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MADISON AL OPERATIONS LLC	1601 WHEELER RD MADISON, WI 53704

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N 000	Initial Comments On 04/17/2025, the bureau of assisted living southern regional office conducted a complaint investigation at Madison AL Operation LLC a CBRF located in Madison, WI. As a result of this survey, 1 violation of DHS Chapter 83 was issued. Complaint was substantiated. Census: 62	N 000		
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 provide prompt and adequate treatment appropriate to Resident 1's needs. Resident 1 was diagnosed with dementia had an indwelling urinary foley catheter. On 02/07/2025, Provider sent Resident 1 to an emergency room (ER) due to blood clots observed in their urinary collection bag. While at the ER Resident 1's indwelling urinary catheter was replaced, and a urine sample was obtained. Resident 1 was then discharged back to the facility. On 02/10/2025, Hospital lab reported Resident	N 353		

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

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N 353	Continued From page 1 1's urine was positive for a urinary tract infection (UTI). Hospital staff called provider on 02/10/2025 and 02/11/2025 to report Resident 1's UTI but did not receive a call back from staff. On 02/12/2025, hospital staff spoke with Caregiver D on the phone and reported Resident 1 tested positive for a UTI. Hospital staff gave Caregiver D instruction if Resident 1 displayed symptoms of a UTI s/he was to be given the antibiotic Keflex 250 mg every 12 hours for the next 7 days. From 02/10/2025 to 03/12/2025, Resident 1 was observed to have increased agitation, cloudy urine, dark urine, and sediment in the urine collection bag. Resident 1 was not administered antibiotic treatment for his/her UTI. On 03/13/2025, Resident 1's was transported to the ER due to increased pain. Resident 1 was diagnosed with septic shock and UTI. Resident 1 was prescribed the antibiotic Cefpodoxime 200 MG for UTI and discharged back to the facility. Resident 1 passed away on 03/27/2025. This is a repeat violation from previous statement of deficiency (SOD) LQL013 dated 01/12/2024 and LQL011 dated 03/19/2023. FINDINGS INCLUDE: Facility was licensed on 12/19/2022 as a class CNA non-ambulatory facility with a capacity of 73 residents. Facility served the following client groups: traumatic brain injury, advanced aged, terminally ill, physically disabled and developmentally disabled. On 02/24/2025, the Department received a complaint concerning resident care at facility.	N 353		

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N 353	Continued From page 2 On 04/17/2025 at approximately 8:45 AM, Surveyor arrived at facility for a complaint investigation. On 04/17/2025 at approximately 9:30 AM, Surveyor requested Resident 1's record from Executive Director A. Surveyor specified Resident 1's record include but not limited to: all the assessments and clinical aftercare summaries documented for him/her in 2025. RECORD REVIEW: On 04/17/2025, Surveyor reviewed Resident 1's face sheet. Resident 1 was admitted to the facility on 09/16/2016. Resident 1 was discharged from facility on 03/27/2025. On 04/17/2025, Surveyor reviewed Resident 1's Progress Notes from 01/01/2025 to 04/17/2025: 1.) On 02/05/2025 at 10:51 AM, Wellness Director B documented Resident 1 had been admitted to hospice service. 2.) On 02/05/2025 at 1:44 PM, Wellness Director B documented, "lab results from last week rec'd, sent to MD to review. Noted BUN and Creatinine elevated. Added fluid tracking to Tasks in POC. Fluids to be encouraged on rounds ..." 3.) On 02/10/2025 at 6:47 PM, Caregiver E documented, "Writer was in resident's room when writer noticed that the resident had some redness in [his/her] groin area. Writer cleaned up the area. MD was notified and asked for an order the redness (sic.)." 4.) On 02/20/2025 at 9:30 AM, Wellness Director B documented, "LATE ENTRY ...Note Text:	N 353		

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Spoke with PCP clinic regarding recent ER visit with catheter change. U/A done in ER. D/T no further symptoms...Hospice RN updated as well and will assist in monitoring for further concerns."

5.) On 03/03/2025 at 8:40 AM. Wellness Director B documented that Resident 1 was consistently refusing to get out of bed.

