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 11/02/2023

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 From 11/02/2023 to 11/21/2023, Surveyor conducted a complaint investigation and verification visit at Cottages of Madison Oakwood, a CBRF in Madison. Eleven deficiencies were identified. Nine deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) EC0P11, dated 03/23/2021, EC0P12, dated 06/15/2021, EC0P13, dated 10/05/2021, GT2Y11, dated 10/13/2021, EC0P14, dated 03/29/2022, EC0P15, dated 07/13/2022, EC0P16, dated 10/07/2022 and M20M11, dated 07/11/2023. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 13	{N 000}		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) GT2Y11, dated 10/13/2021, EC0P16, dated 10/07/2022 and M20M11, dated 07/11/2023.	{N 196}		

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

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{N 196}	Continued From page 1 Findings include: From 11/02/2023 to 11/21/2023, Surveyor conducted a verification visit and complaint investigation at the provider's facility. As a result of the survey, 11 deficiencies were identified, 9 of which were repeat deficiencies. Deficiencies included the following: - Rights of Residents - Adequate Treatment: Resident 8 did not receive adequate pain management or proper treatment after sustaining a fall with fractures. *This is a repeat deficiency. - Individual Service Plan (ISP) Updates: The provider did not ensure ISPs were updated when residents sustained falls or exhibited new behaviors. *This is a repeat deficiency. - Documentation of Medication Administration: The provider did not ensure a resident's need and response to PRN medications was documented. *This is a repeat deficiency. - Proof-of-use Record: The provider did not ensure that schedule II medications were audited daily. *This is a repeat deficiency. - Personal Cares: The provider did not ensure Resident 8 received adequate assistance with toileting needs, icing an injury, repositioning and oxygen needs. - Dishwashing: The provider did not ensure all equipment used by residents was cleaned using separate steps for pre-washing, washing, rinsing and sanitizing. - Nutrition: The provider did not ensure residents were notified of menu changes. *This is a repeat deficiency. - Clean, Homelike Environment: Soiled laundry was observed on the floor in resident rooms, the facility did not have enough utensils to provide residents for meals and a resident room was	{N 196}		

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{N 196}	Continued From page 2	{N 196}		

missing drywall. *This is a repeat deficiency.
- Separate Laundry Storage Areas Or Containers: The provider did not ensure soiled laundry and clean laundry were handled in separate storage areas. *This is a repeat deficiency.
- Toxic Substances: The provider did not ensure all toxic chemicals were secured and not accessible to residents. *This is a repeat deficiency.

On 11/02/2023 at approximately 1:25 p.m., Surveyor reviewed concerns related to assessments, ISPs, proof-of-use, dishwashing, menus, environment, laundry storage and toxic chemicals with Director A and Nurse J. Director A and Nurse J stated there had been recent changes in management between the facility and it's 2 affiliated facilities. Director A stated Administrator K was responsible for the facility effective early October, but s/he was out on vacation.

On 11/16/2023 at approximately 8:40 a.m., Surveyor reached out to the provider regarding PRN administration and documentation. Director A acknowledged PRN administration lacked documentation regarding need and effectiveness of medication.

On 11/21/2023 at approximately 10:00 a.m., Surveyor reviewed personal care and prompt and adequate treatment concerns with Director A and Administrator K. Administrator K stated s/he had no comments regarding Surveyor's concern as s/he was not overseeing the facility at that time. Director A followed up and stated s/he had nothing to add. Neither Director A, nor Administrator K had additional comments regarding Surveyor's verification visit or complaint investigation.

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{N 196}	Continued From page 3 Cross Reference: N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0409 DHS 83.37(1)(j) Proof-of-use Record N0425 DHS 83.38(1)(a) Personal Cares N0447 DHS 83.41(1)(c) Dishwashing N0450 DHS 83.41(2)(c) Nutrition: Menus N0481 DHS 83.43(1) Environment Safe, Clean And Comfortable N0487 DHS 83.44(1)(b) Separate Laundry Storage Areas Or Containers N0499 DHS 83.45(3) Toxic Substances	{N 196}		
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 prompt and adequate treatment was provided. Resident 8 did not receive adequate pain management or prompt treatment following a fall. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P15, dated 07/13/2022. Findings include:	N 353		

