STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 01/02/2023 and 01/03/2023, Surveyor conducted 1 verification visit and 2 complaint investigations at Madison AL Operations LLC. Four deficiencies were identified. Two deficiencies were repeat violations. See Statement of Deficiency (SOD) LQL011, dated 03/29/2023 and SOD LQL012, dated 07/25/2023. Both complaints were substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 50	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was submitted to the Department within 3 days of an incident or accident resulting in serious injury and requiring emergency room treatment and hospitalization. The Department was not notified when Resident 11 fell and lay on the floor for 6 hours and 55 minutes due to staff not answering call light.	N 165		

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
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 165	Continued From page 1	N 165		

Resident was found with blood, bruises, and feces on his/her body. Resident 11 was admitted to the hospital with diagnoses including status post fall with rhabdomyolysis and influenza A.

Findings include:

According to the Centers for Disease Control and Prevention (CDC), "Rhabdo is the breakdown of damaged muscle which results in the release of muscle cell contents into the blood. The proteins and electrolytes released into the blood can cause organ damage ...Rhabdo can cause many problems, including:
Kidney damage or kidney failure
Dangerous heart rhythms (arrhythmias)
Seizures
Nausea and vomiting
Permanent disability
Death
Repeated blood tests for the muscle protein creatine kinase (CK or creatine phosphokinase [CPK]) are the only accurate test for rhabdo. A healthcare provider can do a blood test for CK: The muscle protein CK enters the bloodstream when muscle tissue is damaged. When rhabdo is present, CK levels will rise ...(Source: https://www.cdc.gov/niosh/topics/rhabdo/what.html (retrieval date: 01/08/2024)).

On 12/19/2023, the Department received a complaint alleging hospitalization following a fall.

On 01/02/2024 at approximately 6:30 AM, Surveyor reviewed the Department's facility file in preparation for onsite visit to facility. The file did not contain a self-report regarding Resident 11's 12/16/2023 fall and hospitalization.

On 01/02/2023, Surveyor reviewed Resident 11's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 165	Continued From page 2	N 165		

record. S/he was admitted 06/01/2022. Diagnoses included cerebral infarction, unspecified and essential (primary) hypertension. Resident was his/her own health care decision maker.

Facility progress notes:
12/16/2023 at 11:33 AM- "Note Text: Staff alerted writer that resident was found on the ground early this am, sent to ER. Call placed to [name of hospital] and Rn [sic] overseeing [his/her] care reported [s/he] was being administered fluids and [antibiotic] and would be admitted. Hospital calling emergency contact to update on condition."

12/20/2023 11:50 AM- "Note Text: Resident returning to facility today from hospital stay post fall, influenza A. Needing 1 assist with transfers using walker. Abrasion to elbow from fall ...Also has orders for PT eval and [treatment]."

Fall assessment dated 12/16/2023 at 5:00 AM (summarized)-
Predisposing Physiological Factors- weakness/fainting
Predisposing Situation Factors- during transfer
RA reported finding resident lying on floor in his/her room. Abrasions observed to right and left elbows and right and left knees. Pain level was 5. Resident was alert and oriented. 911 called and resident sent to hospital.

Call light use log- Call light use log dated 12/15/2023 and 12/16/2023 identified Resident 11 pulled his/her bathroom call light on 12/15/2023 at 9:04 PM.

On 01/02/2024 at 10:36 AM, Surveyor interviewed Resident 11. Resident 11 was wearing shorts during interview, and Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 165	Continued From page 3	N 165		

observed 2 scabs on right knee, 3 scabs on left knee, 1 scab on left elbow and a bandage on right elbow. Resident 11 stated on 12/15/2023 s/he was coming down with the flu and fell in his/her bathroom shortly after staff administered bedtime medication. Resident 11 stated s/he pulled the bathroom's call light cord, but no one came. Resident 11 stated s/he did a low military-like crawl from the bathroom to the bed and when s/he got to the bed, s/he was unable to reach his/her call pendant, so s/he lay on the floor and waited for staff who found him/her on the floor in the morning.

