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 02/21/2024

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 02/21/2024 to 02/23/2024, Surveyors conducted a verification visit, standard survey and complaint investigation at Cottages of Madison Oakwood, a CBRF in Madison. Eight deficiencies were identified. One deficiency was a repeat deficiency - See Statement of Deficiency (SOD) M20M11, dated 07/11/2023. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 13	{N 000}		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the	N 302		

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

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N 302	Continued From page 1 provider did not ensure 1 of 1 residents reviewed was screened for clinically apparent communicable disease, including tuberculosis, within 90 days before or 7 days after admission. Resident 10 did not have a tuberculosis test within 90 days prior to admission or 7 days after admission. Findings include: On 02/21/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 10's record. Resident 10 was admitted to the provider's facility on 12/01/2023. Resident 10's record included a tuberculosis test, dated 06/29/2023. On 02/21/2024 at approximately 2:00 p.m., Surveyor interviewed Director Y and Administrator CC. Surveyor shared concern that Resident 10 did not have a tuberculosis test completed within 90 days prior to admission or 7 days after admission. Administrator CC stated s/he would need to follow up with Surveyor. On 02/21/2024 at approximately 8:00 p.m., Administrator CC provided Surveyor with a tuberculosis test, dated 12/12/2023, greater than 7 days after Resident 10's admission.	N 302		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by	N 326		

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N 326	Continued From page 2	N 326		

a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a living arrangement suitable to meet the needs of a resident was available before discharging a resident. Resident 10, who required assistance with personal cares, medications and meals, was discharged to a hotel.

Findings include:

On 02/21/2024, Surveyors conducted a complaint investigation alleging the provider discharged a resident without suitable placement.

On 02/21/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 10's record. Resident 10 was admitted to the provider's facility on 12/01/2023 with diagnoses including diabetes and unspecified mental disorder. Resident 10's individual service plan (ISP), dated 01/02/2024, indicated s/he required assistance for the following: transfers to/from wheelchair, bathing, dressing, grooming, oral cares, food preparations, toileting, including bowel movement monitoring, and transportation for medical appointments. The ISP also indicated Resident 10 was a fall risk. Resident 10's record included a 30-day discharge notice from the provider, dated 01/22/2024, that identified behavioral concerns as the reason for discharge. Resident 10's record

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N 326	Continued From page 3 included the following progress notes: - 02/04/2024 at 12:30 p.m.: Resident yelled loudly at staff this morning and called [him/her] very racist names and grabbed staff's arm aggressively. No marking were left from resident grabbing arm, however, staff is having some pain in [his/her] arm. Staff would like to press charges against resident, however, police stated there wasn't anything to press charges for. Resident decided to go to a hotel for the night, staff assisted [him/her] with packing a small bag and all of [his/her] medications. Resident was issued a risk reduction agreement and a 30-day notice a week or so ago. Writer has notified [his/her] care team of the incident, that [s/he] is going to a hotel and that [s/he] will not be allowed to return to the community due to the safety of our staff and residents. - 02/04/2024 at 1:37 p.m.: Discharged from the system. [S/he] is [his/her] own person and decided to go check into a hotel after police were called on [him/her] due to an incident. [S/he] isn't able to return to the community. On 02/21/2024 at approximately 2:00 p.m., Surveyor interviewed Administrator CC. Surveyor reviewed Resident 10's needs identified in his/her record and asked about discharge arrangements. Administrator CC stated Resident 10 requested to go to a hotel, so staff priced out hotels for Resident 10. Administrator CC stated Resident 10 paid for his/her hotel on his/her own, took food with him/her and the facility packed up all of Resident 10's medications. Surveyor asked Administrator CC if Resident 10 went to the hotel for a leave or if s/he discharged him/her at that time. Administrator CC stated it was his/her understanding that s/he discharged Resident 10 at that time and would not accept him/her back.	N 326		

