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 04/01/2025

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 On 04/01/2025, Surveyors conducted a complaint investigation and a verification visit at Cottages of Madison Oakwood, a CBRF located in Madison, WI. Two deficiencies were identified. Both deficiencies were repeat violations- See statement of deficiency (SOD) EC0P11, dated 03/23/2021, SOD EC0P12, dated 06/15/2025, SOD EC0P19, dated 02/21/2024, SOD EC0P1A, dated 06/11/2024, and SOD EC0P1B, dated 10/18/2024. Five of 6 deficiencies from SOD EC0P1B, dated 10/18/2024, were substantially corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 14	{N 000}		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents received all prescribed medications in the dosage and intervals prescribed by a practitioner. From 02/27/2025 to 03/19/2025, Resident 17 did	N 352		

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

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N 352	Continued From page 1	N 352		

not receive 1 of his/her medications as prescribed.
From 01/01/2025- 03/31/2025, Resident 21 did not receive 6 of his/her medications as prescribed.

This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P11, dated 03/23/2021 and SOD EC0P12, dated 06/15/2021.

Findings include:

Example 1- Resident 17

On 04/01/2025, Surveyor reviewed Resident 17's record and identified the following:

Resident 17 admitted to the provider on 05/14/2024 with diagnosis which included type 2 diabetes and chronic kidney disease. Resident 17's record indicated the provider's staff were responsible for medication administration. Resident 17's Medication Administration Record (MAR), dated 02/01/2025 to 03/31/2025, documented the following occurrences of medications not being administered:

Mounjaro 2.5 / 0.5 Inj (Start date: 02/03/2025)- Inject 2.5 mg subcutaneously once a week on Tuesday. **Medication was not administered from 02/18/2025 - 03/11/2025 (total of 4 consecutive once/week doses) with no pass reason of "medication not available- has been reordered".

Victoza 3-Pak 18 Mg/3 Ml Pen (Start date: 02/26/2025)- Inject (1.8 mg) subcutaneously once daily. **Medication was not administered from 02/27/2025 - 03/19/2025 (total of 23 doses) with no pass reasons of "medication not available- has been reordered", "no pass per hold", and "blood

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N 352	Continued From page 2 sugar not low". On 04/01/2025 from approximately 11:00 AM - 11:30 AM, Surveyors intermittently interviewed Administrator NN regarding the missed doses of insulin. Administrator NN stated s/he noticed the missed doses of Victoza and was having a facility nurse work on the problem. Administrator NN stated s/he knew medications can't be on the MAR for a long time if being refused or if the medications were not in the medication cart. Administrator NN stated the previous administrator discontinued the Victoza on 03/19/2025, but s/he could not locate a discontinue order from the physician. When Administrator NN called the pharmacy, they confirmed the insulin order should have still been active. Administrator NN discovered the Victoza was not covered by insurance and stated s/he would work with the doctor to find an appropriate medication that is covered. The missed doses of Mounjaro related to a delay in medication reorders, a result of facility staff not checking the reorder cue to submit to the pharmacy. S/he stated by 03/27/2025, the facility identified the concern, and it was now being monitored to ensure timely reorder of medications. Example 2- Resident 21 On 04/01/2025, Surveyor reviewed Resident 21's record and identified the following: Resident 21 admitted to the provider on 11/10/2023 with diagnosis which included major depressive disorder, hypertension, heart disease, and absence of left leg above knee. Resident 21's record indicated the provider's staff were responsible for medication administration. Resident 21's Medication Administration Record	N 352		

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N 352	Continued From page 3 (MAR), dated 01/01/2025 to 03/31/2025, documented the following occurrences of medications not being administered: Aquaphor Ointment (Start date: 02/26/2025)- Apply to the affected area(s) twice daily to the left lateral distal thigh stump. **Medication was not administered on 02/26/2025, 03/05/2025, 03/06/2025, 03/08/2025, 03/09/2025, 03/12/2025, 03/13/2025, 03/18/2025 - 03/20/2025, 03/23/2025, or 03/25/2025 - 03/30/2025 with no pass reason "medication not available". Vitamin D3 25 mcg (1000u) Tab (Start date: 12/11/2024)- Take 2 tablets (50 mcg) by mouth daily for nutritional support. Vitamin D3 changed on 03/20/2025 to- Vitamin D3 50 mcg tablet- Take 1 tablet orally once daily. **Medication was not administered from 02/27/2025 - 03/18/2025 (total of 20 doses) with no pass reason "medication not available- has been reordered". Losartan Pot 50 mg Tab (Start date: 12/11/2024)- Take 1 tablet by mouth twice a day for hypertension. **Medication was not administered on 01/01/2025, 01/04/2025, 01/05/2025, or 02/25/2025 with no pass reason "medication not available- has been reordered". Medication was not administered on 03/23/2025 with no pass reason "medication not given". Nac 600 mg Capsule (Start date: 02/25/2025)- Take 1 capsule orally once daily at bedtime, reason for use dermatillomania. **Medication was not administered 02/25/2025 - 03/01/2025, 03/04/2025 - 03/16/2025, or 03/19/2025 - 03/30/2025 (total of 29 doses) with no pass reason "medication not available- has been reordered" for all doses except on 03/23/2025 when it was documented "medication not given".	N 352		

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N 352	Continued From page 4 Vitamin B12 500 mcg Tab (Start date: 03/26/2025)- Take 1 tablet orally once daily, reason for use supplement. **Medication was not administered from 02/27/2025 - 03/18/2025 with no pass reason "medication not available- has been reordered". Acidophilus Capsule (Start date 02/26/2025)- Take 1 capsule orally once daily, reason for use irritable bowel syndrome. **Medication was not administered from 02/27/2025 - 03/31/2025 with no pass reason "medication not available- has been reordered". On 04/01/2025 at approximately 1:00 PM, Surveyors interviewed Administrator NN regarding the missed doses of medication. Administrator NN stated s/he only took over the facility roughly 1 week ago. Administrator NN stated medication passers had been putting medication "on order" but no one at the facility was checking the reorder cue, so the reorder requests were not being sent to the pharmacy. S/he stated by 03/27/2025, the facility identified the concern, and it was now being monitored to ensure timely reorder of medications.	N 352		
{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 doors and trim were in good repair. The providers interior doors and trim had wood scraped off and gouges in wood.	{N 491}		

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{N 491}	Continued From page 5 This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P19, dated 02/21/2024, ECP01A, dated 06/11/2024, and ECP01B, dated 10/18/2024. Findings include: On 04/01/2025 at approximately 10:00 a.m., Surveyors toured the provider's facility and observed the following concerns throughout the facility: -The main entrance had wood scraped off and framing off around window (Photo 6) -Bathroom doors had damaged trim, wood with rough edges and a chunk of wood missing (Photo 3, Photo 4 and Photo 5) - Resident 23's door frame had nails sticking out of the door frame (Photo 1 and Photo 2) On 04/01/2025 at approximately 1:15 p.m., Surveyors reviewed concern with Administrator NN that the facility's door frames, and trim were not in good repair. Administrator NN stated that "maintenance was working on Resident 23's room today." Administrator NN acknowledged the damaged front door and stated that the new consulting company took over the facility and was planning on painting and updating the facility doors.	{N 491}		