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 _____	C 10/22/2025

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 10/07/2025 with information gathered through 10/22/2025, Surveyor conducted a complaint investigation at Cottages of Madison Elmwood, a CBRF in Madison, WI. One deficiency of Chapter DHS 83 was identified. The complaint was substantiated. Census: 14	N 000		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1 received supervision appropriate to meet his/her needs. Resident 1 has a history of offensive behavior towards peers. On 08/07/2025, Resident 1 pushed Resident 2 while unsupervised outside in front of the facility. Resident 2 sustained a significant injury. Findings include:	N 426		

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

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N 426	Continued From page 1 The provider is licensed to care for up to 16 individuals in the following client groups: Irreversible dementia/Alzheimer's, physically disabled, public funding, emotionally disturbed/mental illness, and advanced aged. On 08/12/2025 the Department received a complaint related to a resident injury. Surveyor reviewed the Department's facility records and found the provider submitted several self-reports related to resident injuries. On 10/07/2025, Surveyor conducted a complaint investigation and identified the following: Resident 1 admitted to the facility on 10/10/2023. Resident 1 was his/her own legal decision maker, and had diagnosis which included mood disorder, nicotine dependence, bipolar disorder. Resident 1's individual service plan (ISP) dated 08/07/2025 documented: "Supervision: 24-hour supervision. Aggressive/Combative (Mental Health/ Aggressive/ Combative): [Resident 1] has a history of yelling at other residents and staff if they are not doing what [s/he] wants or if they are going too slow for [him/her]. Staff to redirect and offer a solution of assistance. Daily as needed. Resident requires staff assistance to manage/redirect aggressive/combative behaviors. [Resident 1] will yell or go after other residents if they are not doing what [s/he] wants or if they are going too slow for [him/her]." Resident 2 admitted to the facility on 09/20/2018. Resident 2 had a legal guardian who assisted in making decisions related to Resident 2's care.	N 426		

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N 426	Continued From page 2 Resident 2's diagnosis included Alzheimer's disease. Resident 2's ISP with unknown date, documented: "Supervision: 24-hour supervision. Falls (Physical Health/ Disabilities): [Resident 2] is identified as a fall risk even though [s/he] has not fallen recently. [S/he] needs ongoing support to maintain [his/her] stability and to detect any subtle changes in [his/her] gait or balance that could increase [his/her] risk of a fall. Encourage [Resident 2] to wear proper, non-slip footwear during all transfers and ambulation to enhance [his/her] stability and reduce slipping hazards." On 10/07/2025, Surveyor reviewed the provider's incident reports for the incident on 08/07/2025. The following was documented: In Resident 1's record: "Date: 08/07/2025 Time: 6:31 PM Incident Classification: Behavior- Resident to Resident Altercation [Resident 1] was outside smoking and while the resident was outside the resident pushed another resident to the ground outside in the back. 911 was called for the other resident to get assessed and the police came and spoke with both residents. [Resident 1] received a ticket for pushing the other resident to the ground. When staff asked [Resident 1] why resident pushed the other resident stated to staff because the other resident is a rude [expletive] and resident also stated to staff of an unknown remark made by resident pushed."	N 426		

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N 426	Continued From page 3 In Resident 2's record: "Date: 08/07/2025 Time: 9:22 PM (sic) Incident Classification: Behavior- Resident to Resident Altercation [Resident 2] ambulated outside to have a smoke and [Resident 2] stated to staff while [s/he] was outside having a smoke another resident shoved [him/her] to the ground. Staff went outside to ask what happened the resident stated [s/he] was pushed to the ground by another resident. Staff than [sic] helped assist resident off the ground by picking [him/her] up with a gait belt and helping [him/her] to a chair in the dining area. Staff than [sic] checked [him/her] for injury, redness, and bruising. [Resident 2] stated that [his/her] leg and hip hurt. Staff asked several times if [s/he] wanted to go get checked out. [Resident 2] kept refusing so writer grabbed a wheel chair and helped resident to [his/her] room and into bed. Staff called 911 and paramedics came and [Resident 2] refused to be sent out. Staff and paramedics called state appointed guardian and got no answer so staff and paramedics called the on call number for state appointed guardian to get permission for [Resident 2] to refuse to be sent out. On call gave permission for [Resident 2] to refuse being sent out. Once paramedics left the police came and spoke with both residents. Other resident was cited for pushing [Resident 2] to the ground. Injury Information: Sustained a large goose egg to forehead and complaining of right leg/hip pain." Resident 2's progress notes documented the following: "08/11/2025 2:45 PM - Writer called today to	N 426		

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N 426	Continued From page 4 get an update on resident. Nurse stated that [Resident 2] has a prostatic fracture which they are not going to operate on ..." On 10/07/2025 at approximately 10:45 AM, Surveyor interviewed Assistant Director (AD) B, who stated there has been additional aggressive incidents from Resident 1 since the incident in August, and that s/he was issued a 30-day notice. AD B provided emails for Surveyor to review which confirmed the provider's efforts in finding alternate placement for Resident 1. On 10/07/2025 at approximately 11:00 AM, Surveyor interviewed House Manager C. House Manager C stated Resident 2 was reluctant to leave his/her room in fear of Resident 1. On 10/22/2025 at approximately 9:10 AM, Surveyor interviewed Executive Director (ED) A. Surveyor questioned ED A about the usual level of supervision when residents went outside to smoke. ED A stated the residents did not require constant supervision when outside smoking. ED A stated Resident 1's aggression did not begin to heighten until the incident on 08/07/2025 with Resident 2. ED A stated Resident 1 displaying physical aggression prior was infrequent.	N 426		