scheduled Eliquis for blood clot prevention. Administrator FF and Manager C acknowledged Resident 10's aforementioned care needs and interventions had not been documented in his/her ISP. CROSS REFERENCE: N0381 DHS Chapter 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 389		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medicine cabinets were locked. This is a repeat violation from previous statement of deficiency ZZF212 dated 07/07/2021. FINDINGS INCLUDE: On 05/14/2025, Surveyor arrived at facility for a standard survey. On 05/14/2025 at 10:30 AM, Surveyor was touring facility. Surveyor found the medication	N 419		

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N 419	Continued From page 10 room door and was able to open the door without a key. Upon opening the door Surveyor observed 3 pharmacy blister packs on the counter of the medication room. Surveyor observed the blister packs still contained pills and were within an arm length of entrance. Surveyor was at the door for approximately 1 minute until Manager A approached. Manager A closed the door and found s/he was able to open the door without a key. Manager A acknowledged the 3 blister packs on the counter of the medication room. Manager A acknowledged the 3 blister packs of pills were not secured in a locked cabinet. The 3 blister packs observed on the counter of the medication room were as follows: 1.) Resident 9's blister pack of Atorvastatin 80 mg contained 13 tablets (Picture 5). 2.) Resident 9's blister pack of Diclofenac Sodium 50 mg contained 13 tablets (Picture 6). 3.) Resident 11's blister pack of Melatonin 3mg contained 20 tablets (Picture 7). On 05/20/2025 at 2:00 PM, Surveyors discussed the above concern with Administrator FF. Administrator FF acknowledged staff had not kept the door to the medication room locked. Administrator FF acknowledged there were unsecured blister pack(s) of pills on the counter of the unlocked medication room.	N 419		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF	N 452		

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N 452	Continued From page 11 shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored in a sanitary manner. This is a repeat violation. See Statement of Deficiency 77FZ12, dated 07/07/2021. Findings include: On 05/14/2025 at 9:37 AM, Surveyor toured the provider's kitchen and observed the following: -The interior surfaces of the refrigerator were dirty with evidence of spills that had not been cleaned. -A produce drawer contained 2 bags of rotting onions. The onions were stored next to a small block of cheese that did not have an airtight seal or dated. -Inside the freezer, observed packages of opened tater tots and French toast that was badly freezer burned. The packaged did not have an airtight	N 452		

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N 452	Continued From page 12 seal or a date of opening on it. -Inside a kitchen cupboard with many pantry items stored, Surveyor observed 2 packages of tortillas with an expiration date of 01/30/2025. The cupboard surface was dirty with evidence of spilled sugar and food crumbs. -The stove was very dirty with evidence of grease residue and food splatter. On 05/14/2025 at 9:45 AM, Surveyor interviewed Caregiver KK regarding the provider's policy on cleaning the kitchen and food safety. Caregiver KK reported staff are responsible for cleaning out the refrigerator every couple days. Caregiver KK reported meals are prepared next door and many residents order food. Surveyor shared above concerns observed in the kitchen. Caregiver KK acknowledged the condition of the kitchen but did not respond any further. On 05/14/2025 at 3:30 PM, Surveyor discussed the above concerns with Manager A, Administrator FF, and Consultant GG. Administrator FF acknowledged an understanding of the above concerns and reported the items in refrigerator were most likely the residents since the provider prepared meals/snacks at their sister facility next door. Administrator FF reported s/he would have staff clean out the kitchen.	N 452		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is	N 488		

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N 488	Continued From page 13 of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 clothes dryers utilized a vent that was made of rigid vent tubing. Findings include: On 05/14/2025 at 9:05 AM, Surveyor observed the laundry room. Surveyor observed 1 of 1 clothes dryer vent was made of semi-rigid material for approximately 3 feet. On 05/14/2025 at 3:30 PM, Surveyor discussed the above concerns with Manager A, Administrator FF, and Consultant GG. Administrator AA stated s/he was not the administrator when the dryer vent was installed, but s/he knows the material must be made of rigid material. Administrator FF stated s/he would have maintenance change out the dryer vent.	N 488		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that 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 and toxic substances were stored in a secure area. This is a repeat of statement of deficiency	N 499		