6.) On 03/07/2025 at 11:36 AM, Wellness Director B documented, "[Resident 1] stated to staff that [s/he] "feels like [s/he] is dying" has have (sic.) minimum meal intake going on 3 days. urine dark ..."

7.) On 03/11/2025 at 3:57 PM, Wellness Director B documented, "Hospice RN aware of low bps (blood pressures)."

8.) On 03/13/2025 at 10:14 AM, Wellness Director B documented, "Resident experiencing pain in legs over the night shift. 8/10. APAP (acetaminophen) prn (as needed) no effective. Staff place called (sic.) POA who wanted [him/her] sent to ER for pain management. Writer spoke with ER RN then am, resident returned around 9am with new atb (antibiotic) orders ..."

9.) On 03/27/2025 at 9:55 AM, Wellness Director B documented Resident 1 had passed away.

On 04/17/2025, Surveyor reviewed the assessments completed on Resident 1 during 2025. The following assessments were as follows:
1.) On 01/07/2025, Wellness Director B performed a "Weekly Skin Check," on Resident 1. Wellness Director B documented, "skin breakdown on bilateral buttocks. Cleansed and covered. MD (doctor) updated."

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N 353	Continued From page 4 2.) On 01/14/2025, Caregiver H performed a "Weekly Skin Check," on Resident 1. Caregiver H documented, "Resident still has a bed wound on [his/her] tailbone, it look (sic.) to be getting better however it still needs attention and wound care." 3.) On 01/22/2025, Caregiver I performed a "Weekly Skin Check," on Resident 1. Caregiver I documented Resident 1 had bilateral skin integrity issues on his/her buttocks. 4.) On 01/29/2025, Caregiver E performed a "Weekly Skin Check," on Resident 1. Caregiver E documented Resident 1 did not have any skin integrity issues. 5.) On 02/10/2025, Caregiver E performed a "Weekly Skin Check," on Resident 1. Caregiver E documented, "little bit pf (sic.) redness in groin..." 6.) On 02/17/2025, Caregiver E performed a "Weekly Skin Check," on Resident 1. Caregiver E documented, "Skin tear on left upper back." 7.) On 02/25/2025, Wellness Director B performed a comprehensive assessment on Resident 1. The comprehensive assessment documented: Resident 1's decrease in compliance with personal cares and increase in combative behavior. Under the subsection titled, "Plan of Care," the following was documented, "Summary of services needed and/or changes ...Resident admitted to hospice, 1-2 assist with bed mobility, 1 assist with hygiene and dressing. 2 asses with hoyer (sic.) for transfers, resident requests to stay in bed. Skin monitored by staff. meds (sic.) administered by staff." 8.) On 02/27/2025, an assessment for a "Bed	N 353		

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Device(rails, grab bars, enablers) ..." was performed on Resident 1.

9.) On 03/05/2025, Wellness Director B performed a "Weekly Skin Check," on Resident 1. Wellness Director B documented, "some redness, right hip near catheter tubing."

10.) On 03/12/2025, Med Tech J performed a "Weekly Skin Check," on Resident 1. Med Tech J documented Resident 1 did not have any skin integrity issues.

On 04/17/2025, Surveyor reviewed Resident 1 individualized service plan (ISP) dated 02/25/2025. The ISP documented the following: 1.) Resident 1 had been admitted to hospice service.

2.) Resident 1 was diagnosed with but not limited to: type 2 diabetes mellitus, primary hypertension, heart disease, coronary artery disease, angina, supraventricular tachycardia, and benign prostatic hyperplasia with lower urinary tract symptoms.

3.) On 10/25/2024, the care plan related to Resident 1's indwelling foley urinary catheter was documented in the ISP as, "Goal ...The resident will be/remain free from catheter-related trauma ...The resident will show no s/sx (signs and symptoms) of urinary infection r/t (related to) catheter use ...Interventions/Tasks ...Assist resident as needed with maintaining personal cleanliness ...Remind Resident to not pull on catheter ...Secure catheter tubing to leg to minimize trauma to the insertion site and make that the tubing is free of kinks and urine is present in the tube." All goals and interventions were discontinued on 03/27/2025.