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N 326	Continued From page 4 Surveyor shared concern that a hotel was not suitable placement for Resident 10 given his/her care needs. Administrator CC stated s/he would not accept Resident 10 back for the safety of others at the facility. On 02/23/2024 at approximately 4:00 p.m., Surveyor reviewed progress notes from Resident 10's Managed Care Organization (MCO). A note, dated 02/05/2024, stated "[A friend of member] noted [him/her] in the lobby of the hotel with stool soiled clothing and returned to assist [Resident 10] with bathing, change [his/her] clothing and assist with incontinent cares. [Resident 10] reported to [his/her] friend that [s/he] had a fall out of bed overnight and [s/he] noticed redness to [his/her] buttocks. Following assistance with cares, friend transported member to the [local hospital]. A note, dated 02/16/2024, stated Resident 10 remained hospitalized as the hospital and MCO attempted to find alternate facility placement. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 326		
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		

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N 381	Continued From page 5	N 381		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure an assessment was completed when there was a change in 1 of 3 residents reviewed. The provider did not complete a behavior assessment when Resident 10 exhibited a change in behaviors.

This is a repeat deficiency. See Statement of Deficiency (SOD) M20M11, dated 07/11/2023.

Findings include:

On 02/21/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 10's record. Resident 10 was admitted to the provider's facility on 12/01/2023. Resident 10's assessment/individual service plan (ISP), dated 01/02/2024, stated, "Resident requires staff assistance to manage/redirect aggressive/combative behaviors. Can become loud and upset at times when [s/he] has to wait for things." The assessment/ISP stated "No" to destructive behaviors. Resident 10's progress notes, dated 12/04/2024 to 02/04/2024, included the following:

- 12/04/2024: Behaviors and accusations over the past weekend.
- 12/17/2024: Ran over caregiver's foot with wheelchair. Verbal aggression.
- 12/19/2024: Verbal aggression.
- 12/24/2024: Hitting, swearing and yelling.
- 12/29/2024: Cursing all day. Trying to fight staff.
- 12/30/2024: Cursing at staff and residents.
- 01/19/2024: Extremely rude to staff. Loud and

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N 381	Continued From page 6	N 381		

disrespectful.
- 01/22/2024: Yelling at the top of his/her lungs at staff and other residents. Threw a coffee cup at staff and residents, which broke into pieces and cut a staff member's finger. Staff and residents didn't feel safe with Resident 10 in the building. Called non-emergency transport to take him/her to the hospital and requested that resident not return until psych review was completed. *No follow up on psych review.
02/01/2024: Verbal aggression.
02/04/2024: Yelling at staff. Grabbed staff's arm. Law enforcement contacted but could not do anything. Resident discharged to a hotel.

Resident 10's record included a 30-day discharge notice from the provider, dated 01/22/2024, that identified behavioral concerns as the reason for discharge.

On 02/21/2024 at approximately 12:50 p.m., Surveyor requested an updated assessment from Administrator CC related to behaviors. Administrator CC stated a behavior assessment was not completed and the psych review was refused.

On 02/21/2024 at approximately 2:00 p.m., Surveyor interviewed Administrator CC and Director Y. Surveyor shared concern that Resident 10 exhibited behaviors that led to a 30-day discharge notice; however, the provider had not completed an assessment when they observed a change in behaviors. Administrator CC confirmed s/he did not complete a behavior assessment and stated, "It's like [s/he] just flipped. [S/he] was fine until [s/he] started having all these behaviors."

Cross Reference: N0326 DHS 83.31(4)(a) Notice

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N 381	Continued From page 7 Of Facility Initiated Discharge	N 381		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least 1 qualified care staff was present in the CBRF when 1 or more residents were present in the CBRF. Caregiver DD worked an overnight shift by him/herself without all trainings completed. Findings include:	N 397		