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N 353	Continued From page 4 From 11/02/2023 to 11/07/2023, Surveyor conducted a complaint investigation regarding resident falls. On 11/02/2023 at approximately 9:00 a.m., Surveyor reviewed a self-report, not dated, that stated Resident 8 fell on 10/01/2023 and sustained a right elbow fracture and left femur fracture. On 11/02/2023 at approximately 10:30 a.m., Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider's facility on 09/24/2021 and discharged on 10/23/2023. Resident 8's record identified the following concerns: Example 1 - Pain Control Resident 8's medication administration record (MAR), dated 10/01/2023 to 10/23/2023, documented Resident 8 had not received PRN Morphine until 11:52 a.m. on 10/12/2023. On 11/03/2023 at approximately 11:00 a.m., Surveyor reviewed hospice records. Hospice note, dated 10/12/2023 stated, "[Resident 8] was tearful, moaning in pain and states pain as a level 9. Staff report patient has not had PRN Morphine in almost 24 hours despite recommendations that Morphine was given prior to turning and repositioning or cares ... [Physician] updated on patient's pain level and that staff had not been utilizing PRN Morphine. [Physician] has scheduled the Morphine BID in addition to the PRN." On 11/06/2023 at approximately 1:00 p.m., Surveyor interviewed Hospice Nurse I. Hospice	N 353		

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N 353	Continued From page 5	N 353		

Nurse I stated staff reported they had not given Resident 8 any Morphine on 10/12/2023 because they had not completed any cares prior to Hospice Nurse I's late morning arrival. Hospice Nurse I stated Resident 8 reported s/he had been in pain since the night prior.

On 11/21/2023 at approximately 10:00 a.m., Surveyor reviewed pain management concern with Director A and Administrator K. Administrator K stated Director A would be the one to weigh in on pain management concerns because Administrator K was in an affiliated facility during the date of the concern. Director A stated s/he had no further information to provide.

Example 2 - Fall:

An incident report, dated 10/01/2023, stated resident was found on the ground by staff during their 5:30 a.m. rounds. The report stated resident told staff s/he fell out of bed and could not push his/her call button because it was on the table. The report stated the resident was taken to the hospital via ambulance. The report did not document the duration Resident 8 was on the ground.

On 11/03/2023 at approximately 11:00 a.m., Surveyor reviewed hospice records. Hospice note, dated 10/04/2023, stated "Asked [him/her] about [his/her] fall. Says it was [his/her] fault because [s/he] was too close to the edge of the bed but said [s/he] was frustrated because the facility had the door closed and no one would help [him/her]."

On 11/06/2023 at approximately 1:00 p.m., Surveyor interviewed Hospice Nurse I. Hospice Nurse I stated Resident 8 was found with his/her

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N 353	Continued From page 6 arm caught in the rail on 10/01/2023. Hospice Nurse I stated Resident 8 reported calling out for help for 30-60 minutes because his/her door was closed, and the call pendant was not within reach. Hospice Nurse I stated Resident 8 had a hoarse voice after his/her fall from calling out for help. Hospice Nurse I stated it was not protocol to keep Resident 8's door shut since s/he was on 10L of oxygen and his/her room would get very warm. On 11/21/2023 at approximately 10:00 a.m., Surveyor reviewed concerns related to Resident 8's fall with Director A and Administrator K. Neither Director A, nor Administrator K were able to confirm how long Resident 8 was calling out for help. Director A stated Resident 8's door should have been left open and s/he wasn't sure why it was closed.	N 353		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by:	{N 389}		

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{N 389}	Continued From page 7 Based on record review and interview, the provider did not ensure 3 of 4 individual service plans (ISP) reviewed were updated upon changes. Resident 4's ISP was not updated after s/he sustained 2 falls. Resident 7's ISP was not updated after s/he exhibited sexual behaviors and sustained a fall. Resident 8's ISP was not updated after s/he sustained a fall. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P15, dated 07/13/2022 and SOD M20M11, dated 07/11/2023. Findings include: On 11/02/2023 at approximately 11:55 a.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 4 Resident 4 was admitted to the provider's facility on 07/03/1954 with diagnoses including schizoaffective disorder. Resident 4's record included the following incident reports from 10/13/2023 to 10/27/2023: - 10/14/2023: Resident was walking to the bathroom and tripped over a card. Resident said his/her head was hit and it hurts. - 10/27/2023: Resident fell and said s/he hit his/her back on the toilet pretty bad. Resident 4's ISP, not dated, stated "Resident will fall when overwhelmed. [S/he] must use walker." The ISP did not include interventions to prevent further falls in the bathroom. Example 2 - Resident 7	{N 389}		

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{N 389}	Continued From page 8 Resident 7 was admitted to the provider's facility on 08/10/2020 with diagnoses including schizoaffective disorder and bipolar disorder. Sexual Behaviors: On 08/28/2023, the department issued SOD M20M11, dated 07/11/2023, that indicated Resident 7's ISP was not updated to include his/her history of sexual behaviors with another resident. Resident 7's ISP, not dated, did not include documentation of Resident 7's history of sexual behaviors. On 11/02/2023 at approximately 12:30 p.m., Surveyor interviewed Director A. Surveyor asked Director A if Resident 7's ISP was updated to include his/her history of sexual behaviors. Director A replied, "No, but [s/he] hasn't had any since the last time you were here." Falls: Resident 7's record included the following incident report from 10/13/2023 to 10/27/2023: - 10/16/2023: Unwitnessed fall. The corresponding progress note stated, "Resident left the building without informing staff to go visit another resident outside ... Another resident found [Resident 7] on the ground ..." Resident 7's ISP, not dated, identified him/her as a fall risk. The ISP did not include preventative measures following his/her 10/16/2023 fall. On 11/02/2023 at approximately 12:30 p.m., Surveyor interviewed Director A. Surveyor asked	{N 389}		

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{N 389}	Continued From page 9	{N 389}		

Director A if Resident 7's ISP was updated with preventative measures related to his/her 10/16/2023 fall. Director A replied, "No."