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4.) From 01/16/2025 to 03/24/2025, the behavior plan the ISP was updated as follows, "Focus ...The resident has a behavior problem r/t refusing showers. Combative during cares d/t (due to) end of life, hitting staff, punching. Date Initiated: 01/26/2025 ... Cancelled Date: 03/17/2025 ...Goal ...The resident will have fewer episodes (sic.) Date Initiated: 02/15/2025 ...Cancelled Date: 03/27/2025 ...Interventions/Tasks ...If resident is capable of understanding and changing his/her behavior, explain/reinforce to the resident why behavior is inappropriate and/or unacceptable. Date Initiated: 01/26/2025 ...Cancelled Date: 03/27/2025 ...Reapproach if combative, provide soft touch and run arm if be (sic.) will allow. Date Initiated: 03/24/2025 ...Cancelled Date: 03/27/2025 ...Reapproach Resident if resistant to shower. Knock on door approach Resident in a slow manner, speak clearly. If Resident is sleeping reapproach at a later time. If Resident is woken, [s/he] may become agitated and attempt to swing, kick, or yell at Staff. Date Initiated: 02/10/2025 ...Cancelled Date: 03/27/2025 ...Update hospice is unable to provide daily care d/t combativeness. Date Initiated: 03/24/2025 ...Cancelled Date: 03/27/2025."

5.) On 02/25/2025, the care plan related to Resident 1's skin integrity was documented in the ISP as, "Observe skin. Keep skin clean and dry. Hydrate skin with lotion, as needed. Specify any areas that should not have lotion applied (sic.) Report any skin alterations to nurse. Date Initiated: 02/25/2025 ...Cancelled Date: 03/27/2025 ...Obtain lab work as ordered by physician. Date Initiated: 02/25/2025 ...Cancelled Date: 03/27/2025."

On 04/17/2025, Surveyor reviewed Resident 1's

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hospice record. The following was documented:
1.) On 03/07/2025, Hospice Nurse F documented, "Lying in bed, sleeping. Open mouth breathing. Did not awaken to writer talking to [him/her] loudly in [his/her] ear as [s/he] typically does ...became combative briefly and attempted to shoo writers (sic.) hands away ..."

2.) On 03/08/2025, Hospice Nurse F documented, " ...Foley with urine that looks dark and thick with cloudy sediment. Patient calm initially, then became combative upon awakening and pushing writers (sic.) hand away.."

3.) On 03/13/2025, Hospice Nurse F documented, "...Writer attempted to alert patient of my presence and [s/he] became very startled and agitated, yelling out obscenities at the top of [his/her] lungs, flailing [his/her] arms with any touch..."

4.) On 03/13/2025, Hospice Nurse X documented, "Patient was in bed and yelling for help when writer arrived. [S/He] would not even let writer touch [him/her] without [him/her] yelling in pain. Patient just repeated wanting to go to the hospital to get the pain under control and then agreed [s/he] would like to come back to the facility..."

5.) Under the subsection titled, "IDG Discussion," the following was documented, "Updates: appetite waxes and wanes. had (sic.) an episode when [s/he] was less responsive, refusing to eat, and grey in color. mood also waxes and wanes. remains bed bound. hospitalized (sic.) for a few hours recently for pain episode/ septic shock (sic.). returned (sic.) back. currently (sic.) placed on daily visits..."