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N 397	Continued From page 8 On 02/21/2024 at approximately 11:00 a.m., Surveyor reviewed Caregiver DD's record. Caregiver DD was hired on 01/16/2024. Caregiver DD's record did not include documentation of training in First Aid and Choking and Fire Safety. Surveyor reviewed the facility's schedule, dated 02/11/2024 to 02/17/2024. The schedule indicated Caregiver DD worked 02/20/2024 at 11:00 p.m. to 02/21/2024 at 7:00 a.m. by him/herself. DHS Chapter 83.02(42) identifies "Qualified resident care staff" as an employee who has successfully completed all of the applicable training and orientation under subch. IV. On 02/21/2024 at approximately 2:00 p.m., Surveyor interviewed Administrator CC and Director Y. Director Y confirmed Caregiver DD worked the overnight shift by him/herself, with a caregiver that "floated" between the other 2 affiliated facilities on the campus. Surveyor shared that Caregiver DD's record did not include all necessary trainings. Administrator CC was given until 02/22/2024 to provide any follow up documentation, including documentation of any training exemptions. On 02/22/2024 at approximately 11:00 a.m., Surveyor confirmed with the Community-Based Care and Treatment Training Registry that Caregiver DD did not have training in First Aid and Choking or Fire Safety. On 02/22/2024 at approximately 11:00 a.m., Administrator CC confirmed Caregiver DD did not have all department approved trainings. Administrator CC stated s/he was unaware the caregiver needed to have all the trainings completed in order to work alone since Caregiver	N 397		

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N 397	Continued From page 9 DD was still within his/her 90 days of employment.	N 397		
{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 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.	{N 431}		

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{N 431}	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed had their health monitored and that arrangements for their physical health were arranged. The provider did not clarify Resident 11's blood sugar check order. The provider did not ensure Resident 11 had an annual physical. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P16, dated 10/07/2022, EC0P17, dated 04/06/2023 and EC0P18, dated 09/11/2023. Findings include: From 02/21/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 11's record. Resident 11 was admitted to the provider's facility on 12/01/2022 with diagnosis of diabetes. The following concerns were identified: Example 1 - Blood Sugar Checks Resident 11's record included a physician order, dated 12/06/2022, that stated "Check blood sugar right before and 2 hours after start of meal every other day." There was a notation that the order needed to be clarified and that a voicemail was left with the primary care physician to clarify on 02/14/2024, greater than 14 months after the order had been written. Resident 11's medication administration record (MAR), dated 02/01/2024 to 02/21/2024, indicated the following blood sugar checks were completed: - 16 blood sugar checks ranging from 8:05 a.m. to 8:59 a.m. - 8 blood sugar checks ranging from 1:49 p.m. to	{N 431}		

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{N 431}	Continued From page 11 2:46 p.m. - 4 entries stated "Results not recorded." One notation stated the glucose meter needed a new battery. One notation stated "Sleeping - Med passer busy." *7 occurrences stated blood sugar was not checked because Resident 11 was out of the building and 3 occurrences stated Resident 11 refused to have blood sugar checked. On 02/21/2024 at approximately 2:00 p.m., Surveyor interviewed Director Y and Administrator CC. Surveyor shared concern that Resident 11's physician order did not clarify if blood sugar should be checked before and 2 hours after every meal or 1 meal per day. Surveyor shared observation that the facility was routinely checking Resident 11's blood sugar at approximately 8:00 a.m., presumably before breakfast, but that there were not routine blood sugars taken 2 hours after breakfast or with any other meals. Surveyor shared observation that the physician order was written in December 2022, yet notation indicated the facility had not sought clarification until 02/14/2024. Administrator CC nodded his/her head in agreement with Surveyor's observations and wrote down Surveyor's concern. Administrator CC and Director Y were unable to confirm how many times per day Resident 11's blood sugar was supposed to be taken, every other day. Example 2 - Annual Physical: Resident 11's record did not include an annual physical. Surveyor requested documentation of Resident 11's most recent physical from Administrator CC. On 02/21/2024 at approximately 12:00 p.m.,	{N 431}		

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{N 431}	Continued From page 12 Administrator CC provided Surveyor with a post-it note that stated "Annual Physical rescheduled to 05/29/2024" due to being sick. Administrator CC did not provide documentation of the initially scheduled physical or the most recent physical. On 02/21/2024 at approximately 2:00 p.m., Surveyor interviewed Administrator CC and Director Y. Surveyor shared concern that based on record review, Resident 11 had not had a physical in greater than 14 months. Administrator CC nodded his/her head in agreement and wrote down Surveyor's concern. Administrator CC was given until 02/22/2024 to provide follow up documentation. No documentation related to an annual physical within the past year was received for Resident 11.	{N 431}		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that toilet and bathing areas for 2 resident bathrooms were clean and in good working order which effected 13 of 13 residents at the facility. Findings include: On 02/21/2024 at 9:00 AM, Surveyor conducted a standard survey and toured the physical environment. The following was observed during the tour: Public bathroom 1, located on the east side of	N 490		

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N 490	Continued From page 13	N 490		

building and used by all residents, was visibly unclean. Observed on the bathroom floor were many dried on splatters of brown matter surrounding the toilet area and particles of toilet paper and other various debris. On the counter of the public bathroom, Surveyor observed a set of personal dentures sitting in a cup of water by the sink. Surveyor noted many residents ambulating and using the bathroom independently.