On 01/02/2024 at 10:50 AM, Surveyor interviewed Executive Director EE who stated on 12/16/2023, staff answered Resident 11's call light at 4:29 AM and sent him/her to hospital at 5:00 AM. Executive Director EE stated the incident was not self-reported to the Department.

On 01/08/2024 at approximately 9:30 AM, Surveyor interviewed Regional Director of Operations GG who stated they did not self-report Resident 11's 12/16/2023 incident to the Department because s/he was admitted to hospital with influenza A, not due to injuries. Surveyor explained laying on the floor for 6 hours and 55 minutes and being found with bruises and abrasions should have been reported due to the seriousness of the incident and subsequent 4-day hospitalization. Surveyor stated if Resident 11 had not fallen, they may have been able to treat the influenza A at the facility.

On 01/08/2024 at 1:58 PM, Surveyor received hospital documentation dated 12/16/2023-12/20/2023 from hospital:

Emergency Course and Interventions (dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 165	Continued From page 4 12/16/2023): " ...[Resident 11] had what sounds like a mechanical fall and has been on the floor for a prolonged period of time. [S/he] is covered in stool and has multiple abrasions and dried blood about [his/her] body ...Diagnosis: 1. Fall, initial encounter 2. Traumatic rhabdomyolysis, initial encounter ... 3. Acute cystitis with hematuria 4. Influenza ..." RN Progress Note dated 12/16/2023: " ...Skin/Incision/Wounds: Multiple abrasions and bruises to entire body..." Discharge Summary dated 12/20/2023: " ...admitted with non-traumatic rhabdomyolysis after a fall and being down for an unknown amount of time. S/p fall with rhabdomyolysis, CK improving, CK >20,000 on admission. Weakness/Influenza A infection/Possible UTI ...Patient said [s/he] felt ill for several days prior to the fall. [S/he] was too weak to get off the floor on [his/her] own, potentially related to influenza induced weakness ..." Cross Reference: N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment	N 165		
{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.	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 352}	Continued From page 5 This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the resident right to receive medication as ordered by the physician. Resident 12 did not receive prn pain medication due to facility not requesting refill from pharmacy before running out of the pain medication. This is a repeat violation. See Statement of Deficiency (SOD) #LQL011, dated 03/29/2023, and SOD #LQL012, dated 07/25/2023. Findings include: On 01/02/2024, the Department received a complaint alleging facility ran out of physician ordered pain medication. On 01/03/2024, Surveyor reviewed Resident 12's record. S/he was admitted 08/18/2023. Diagnoses included other fracture of lower end of right femur, subsequent encounter for closed fracture with routine healing. Skilled nursing facility (SNF) documentation including therapy notes and discharge summary (summarized): Resident 12 was hospitalized following a fall and underwent ORIF surgery on 07/24/2023 for distal femur fracture. S/he was admitted to SNF on 07/27/2023 for therapy with order for weight bearing as tolerated on left. Resident was nearly independent with pivot transfers and wheelchair mobility but due to left foot pain, resident was discharged from SNF to Madison AL Operations LLC for a 30-day respite stay with therapy recommendation for Hoyer lift transfers. MD orders dated 08/17/2023 included	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 352}	Continued From page 6 acetaminophen 500 MG 2 tablets 3 times daily for pain and oxycodone HCl 5 MG 1-2 tablets every 8 hours as needed for pain. Assessment dated 08/18/2023 (summarized): In the area of Pain- Acute pain, current level of pain (scale of 1-10) = 6. Intervention- Administer medication per MD orders. Individual Narcotic Log (summarized): 40 tablets of oxycodone 5 MG were received by facility from pharmacy on 08/17/2023. From 08/18/2023 at 8:00 PM to 08/27/2023 at 12 AM, staff documented 40 tablets were administered, including: 2 tablets on 08/25/2023 at 5 PM, with 7 remaining; 2 tablets on 08/25/2023 at 8:45 PM, with 5 remaining; 2 tablets on 08/26/2023 at 7:07 