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N 353	Continued From page 8 On 04/17/2025, Surveyor received Resident 1's hospital record from [Name Of Hospital] via email. Surveyor reviewed Resident 1's hospital record from 02/01/2025 to 03/01/2025: 1.) On 02/07/2025 at approximately 5:00 AM, Resident 1 was admitted to the ER due to increased abdominal pain with blood clots in urinary foley collection bag. Resident 1 was diagnosed with but not limited to: anxiety disorder, benign prostatic hyperplasia (BPH), coronary artery disease (CAD), history of stroke with left sided weakness, depression, urinary retention, and dementia. 2.) On 02/07/2025 at approximately 5:30 AM, Doctor S ordered a urinary analysis (UA) for Resident 1. The UA contained evidence of urinary tract infection (UTI). Doctor S ordered Resident 1's urinary specimen be cultured to identify the infectious organism. Resident 1 was discharged back to the facility. 3.) On 02/10/2025 at 8:11 AM, Resident 1's urinary specimen culture resulted in a positive amount of the infectious organism Staphylococcus epidermidis. 4.) On 02/10/2025 at 12:32 PM, Nurse R documented a message from Pharmacist T, "Patient with chronic foley catheter has their urine culture growing MSSE. Patient not prescribed antibiotics at discharge. Per encounter notes: small amounts of clots in bladder, catheter removed, removed with approximately 700 mL of urine. Treatment was deferred given catheter exchange and pending the results of this urine culture ...Given uncertainty of the quality of this culture, recommend following up with patient regarding UTI symptoms, if present recommend prescribing Keflex 250 mg every 12 hours for 7	N 353		

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days. If asymptomatic no further action required ...Attempt #1 Unable to reach the patient at [XXX-XXX-XXXX] VM left with return call instructions ..."

5.) On 02/11/2025 at 2:00 PM, Nurse Q documented, "Attempt # 2 to contact caregiver [Name Of Facility XXX-XXX-XXXX]- Staff unavailable at time of call (sic.) Message left with receptionist requesting call back- ER contact # provide."

6.) On 02/12/2025 at 1:47 PM, Nurse P documented, "#3 attempt to contact pt's caregiver... Receptionist at pt's facility stated caregiver was unavailable at this time. Call back number provided. Reason for call to assess if pt is having UTI symptoms. "if present recommend prescribing Keflex 250 mg every 12 hours for 7 days. If asymptomatic no further action required."

7.) On 02/13/2025 at 9:04 AM, Nurse O documented a telephone conversation with Wellness Director B, "Received call from [Wellness Director B] at [Name Of Facility]. [Wellness Director B] calling to ask if we have received lab results. Advised [Wellness Director B] at [Name Of Facility] that no recent lab results have been received ..."

8.) On 02/13/2025, Facility faxed lab Resident 1's lab results from a blood specimen drawn on 02/11/2025.

9.) On 02/19/2025 at 1:02 PM, Medical Assistant M documented, "When speaking to facility nurse please also review messages from the ED who have tried multiple times to reach facility. "

10.) On 02/20/2025 at 8:49 AM, Doctor V

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documented, "Once we get an update, I'd be fine with offering treatment as suggested with Keflex but only if [s/he's] still demonstrating symptoms as Staph (abbreviated term for an infectious organism) is often a contaminant/colonizer."

11.) On 02/20/2025 at 1:25 PM, Nurse L documented a conversation with Doctor V, "Update: Received call from [Wellness Director B] at [Name Of Facility]. [S/He] was not aware that [Resident 1] was in the ER, [s/he] said [s/he] was on vacation ...[S/He] said that [Resident 1] has been declining ever since first getting the foley catheter placed. After [s/he] got the catheter placed, [s/he] never wanted to get out of [his/her] chair, became weak and deconditioned. [S/He] is no longer getting out of bed, [s/he's] eating and drinking very little. [His/Her] urine and is afebrile (lack of fever) ...[S/He] said that [s/he] signed onto [Name Of Hospice] on 2/18/25."

12.) On 02/20/2025 at 3:33 PM, Nurse K documented a conversation with MCO Nurse U, "Writer called [MCO Nurse U] to see if [s/he] had any additional insight. [S/He] has not seen pt for a visit recently but has been in contact with facility staff. [MCO Nurse U] was aware that facility RN was on vacation around the time [Resident 1] went into the ED and the [s/he] has been declining and is now on hospice. [S/He] is not aware of any other urinary symptoms, aside from cloudy urine ..."

