STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017702	A. BUILDING: _____ B. WING _____	R-C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON OAKWOOD	5555 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 From 09/11/2023 to 09/13/2023, Surveyor conducted a complaint investigation and verification visit at Cottages of Madison Oakwood, a CBRF in Madison. Two deficiencies were identified. One deficiency is a repeat deficiency. See Statement of Deficiency (SOD) EC0P16, dated 10/07/2022 and EC0P17, dated 04/06/2023. The complaint was substantiated. Under statutory provisions of Wis. State. Ch 50, a $200 revisit fee is being assessed. Census: 16	{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: Based on record review and interview, the provider did not ensure Resident 9 was free from physical abuse. Resident 9 was physically abused by Caregiver Z. Findings include:	N 348		

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
	0017702	A. BUILDING: _____ B. WING _____	R-C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON OAKWOOD	5555 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 348	Continued From page 1 On 09/11/2023, Surveyor conducted a complaint investigation alleging physical abuse occurred at the provider's facility. On 09/11/2023 at approximately 12:10 p.m., Surveyor interviewed Director Y. Director Y stated in July 2023, s/he was notified that Caregiver Z had been heard yelling at Resident 9 in his/her room with the door shut. Director Y stated s/he was sent a picture of a bruise on Resident 9's forearm. Director Y stated Caregiver Z was taken off the schedule until an investigation was completed, which led to Caregiver Z's termination. Director Y stated s/he updated Resident 9's Healthcare Power of Attorney. On 09/11/2023 at approximately 12:20 p.m., Surveyor interviewed Caregiver AA. Caregiver AA stated s/he was working with Caregiver Z on 07/15/2023. Caregiver AA stated Caregiver Z had a history of being rude to residents. Caregiver AA stated on 07/15/2023, s/he heard arguing and went to see what was going on. Caregiver AA stated Caregiver Z then slammed Resident 9's door in Caregiver AA's face and Caregiver AA heard Resident 9 state, "Ow. You're hurting me ... Stop ... Someone help me." Caregiver Z stated s/he heard Resident 9's walker get thrown. On 09/11/2023 at approximately 12:40 p.m., Surveyor interviewed Resident 9 who stated Caregiver Z "didn't like me from the beginning." Resident 9 stated Caregiver Z was upset with Resident 9 on 07/15/2023 because Resident 9 had requested 2 glasses of water within 4 hours and when Caregiver Z didn't get Resident 9 water, Resident 9 requested water from another resident. Resident 9 stated Caregiver Z then kicked the other resident out of Resident 9's room, grabbed Resident 9 by the wrists while	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017702	A. BUILDING: _____ B. WING _____	R-C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON OAKWOOD	5555 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 348	Continued From page 2 yelling at him/her and threw Resident 9's walker into the closet. Resident 9 stated s/he yelled at Caregiver Z to stop. Resident 9 stated s/he contacted law enforcement him/herself. On 09/11/2023 at approximately 1:00 p.m., Surveyor reviewed a misconduct report completed by the provider and submitted to Office of Caregiver Quality, dated 07/27/2023, which stated, "[Caregiver Z] aggressively grabbed both of [Resident 9]'s arms and would not let go and was swearing at [him/her] ... [Resident 9] was very clearly shaken and in pain." The report stated physical marks/bruises were seen nearly immediately on Resident 9's left wrist with pain. Surveyor observed a picture, reportedly taken by Caregiver AA minutes after the abuse, which showed a bruise on Resident 9's left forearm (Photo 1). On 09/12/2023 at approximately 12:20 p.m., Surveyor received an update from Detective BB that Caregiver Z was charged with Physical Abuse of Elder Person - Intentionally Cause Bodily Harm and Disorderly Conduct. Caregiver Z had his/her initial appearance in court and was currently out on signature bond. Cross Reference: N0431 DHS 83.38(1)(g) Health Monitoring	N 348		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents 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	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017702	A. BUILDING: _____ B. WING _____	R-C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON OAKWOOD	5555 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 431}	Continued From page 3 the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents health was monitored and documented in the resident's record. The physical and mental health of Resident 9 was not monitored or documented in his/her record after allegedly being physically abused by Caregiver Z. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P16, dated 10/07/2022 and	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017702	A. BUILDING: _____ B. WING _____	R-C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON OAKWOOD	5555 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 431}	Continued From page 4 EC0P17, dated 04/06/2023. Findings include: On 09/11/2023, Surveyor conducted a complaint investigation alleging physical abuse occurred at the provider's facility. On 09/11/2023 at approximately 12:10 p.m., Surveyor interviewed Director Y. Director Y stated Caregiver Z was terminated in July 2023 due to physically abusing Resident 9. On 09/11/2023 at approximately 12:20 p.m., Surveyor interviewed Caregiver AA. Caregiver AA stated s/he was working with Caregiver Z on 07/15/2023 when s/he heard arguing and went to see what was going on. Caregiver AA stated Caregiver Z then slammed Resident 9's door in Caregiver AA's face and Caregiver AA heard Resident 9 state, "Ow. You're hurting me ... Stop ... Someone help me." Caregiver Z stated s/he heard Resident 9's walker get thrown. Caregiver Z stated after Caregiver AA came out of Resident 9's room, Caregiver AA observed a bruise on Resident 9's arm and took a picture. On 09/11/2023 at approximately 12:40 p.m., Surveyor interviewed Resident 9. Resident 9 stated Caregiver Z was upset with Resident 9 on 07/15/2023 because Resident 9 had requested 2 glasses of water within 4 hours and when Caregiver Z didn't get Resident 9 water, Resident 9 requested water from another resident. Resident 9 stated Caregiver Z then kicked the other resident out of Resident 9's room, grabbed Resident 9 by the wrists while yelling at him/her and threw Resident 9's walker into the closet. Resident 9 stated s/he yelled at Caregiver Z to stop.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017702	A. BUILDING: _____ B. WING _____	R-C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON OAKWOOD	5555 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 431}	Continued From page 5 On 09/11/2023 at approximately 1:00 p.m., Surveyor reviewed a misconduct report completed by the provider and submitted to Office of Caregiver Quality, dated 07/27/2023, which stated, "[Caregiver Z] aggressively grabbed both of [Resident 9]'s arms and would not let go and was swearing at [him/her] ... [Resident 9] was clearly shaken and in pain." The report stated physical marks/bruises were seen nearly immediately on Resident 9's left wrist with pain. Surveyor observed a picture, reportedly taken by Caregiver AA minutes after the abuse, which showed a bruise on Resident 9's left forearm (Photo 1). On 09/11/2023 at approximately 1:15 p.m., Surveyor reviewed Resident 9's record. Surveyor reviewed a behavior incident report, dated 07/15/2023, which stated, "On Saturday [07/15/2023] I was in [affiliated facility]. I was called to [facility] because there was a disturbance and the police wanted to speak to writer, Writer went to [facility] and spoke to police about an incident that occurred earlier in the day." The report did not state what happened and stated Resident 9 didn't have any injuries. Surveyor then reviewed Resident 9's progress/observation notes, dated 07/01/2023 to 09/11/2023, and noted the only comment related to the 07/15/2023 incident was dated 07/27/2023 and stated "Detective stopped by to talk to [Resident 9] and left [his/her] card with [Resident 9] if [s/he] had any concerns or questions." On 09/11/2023 at approximately 1:30 p.m., Surveyor interviewed Director Y. Surveyor shared concern that Resident 9's record did not include documentation of abuse or the monitoring of Resident 9's mental and physical health following	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017702	A. BUILDING: _____ B. WING _____	R-C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON OAKWOOD	5555 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 431}	Continued From page 6 the abuse. Director Y acknowledged concern and stated the only documentation of the abuse was in the facility's investigation and that monitoring of Resident 9's physical and mental health took place but was not documented. Cross Reference: N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment	{N 431}		