AM, with 3 remaining; 1 tablet on 08/26/2023 at 4:00 PM, with 2 remaining; and 2 tablets on 08/27/2023 at 12:00 AM, with none remaining. Medication Administration Record (MAR)- On 08/27/2023 at AM med pass, staff began documenting medications were not administered due to resident hospitalized. Facility progress note dated 08/28/2023 at 9:05 AM- "Note Text: Resident call [sic] 911 [his/herself] because [s/he] ran out of oxycodone." On 01/03/2024 at 8:48 AM, Surveyor interviewed Resident 12 who stated on 08/28/2023 staff informed him/her that s/he had run out of his/her as needed oxycodone and because s/he was in pain, s/he called 911. Resident 12 stated s/he was hospitalized overnight and discharged 08/29/2023.	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 352}	Continued From page 7 On 01/03/2024 at approximately 4:00 PM, Surveyor discussed concern of staff not calling pharmacy to request a refill of Resident 12's as needed oxycodone when number of tablets was running low with Executive Director EE, Regional Director of Wellness FF, and Regional Director of Operations GG. Executive Director EE stated typically staff sent refill requests to the pharmacy when medications were running low, then the pharmacy contacted the physician for the refill order. Executive Director EE stated staff should have contacted the pharmacy to request a refill when they saw it was running low.	{N 352}		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident right to prompt and adequate treatment. Due to staff not answering Resident 11's call light promptly, Resident 11 was on the floor 6 hours and 55 minutes following a fall. S/he was admitted to hospital with diagnoses including S/P [status post] fall with rhabdomyolysis. This is a repeat violation. See Statement of Deficiency (SOD) #LQL011, dated 03/29/2023. Findings include:	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 353	Continued From page 8 According to the Centers for Disease Control and Prevention (CDC), "Rhabdo is the breakdown of damaged muscle which results in the release of muscle cell contents into the blood. The proteins and electrolytes released into the blood can cause organ damage ...Rhabdo can cause many problems, including: Kidney damage or kidney failure Dangerous heart rhythms (arrhythmias) Seizures Nausea and vomiting Permanent disability Death Repeated blood tests for the muscle protein creatine kinase (CK or creatine phosphokinase [CPK]) are the only accurate test for rhabdo. A healthcare provider can do a blood test for CK: The muscle protein CK enters the bloodstream when muscle tissue is damaged. When rhabdo is present, CK levels will rise ...(Source: https://www.cdc.gov/niosh/topics/rhabdo/what.html (retrieval date: 01/08/2024)). On 12/19/2023, the Department received a complaint alleging staff not responding to call light. On 01/02/2023, Surveyor reviewed Resident 11's record. S/he was admitted 06/01/2022. Diagnoses included cerebral infarction, unspecified and essential (primary) hypertension. Resident was his/her own health care decision maker. Facility progress notes: 12/16/2023 at 11:33 AM- "Note Text: Staff alerted writer that resident was found on the ground early this am, sent to ER. Call placed to [name of hospital] and Rn [sic] overseeing [his/her] care reported [s/he] was being administered fluids and	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 353	Continued From page 9	N 353		

[antibiotic] and would be admitted. Hospital calling emergency contact to update on condition."

12/20/2023 11:50 AM- "Note Text: Resident returning to facility today from hospital stay post fall, influenza A. Needing 1 assist with transfers using walker. Abrasion to elbow from fall ...Also has orders for PT eval and [treatment]."

Fall assessment dated 12/16/2023 at 5:00 AM (summarized)-
Predisposing Physiological Factors- weakness/fainting
Predisposing Situation Factors- during transfer
RA reported finding resident lying on floor in his/her room. Abrasions observed to right and left elbows and right and left knees. Pain level was 5. Resident was alert and oriented. 911 called and resident sent to hospital.

Call light use log- Call light use log dated 12/15/2023 and 12/16/2023 identified Resident 11 pulled his/her bathroom call light on 12/15/2023 at 9:04 PM.