13.) On 02/20/2025 at 4:43 PM, Nurse K documented a telephone conversation with Hospice Nurse F, "[Hospice Nurse F] called to check in and make sure clinic is aware pt started on hospice earlier this week ... [Hospice Nurse F] did not note any urinary symptoms aside from the cloudy urine in [his/her] collection bag during

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N 353	Continued From page 11 [his/her] admission visit ..." On 04/17/2025, Surveyor reviewed the clinical aftercare summaries maintained in Resident 1's record for the year of 2025. The sole clinical aftercare summary maintained was dated 03/13/2025, and titled 'Emergency Department Facility After Visit Summary." The after visit summary documented Resident 1 had been diagnosed with septic shock and urinary tract infection associated with indwelling urethral catheter. On page 7, the following education was included, "What is sepsis?...Sepsis is a serious reaction to an infection. It causes inflammation across large areas of the body and can damage tissue and organs. Sepsis can develop quickly. It requires immediate care in a hospital ...Infections that can lead to sepsis include: A skin infection such as from a cut ...A lung infection like pneumonia ...A urinary tract infection ...Symptoms can include low blood pressure, breathing problems, fast heartbeat, and confusion ...Septic shock is sepsis that causes extremely low blood pressure, which limits blood flow to the body. It can cause organ failure and death ..." On 04/17/2025, Surveyor reviewed Resident 1's February 2025 medication administration record (MAR). On 02/11/2025, Resident 1's vital signs were documented as: blood pressure 116/46, temperature 99.1 F, heart rate 54 beats per minute, respiratory rate was 16 breaths per minute, and blood oxygen concentration was 89%. No, order of antibiotic treatment for UTI was documented. On 04/17/2025, Surveyor reviewed Resident 1's March 2025 MAR. On 03/10/2025, Resident 1's vital signs were documented as: blood pressure 81/47, temperature 97.6 F, heart rate 69 beats	N 353		

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per minute, and respiratory rate was 15 breaths per minutes. On 03/13/2025, the following order was initiated, "CEFPODOXIME 200 MG TABLET ONE TABLET BY MOUTH ONCE DAILY FOR 7 DAYS(Indications for Use: UTI)."

The Center of Disease Control (CDC) is an entity of the United States government focused on infection prevention practices. The CDC website article titled, "Catheter-associated Urinary Tract Infection Basics," reported the following, " ...A catheter-associated urinary tract infection (CAUTI) occurs when germs enter the urinary tract through a urinary catheter and cause infection. They are one of the most common types of HAIs (hospital acquired infections) but are preventable and treatable ...Signs and symptoms: Burning or pain in the lower abdomen, Burning while peeing, Peeing more frequently than usual ...Risk factors: The most important risk factor for developing a CAUTI is prolonged use of a urinary catheter ...Quick facts: CAUTIs are associated with increased morbidity, healthcare costs, and length of stay ...Treatment and recovery: Most CAUTIs can be treated with antibiotics and/or removal or change of the catheter. The healthcare provider will determine the best treatment for each patient ..." (Source: The CDC Website, Catheter-associated Urinary Tract Infection Basics, April 15, 2024, https://www.cdc.gov/uti/about/cauti-basics.html (retrieval date - April 23, 2025).)

INTERVIEWS:

On 04/15/2025 at 12:45 PM, Surveyor interviewed hospital social worker (Social Worker Y). Social Worker Y stated Resident 1 had been seen in the hospital ER in February. Social Worker Y reported Resident 1 tested positive for

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	0019059	A. BUILDING: _____ B. WING _____	C 04/17/2025

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
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a UTI after leaving the ER, and anti-biotics were ordered. Social Worker Y reported hospital attempted to contact facility multiple times without success to report Resident 1's UTI and antibiotic treatment.