Example 3- Resident 8

Resident 8 was admitted to the provider's facility on 09/24/2023. Resident 8's record included an incident report, dated 10/01/2023, that stated resident was found on the ground by staff. The report documented that Resident 8 had fallen out of bed. A self-report, not dated, submitted to the department indicated Resident 8 sustained a right elbow fracture and left femur fracture. The self-report documented the facility would take the following action to ensure Resident 8's safety:

- Staff will ensure resident's bed is in its lowest position as possible when resident is lying in it.
- Staff have requested a fall mat for resident to use while in bed.
- Management will provide additional training to staff on fall prevention.

Resident 8's ISP, not dated, stated "Resident is no longer fall risk as [s/he] is unable to walk or get out of bed on [his/her] own (02/17/2022)."

On 11/02/2023 at approximately 12:30 p.m., Surveyor reviewed concern with Director A that Resident 8's record did not include preventative fall measures after his/her 10/01/2023 fall. Director A nodded his/her head in response.

On 11/02/2023 at approximately 1:25 p.m., Surveyor reviewed concerns related to ISP updates with Director A and Nurse J. Nurse J stated Administrator K was responsible for ISP updates effective early October 2023. Director A and Nurse J stated Administrator K was on

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{N 389}	Continued From page 10 vacation during Surveyor's visit to the facility.	{N 389}		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the need for PRN medication and the resident's response were documented. The provider did not document the reason and/or effectiveness each time Resident 8 was administered PRN Lorazepam, Acetaminophen and Morphine Sulfate. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P11, dated 03/23/2021.	N 408		

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N 408	Continued From page 11	N 408		

Findings include:

On 11/02/2023 at approximately 10:30 a.m., Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider's facility on 09/24/2021 and discharged on 10/23/2023. Resident 8's Medication Administration Record (MAR), dated 10/01/2023 to 10/23/2023, documented the following:

Lorazepam:

Resident 8 had an order for Lorazepam .5 mg (Start Date: 10/01/2023) - Give every 4 hours as needed for anxiety/agitation/restlessness. Resident 8's MAR documented the following administrations:

- 10/01/2023 6:03 p.m. - No reason or effectiveness documented.
- 10/02/2023 12:11 p.m. - No reason documented.
- 10/03/2023 7:34 p.m. - No reason or effectiveness documented.
- 10/04/2023 6:15 a.m. - No reason documented.
- 10/05/2023 2:33 a.m. - No reason documented.
- 10/06/2023 1:14 a.m. - No reason or effectiveness documented.
- 10/07/2023 4:13 p.m. - No reason or effectiveness documented.
- 10/08/2023 9:35 p.m. - No reason or effectiveness documented.
- 10/14/2023 9:52 a.m. - No reason documented.
- 10/17/2023 8:25 p.m. - No reason documented.

Acetaminophen:

Resident 8 had an order for Acetaminophen 325 mg (Start Date: 05/23/2023) - Take 2 tablets every 4 hours as needed for pain. Resident 8's

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N 408	Continued From page 12 MAR documented the following administrations: - 10/02/2023 12:11 p.m. - No reason documented. - 10/07/2023 3:35 a.m. - No reason or effectiveness documented. - 10/09/2023 4:01 a.m. - No effectiveness documented. Morphine Sulfate 20 mg/ml: Resident 8 had an order for Morphine Sulfate 20 mg/ml (Start Date: 06/22/2023) - Take .25 ml every 4 hours as needed for pain or air hunger. Resident 8's MAR documented the following administrations: - 10/03/2023 7:35 p.m. - Reason and follow up not documented. - 10/03/2023 11:37 p.m. - Follow up not documented. - 10/04/2023 1:00 p.m. - Reason not documented. - 10/05/2023 2:35 p.m. - Reason and follow up not documented. - 10/05/2023 9:04 a.m. - Follow up not documented. - 10/06/2023 1:14 a.m. - Follow up not documented. - 10/06/2023 12:26 p.m. - Reason not documented. - 10/07/2023 3:37 a.m. - Reason and follow up not documented. - 10/07/2023 1:14 p.m. - Reason not documented. - 10/07/2023 4:15 p.m. - Follow up not documented. - 10/08/2023 9:35 p.m. - Follow up not documented. - 10/09/2023 6:59 p.m. - Follow up not	N 408		