Handwritten statement signed (not dated) by Caregiver CC- "Resident call [sic] at 4 am. I tought [sic] the calle [sic] wasn't clear from Previous [sic] shift. When the call light kept going. [sic] not: [sic] I Decided [sic] to check. I found Resident [sic] on the floor with bruises. I called the nurse and 911."

Disciplinary Action- to Caregiver CC, signed (not dated) by Business Office Manager DD- " ...I am writing to inform you that disciplinary action is being taken against you due to your not responding to call light on time. This behavior is unacceptable and goes against the company's values and policies ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 353	Continued From page 10 On 01/02/2024 at 10:36 AM, Surveyor interviewed Resident 11. Resident 11 was wearing shorts during interview, and Surveyor observed 2 scabs on right knee, 3 scabs on left knee, 1 scab on left elbow and a bandage on right elbow. Resident 11 stated on 12/15/2023 s/he was coming down with the flu and fell in his/her bathroom shortly after staff administered bedtime medication. Resident 11 stated s/he pulled the bathroom's call light cord, but no one came. Resident 11 stated s/he did a low military-like crawl from the bathroom to the bed and when s/he got to the bed, s/he was unable to reach his/her call pendant, so s/he laid on the floor and waited for staff who found him/her on the floor in the morning. Resident 11 stated prior to fall s/he did not want his/her name posted on the outside of his/her room door, so it was not posted. On 01/02/2024 at 9:04 AM, Surveyor interviewed Executive Director EE who stated on 12/16/2023, staff answered Resident 11's call light at 4:29 AM and sent him/her to hospital at 5:00 AM. Executive Director EE stated the caregiver claimed s/he did not know Resident 11 lived in that room and thought it was an unoccupied room. Executive Director EE stated the caregiver was new but had been trained by 12/16/2023. Executive Director EE stated the call light log shows when the call light was activated but does not show when it was turned off. On 01/02/2024 at 12:32 PM, Surveyor discussed concern of staff not promptly responding to Resident 11's call light on 12/15/2023 with Executive Director EE who stated there was no excuse for staff to not promptly respond to the call light.	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 353	Continued From page 11 On 01/08/2024 at 1:58 PM, Surveyor received hospital documentation dated 12/16/2023-12/20/2023 from hospital: Emergency Course and Interventions (dated 12/16/2023): " ...[Resident 11] had what sounds like a mechanical fall and has been on the floor for a prolonged period of time. [S/he] is covered in stool and has multiple abrasions and dried blood about [his/her] body ...Diagnosis: 1. Fall, initial encounter 2. Traumatic rhabdomyolysis, initial encounter ... 3. Acute cystitis with hematuria 4. Influenza ..." RN Progress Note dated 12/16/2023: " ...Skin/Incision/Wounds: Multiple abrasions and bruises to entire body..." Discharge Summary dated 12/20/2023: " ...admitted with non-traumatic rhabdomyolysis after a fall and being down for an unknown amount of time. S/p fall with rhabdomyolysis, CK improving, CK >20,000 on admission. Weakness/Influenza A infection/Possible UTI ...Patient said [s/he] felt ill for several days prior to the fall. [S/he] was too weak to get off the floor on [his/her] own, potentially related to influenza induced weakness ..." Cross Reference: N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury	N 353		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform	N 409		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 409	Continued From page 12	N 409		

controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 12's proof-of-use record for as needed oxycodone, a schedule II drug, was maintained accurately with date and time administered, dose administered and remaining balance of the drug, and signature of administrator or designee auditing the proof-of use record daily.

Findings include:

On 01/03/2024, Surveyor reviewed Resident 12's record. S/he was admitted 08/18/2023. Diagnoses included other fracture of lower end of right femur, subsequent encounter for closed fracture with routine healing.

MD orders dated 08/17/2023 included oxycodone HCl 5 MG 1-2 tablets every 8 hours as needed (prn) for pain.