On 04/17/2025 at 11:44 AM, Surveyor interviewed Hospice Nurse F. Hospice Nurse F stated s/he was not made aware Resident 1 had tested positive for a UTI while in the ER on 02/07/2025. Hospice Nurse F stated s/he recalled someone had with the facility had been on vacation and communication had been difficult. Hospice Nurse F stated s/he remembered the facility had sent Resident 1 to the ER without calling hospice, and facility, and ER staff changed the indwelling foley catheter before sending him/her back to the facility. Hospice Nurse F reported s/he was not made aware the ER physician had ordered the antibiotic Keflex to be administered if Resident 1 should display an increase in signs/symptoms of UTI. Hospice Nurse F stated Resident 1's condition had deteriorated after his/her 02/07/2025 hospitalization. Hospice Nurse F reported Resident 1 was more resistant to personal cares, s/he would become physically and verbally combative with staff. Hospice Nurse F reported Resident 1 refused personal cares so frequently s/he developed multiple pressure wounds on his/her backside. Hospice Nurse F reported Resident 1's urine was usually cloudy at baseline. Hospice Nurse F reported from February to March Resident 1's urine was dark red in color with contained visible sediment. Hospice Nurse F stated if s/he had known about the 02/07/2025 antibiotic order for Keflex to treat Resident 1's UTI, s/he would have encouraged the medication dispensed/administered. Hospice Nurse F stated UTIs cause resident's pain and thus antibiotic treatment was indicated for

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N 353	Continued From page 14 Resident 1. On 04/17/2025 at 12:14 PM, Surveyor discussed the above concerns with Executive Director A, Wellness Director B, Regional Director C, Caregiver D, and Caregiver E. Executive Director A, Wellness Director B, and Regional Director C acknowledged Resident 1 was sent to the ER on 02/07/2025, and the facility did not maintain a clinical aftercare summary from that ER visit in Resident 1's record. Executive Director A, Wellness Director B, and Regional Director C acknowledged on 02/07/2025 Resident 1's experienced a change in condition when facility staff observed blood clots in the urinary collection bag, followed by the ER visit where the indwelling urinary foley appliance was replaced. Caregiver D reported s/he had worked on 02/07/2025 and denied ER discharge instructions for Resident 1. Caregiver D stated s/he was made aware his/her indwelling urinary catheter had been replaced. Caregiver E reported s/he had worked on 02/07/2025 and denied receiving discharge instructions from the ER for Resident 1. Wellness Director B stated s/he is the facility contact who normally coordinated emergency transfers. Wellness Director B stated s/he had been on vacation when Resident 1 had been sent to the ER on 02/07/2025. Wellness Director B stated s/he was not made aware of Resident 1's 02/07/2025 ER visit, nor provided the ER discharge instructions. Executive Director A, Wellness Director B, Regional Director C, Caregiver D, and Caregiver E acknowledged Resident 1 was not provided a comprehensive assessment upon return from the ER on 02/07/2025 and 03/13/2025. Executive Director A, Wellness Director B, Regional Director C, Caregiver D, and Caregiver E acknowledged the only comprehensive assessment completed on	N 353		

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Resident 1 during the year of 2025 was on 02/25/2025. Wellness Director B stated Resident 1's condition deteriorated significantly from 02/07/2025 to 03/13/2025. Wellness Director B reported Resident 1 would become physically combative with staff to refuse care. Wellness Director B reported it was difficult for facility to manage Resident 1's care due to his/her verbal agitation and physical combativeness towards staff. Caregiver D stated, "Yeah, we assess for UTIs with agitation all that time. We just need to document it." Surveyor asked if facility had been aware that Resident 1's urine had tested positive for a UTI after his/her discharge from the ER and had been ordered an antibiotic treatment should s/he have symptoms of a UTI. Executive Director A, Wellness Director B, Regional Director C, Caregiver D, and Caregiver E denied knowledge of Resident 1's urine collected on 02/07/2025 testing positive for a UTI or the stand-by antibiotic treatment order. Surveyor asked why hospital had documented 3 different attempts to communicate Resident 1's medical condition with facility staff. Wellness Director B stated the hospital called facility while s/he had been on vacation. Wellness Director B acknowledged s/he had talked to the hospital on 02/20/2025, and reported Resident 1 wasn't having symptoms of UTI. Wellness Director B acknowledged increased agitation was a common sign of UTI in dementia residents. Executive Director A, Wellness Director B, Regional Director C, Caregiver D, and Caregiver E acknowledged on 03/13/2025 Resident 1 was sent to the ER for abdominal pain where s/he had been diagnosed with septic shock and UTI. Executive Director A, Wellness Director B, Regional Director C, Caregiver D, and Caregiver E acknowledged multiple missed communications with Resident 1's medical provider resulted him/her being denied antibiotic treatment from

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