

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017702	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/24/2025
NAME OF PROVIDER OR SUPPLIER COTTAGES OF MADISON OAKWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 06/24/2025, Surveyors conducted a verification visit at Cottages of Madison Oakwood, a CBRF in Madison, WI. Two deficiencies of Chapter DHS 83 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, SOD EC0P1B, dated 10/18/2024, and SOD EC0P1C, dated 04/01/2025. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 11	{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 observation, interview, and record review, the provider did not ensure 2 of 2 residents reviewed received all prescribed medications in the dosage and at intervals prescribed by the practitioner. Resident 13's latanoprost eye drops were not	{N 352}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{N 352}	Continued From page 1 administered 7 times between 06/09/2025 and 06/18/2025. Resident 13's levothyroxine was not administered on 06/20/2025 or 06/24/2025. Resident 21's Aquaphor was not administered 8 times between 06/07/2025 and 06/23/2025. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P11, dated 03/23/2021, SOD EC0P12, dated 06/15/2021, and SOD EC0P1C, dated 04/01/2025. Findings include: On 06/24/2025, Surveyors observed the provider's medication cart with Caregiver LL and identified the following: Example 1- Resident 13 Resident 13's latanoprost drops were dated as filled 06/16/2025 and the bottle was nearly full. The pharmacy label read: "Instill 1 drop into each eye once daily." Resident 13's levothyroxine bubble pack, labeled "morning" contained a pharmacy label that read: "Take 1 tablet orally once daily." The bubble pack still had a pill in the bubbles numbered "20" and "24". On 06/24/2025 at approximately 11:15 AM, Surveyor interviewed Caregiver LL who stated most bubble packs were punched based on the date. So, on June 20th, the bubble "20" should have been used. Caregiver LL stated the levothyroxine was part of the NOC shift's med pass, so s/he was unaware of why the pills were still in the pack for the 20th and 24th.	{N 352}		

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{N 352}	Continued From page 2 Surveyor reviewed Resident 13's record which documented the following: Resident 13 admitted to the facility on 08/31/2023 with diagnosis including hypothyroidism and glaucoma. Resident 13's individual service plan (ISP) stated his/her medications are administered by staff. Resident 13's physician orders included the following orders: "Latanoprost 0.005% Eye Drops- Instill (1) drop into each eye once daily ... Levothyroxine 75 Mcg Tablet- Take (1) tablet orally once daily ..." Resident 13's medication administration record (MAR) included the following notations for the latanoprost administration from 06/07/2025 - 06/24/2025: "06/09/2025- 7:38PM- No Pass Reason: Medication not available, has been reordered. 06/10/2025- 7:21PM- No Pass Reason: Medication not available, has been reordered. 06/11/2025- 8:12PM- No Pass Reason: Medication not available, has been reordered. 06/12/2025- 7:42PM- No Pass Reason: Medication not Available, has been reordered. 06/14/2025- 7:30PM- No Pass Reason: Medication not Available, has been reordered. 06/15/2025- 7:10PM- No Pass Reason: Medication not Available, has been reordered. 06/18/2025- 8:21PM- No Pass Reason: Medication not Available, has been reordered. " Resident 13's MAR did not document any exceptions or notes related to the administration of the levothyroxine on June 20th or 24th, 2025. Both doses were signed out as administered.	{N 352}		

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{N 352}	Continued From page 3 On 06/24/2025 at approximately 12:35PM, Surveyor interviewed Pharmacy Tech OO. Pharmacy Tech OO stated Resident 13's latanoprost was last filled on 06/16/2025 and delivered on 06/17/2025. Prior to that, the last fill was on 03/28/2025. On 06/24/2025 at approximately 1:10PM, Surveyors interviewed Administrator NN. Administrator NN stated there had been many medication concerns previously but that since taking over at the facility, they were working on improving things and have made progress. Administrator NN stated medication reorders are processed through the electronic MAR and sent to pharmacy electronically. Administrator NN stated there are issues with insurances and authorizations sometimes which can cause delays on the delivery of some medications. Administrator NN did not have a specific explanation for the unavailability of the latanoprost eye drops, and stated they would continue to provide education to staff. Administrator NN stated s/he would need to look into the missed doses of levothyroxine. Example 2- Resident 21 Resident 21's Aquaphor was over 75% full, and dated as opened 02/2024. The pharmacy label read: "Apply to the affected area(s) twice daily to the left lateral distal thigh stump." Surveyor reviewed Resident 21's record which documented the following: Resident 21 admitted to the facility on 11/10/2023 with diagnosis including localized edema and absence of left leg above knee. Resident 21's	{N 352}		

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{N 352}	Continued From page 4 physician orders included the following order: "Aquaphor Ointment- Apply to the affected area(s) twice daily to the left lateral distal thigh stump ..." Resident 21's MAR included the following notations for the Aquaphor administration from 06/07/2025 - 06/24/2025: "06/07/2025- 8:25PM- No Pass Reason: Medication not Available, has been reordered. 06/08/2025- 8:51PM- No Pass Reason: Medication not Available, has been reordered. 06/09/2025- 7:43PM- No Pass Reason: Medication not Available, has been reordered. 06/10/2025- 7:30PM- No Pass Reason: Medication not Available, has been reordered. 06/13/2025- 7:22PM- No Pass Reason: Medication not Available, has been reordered. 06/16/2025- 7:56PM- No Pass Reason: Medication not Available, has been reordered. 06/21/2025- 8:23PM- No Pass Reason: Medication not Available, has been reordered. 06/23/2025- 7:04PM- No Pass Reason: Medication not Available, has been reordered." On 06/24/2025 at approximately 12:35PM, Surveyor interviewed Pharmacy Tech OO. Pharmacy Tech OO stated Resident 21's Aquaphor ointment has never been filled by this pharmacy and there was no authorization entered to cover the prescription either. On 06/24/2025 at approximately 1:10PM, Surveyor interviewed Administrator NN. Administrator NN was not aware some staff were not administering the Aquaphor ointment. Administrator NN stated s/he would continue to provide education to staff on protocol if they	{N 352}		

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{N 352}	Continued From page 5 cannot locate a medication. Administrator NN also explained the provider is working through each resident individually to ensure their medication regimen is correct with the pharmacy, physician, and any other involved parties, due to discrepancies when Administrator NN started.	{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. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P19, dated 02/21/2024, ECP01A, dated 06/11/2024, ECP01B, dated 10/18/2024 and ECP01C, dated 04/01/2025. Findings include: On 06/24/2025 at approximately 11:00 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 3 and Photo 4) -Bathroom doors had damaged trim, wood with rough edges and a chunk of wood missing (Photo 5) - Room 12's door frame and door had wood scraped off and broken plastic trim (Photo 1 and Photo 2)	{N 491}		

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{N 491}	Continued From page 6 On 06/24/2025 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 room 12 door frame today." Administrator NN acknowledged the damaged front door and stated that the facility had replaced the exterior doors and was still working on the interior doors.	{N 491}			