Individual Narcotic Log (summarized): 40 tablets of oxycodone 5 MG were received from pharmacy on 08/17/2023. Staff documented administration of prn oxycodone including (summarized):

Line 10 dated 08/21/2023 at 9:42 PM:
27 tablets on hand (prior to administration)
2 tablets administered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 409	Continued From page 13 26 tablets remaining (should be 25 tablets remaining) Line 11 dated 08/22/2023 at 1:00 AM: 26 tablets on hand (should be 25 tablets on hand) 1 tablet administered 24 tablets remaining Line 12- no date or time Number of tablets on hand = blank Number of tablets administered = blank 23 tablets remaining Column for nurse's signature was signed and stated, "on counting?" Line 13 dated 08/22/2023 at 7:12 (AM or PM not documented) 23 tablets on hand 2 tablets administered 21 tablets remaining Line 15 dated 08/23/2023 at 1:46 PM 19 tablets on hand 2 tablets administered 17 tablets remaining Line 16- unable to read date, time, # of tablets on hand, # of tablets administered, # of tablets remining, and signature indicating daily audit. Line 17 dated 08/24/2023 at 9:26 (AM or PM not documented) 13 tablets on hand (indicating 2 tablets were administered on Line 16, and a there was a nondocumented administration of 2 tablets between Line 16 and Line 17) 2 administered 13 tablets remaining No signature indicating daily audit.	N 409		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 409	Continued From page 14	N 409		

Line 18 dated 08/24/2023
13 tablets on hand
2 administered
11 tablets remaining

Line 19 dated 08/24/2023 at 8:00 AM
"10 11" on hand
2 tablets administered
9 remaining

Line 20 dated 08/25/2023 at 5:00 PM
9 tablets on hand
2 tablets administered
7 remaining

Line 21 dated 08/25/2023 at 8:45 "qm"
7 tablets on hand
2 tablets administered
5 tablets remaining

Line 22 dated 8/26/2023 at 7:05 AM
5 tablets on hand
2 tablets administered
3 tablets remaining

Line 23 dated 08/26/2023 at 4:00 PM
3 tablets on hand
1 tablet administered
2 tablets remaining
No nurse's signature indicating daily audit.

Line 24 dated 08/27/2023 at 12 AM
2 tablets on hand
2 tablets administered
0 tablets remaining.

Mediation Administration Record (MAR) and facility progress notes: From 08/18/2023 - 08/28/2023, staff documented administration of oxycodone HCl 5 MG 1-2 tablets every 8 hours

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 409	Continued From page 15	N 409		

as needed on MAR (with corresponding auto-fill facility progress) notes 10 times:
08/19/2023 at 2:35 PM
08/20/2023 at 11:13 AM and 6:06 PM
08/21/2023 at 9:39 PM
08/22/2023 at 7:55 AM
08/23/2023 at 1:47 PM and 9:59 PM
08/24/2023 at 9:37 PM
08/25/2023 at 7:17 AM
08/26/2023 at 5:32 AM
The record contained no additional documentation of administration of prn oxycodone.

On 01/08/2024 at 8:23 AM, Surveyor interviewed Administrator EE regarding Resident 12's Individual Narcotic Log for prn oxycodone. Administrator EE stated staff documented in pink ink on lines 12 and 16 which could not be seen on the black and white copy provided to Surveyor on 01/03/2024. Administrator EE stated all 40 tablets were accounted for and s/he would email Surveyor a colored copy of the log.

On 01/11/2024 at 3:06 PM, Surveyor interviewed Administrator EE who stated the med tech stated s/he administered 2 prn oxycodone tablets to Resident 12 on 08/23/24 but forgot to document it on the log and the MAR. Administrator EE stated they would retrain staff and audit medication carts and narcotic counts daily. Administrator EE again stated s/he would email Surveyor a colored copy of the Individual Narcotic log.

As of 01/16/2024 at 10:45 AM, no colored copy of Resident 12's Individual Narcotic Log was received by the Department.

Cross Reference:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019059	A. BUILDING: _____ B. WING _____	R-C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

(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 409	Continued From page 16 N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	N 409		