Public bathroom 2, located on the west side of the building and used by all residents, was visibly unclean. The toilet seat contained strips of fabric based tape that contained brown matter. All residents who use the toilet sit on the tape containing the brown matter. Surveyor observed that the bathroom toilet paper roll was empty. The floor in the bathroom contained splatters and various debris strewn across the floor. Surveyor re-entered the bathroom at 1:40 PM and noticed that someone had placed a new roll of toilet paper on the back of the toilet tank and the empty roll remained on the toilet paper holder. Observed on the counter of the bathroom sink were several resident toothbrushes. Surveyor noted many resident ambulating and using the bathroom independently.

On 02/21/2024 at 2:00 PM, Surveyor interviewed Director Y and Administrator CC and asked who was responsible for cleaning the facility. Administrator CC stated they do have a contracted cleaning company that comes in and cleans the facility on Monday, otherwise caregivers can spot clean in-between but knows the bathrooms need a little work. Administrator CC confirmed the fabric based tape on the toilet seat in public bathroom 2 was used as an anti-slip precaution for a specific resident but

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	0017702	A. BUILDING: _____ B. WING _____	R-C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON OAKWOOD	5555 BURKE RD MADISON, WI 53718

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N 490	Continued From page 14 agreed that a more sanitary alternative should be used for the resident in the public bathroom. Administrator CC agreed that the dentures located in the public bathroom should be stored in the resident's room vs the counter where all residents have access to them.	N 490		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all interior floors and walls were clean and in good repair. The providers walls had scrapes and stains. The provider's floor had debris and dust build up throughout the facility. Findings include: On 02/21/2024 at approximately 9:00 a.m., Surveyor toured the provider's facility. Surveyor observed the facility's walls and trim had liquid staining, gray marks and black marks throughout the hallways and resident rooms. Surveyor noted drywall was scraped at the entrance of resident rooms. Surveyor observed brown matter on a bathroom wall, near the toilet paper holder. Surveyor observed black build up along the trim throughout the facility hallway, common areas and resident rooms. Surveyor observed debris of lint, paper, food and hair throughout the common areas, hallways, and resident rooms. On 02/21/2024 at approximately 2:00 p.m., Surveyor interviewed Administrator CC and Director Y. Surveyor shared concerns regarding	N 491		

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N 491	Continued From page 15 the cleanliness of the facility. Administrator CC stated caregivers were responsible for cleaning resident rooms, but that an agency came 1 time per week to clean the common areas and bathrooms. Administrator CC believed the agency had been to the facility approximately 2 days prior to Surveyor's visit. Administrator CC stated the provider's maintenance staff was working on a "refresh" of the facility.	N 491		
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 have an annual fire inspection conducted by the local fire marshal or certified inspector. Findings include: On 02/21/2024 Surveyor conducted a standard survey review. On 02/21/2024, at approximately 9:30 AM, Surveyor asked Director Y for documentation showing that an annual fire inspection had been conducted since the last survey. Director Y provided Surveyor with copies of an annual sprinkler report that did not include any documentation that the annual fire inspection was completed. Surveyor interviewed Director Y and asked if s/he had knowledge of an annual fire	N 530		

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N 530	Continued From page 16 inspection taking place. Director Y stated they thought the fire inspection was completed but was unsure. On 02/21/2024 at 2:00 PM, Surveyor interviewed Administrator CC and Director Y who stated they were unable to find the documentation regarding the annual fire inspection. Surveyor requested fire inspection documentation be emailed by the end of the day. As of 02/22/2024 at 7:00 AM, no documentation regarding the annual fire inspection was received.	N 530		