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 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 499	Continued From page 14 77FZ11 dated 02/25/2021. FINDINGS INCLUDE: Facility is a Class CNA non-ambulatory facility. Has a capacity of 16 residents and serves advanced aged, irreversible dementia, Alzheimer's, physically disabled, mentally ill and emotionally disturbed. On 05/14/2025, Surveyor arrived at facility for a standard survey. On 05/14/2025 at 12:00 PM, Surveyor was touring the facility. Surveyor found a door to the laundry room and was able to open the door without a key. Surveyor observed the following: 1.) A partially full bottle of calcium lime and rust remover (CLR) on the counter (Picture 1). 2.) A partially full bottle of OxyDol brand laundry detergent on the counter (Picture 2). 3.) A partially full bottle of Clorox brand laundry sanitizer on the counter (Picture 3). 4.) A mop bucket half-way fill with soapy water on the floor (Picture 4). On 05/14/2025 at 12:05 PM, Surveyor asked Manager A to follow them to the laundry room door. Manager A was able to open the door without a key. Manager A acknowledged there were cleaning compounds stored on the counter and on the floor of the laundry room. Manager A stated s/he would speak with staff about keeping doors locked. On 05/20/2025 at 2:00 PM, Surveyor discussed the above concern with Administrator FF. Administrator FF acknowledged that cleaning compounds were considered toxic substances and were found stored in an unlocked room.	N 499		

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N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted quarterly and at least one drill simulated the conditions during usual sleeping hours for 2 of 2 years reviewed (2023 and 2024). This is a repeat violation. See Statement of Deficiency 88ZV12, dated 01/26/2023. Findings include: On 05/14/2025, Surveyor reviewed the provider's safety records and identified the following: -There was no record of fire drills completed in the 3rd and 4th quarters of 2024. Additionally,	N 525		

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N 525	Continued From page 16 there was no record of at least one drill simulating the conditions during usual sleeping hours in 2023 and 2024. On 05/14/2025 at 10:15 AM, Surveyor requested the provider's fire drills for 2023 and 2024 from Manager A. On 05/14/2025 at 3:30 PM, Surveyor discussed the above concerns with Manager A, Administrator FF, and Consultant GG. Administrator AA stated s/he was not the administrator when the above fire drills were due. Administrator FF stated if s/he found documentation of fire drills being completed s/he would email it to the Surveyor within the next 24 hours. On 05/20/2025 at 2:00 PM, Surveyor interviewed Administrator FF. Administrator FF confirmed fire drills were missed in 2023 and 2024. Administrator FF reported s/he would ensure fire drills are completed going forward.	N 525		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility was inspected annually by the local fire authority or certified fire inspector. The facility had not completed a fire inspection in 2023 and 2024.	N 530		

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N 530	Continued From page 17 Findings include: The provider is able to serve up to 16 residents in the following client groups, physically disabled, advanced age, irreversible dementia/Alzheimer's, and emotionally disturbed/mental illness. On 05/14/2025 at 10:15 AM, Surveyor requested the provider's fire inspections for 2023 and 2024 from Manager A. On 05/14/2025 at 2:15 PM, Surveyor interviewed Manager A regarding the requested fire inspections. Manager A reported s/he checked with management and the fire inspections could not be located. On 05/14/2025 at 3:30 PM, Surveyor discussed the above concerns with Manager A, Administrator FF, and Consultant GG. Administrator AA stated s/he was not the administrator when the above inspections were due. Administrator FF stated if s/he found documentation of fire inspections being completed s/he would email it to the Surveyor within the next 24 hours. On 05/20/2025 at 2:00 PM, Surveyor interviewed Administrator FF. Administrator FF confirmed fire inspections for 2023 and 2024 were never completed.	N 530		