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(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 408	Continued From page 13 documented. - 10/10/2023 2:42 p.m. - Follow up not documented. - 10/10/2023 8:12 a.m. - Follow up not documented. - 10/12/2023 11:52 a.m. - Reason not documented. - 10/13/2023 3:34 a.m. - Follow up not documented. - 10/15/2023 11:04 a.m. - Reason and follow up not documented. - 10/16/2023 12:50 p.m. - Reason not documented. - 10/18/2023 2:29 p.m. - Follow up not documented. - 10/20/2023 12:37 p.m. - Reason not documented. - 10/22/2023 12:47 p.m. - Reason not documented. - 10/23/2023 11:04 a.m. - Reason not documented. On 11/16/2023 at approximately 8:40 a.m., Surveyor requested information regarding the reason and/or effectiveness of Resident 8's PRN administrations. On 11/16/2023 at approximately 12:45 p.m., Director A followed up with Surveyor and stated s/he had no follow up documentation to provide.	N 408		
{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 controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose,	{N 409}		

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{N 409}	Continued From page 14 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 schedule II drugs were audited on a daily basis for 2 of 2 residents reviewed. Resident 3's Morphine Sulfate 15 mg PRN and Resident 4's Morphine Sulfate 20 mg scheduled every 4 hours were not audited daily. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P14, dated 03/29/2022 and M20M11, dated 07/11/2023. Findings include: On 11/02/2023 at approximately 11:15 a.m., Surveyor reviewed the provider's schedule II medications with Nurse J and requested the schedule II audits from 10/13/2023 to 11/03/2023 for Resident 3's Morphine Sulfate 15 mg (PRN medication started 04/12/2023) and Resident 4's Morphine Sulfate (scheduled every 4 hours, started 10/03/2023). Surveyor reviewed the audits, which indicated audits were not completed on 10/17/2023, 10/20/2023, 10/30/2023 and 10/31/2023. Surveyor inquired about the days that were not accounted for and asked Nurse J if the provider put a system in place to ensure schedule II medications were audited daily. Nurse J stated medication passers were supposed to complete a count every day and put it in the electronic record, but the internet had been down at times. Nurse J stated s/he was going to implement a paper count but hadn't done so.	{N 409}		

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{N 409}	Continued From page 15 On 11/02/2023 at approximately 1:25 p.m., Surveyor interviewed Director A and Nurse J regarding concern that schedule II medications were not audited daily. Director A stated directors were going to be responsible for ensuring daily audits occurred, but that plan was just discussed and not started.	{N 409}		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the need for PRN medication and the resident's response were documented. The provider did not document the reason and/or effectiveness each time Resident 8 was administered PRN Lorazepam, Acetaminophen and Morphine Sulfate. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P11, dated 03/23/2021. Findings include:	N 415		

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N 415	Continued From page 16 On 11/02/2023 at approximately 10:30 a.m., Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider's facility on 09/24/2021 and discharged on 10/23/2023. Resident 8's Medication Administration Record (MAR), dated 10/01/2023 to 10/23/2023, documented the following: Lorazepam: Resident 8 had an order for Lorazepam .5 mg (Start Date: 10/01/2023) - Give every 4 hours as needed for anxiety/agitation/restlessness. Resident 8's MAR documented the following administrations: - 10/01/2023 6:03 p.m. - No reason or effectiveness documented. - 10/02/2023 12:11 p.m. - No reason documented. - 10/03/2023 7:34 p.m. - No reason or effectiveness documented. - 10/04/2023 6:15 a.m. - No reason documented. - 10/05/2023 2:33 a.m. - No reason documented. - 10/06/2023 1:14 a.m. - No reason or effectiveness documented. - 10/07/2023 4:13 p.m. - No reason or effectiveness documented. - 10/08/2023 9:35 p.m. - No reason or effectiveness documented. - 10/14/2023 9:52 a.m. - No reason documented. - 10/17/2023 8:25 p.m. - No reason documented. Acetaminophen: Resident 8 had an order for Acetaminophen 325 mg (Start Date: 05/23/2023) - Take 2 tablets every 4 hours as needed for pain. Resident 8's MAR documented the following administrations:	N 415		

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N 415	Continued From page 17	N 415		

- 10/02/2023 12:11 p.m. - No reason documented.
- 10/07/2023 3:35 a.m. - No reason or effectiveness documented.
- 10/09/2023 4:01 a.m. - No effectiveness documented.

Morphine Sulfate 20 mg/ml:

Resident 8 had an order for Morphine Sulfate 20 mg/ml (Start Date: 06/22/2023) - Take .25 ml every 4 hours as needed for pain or air hunger. Resident 8's MAR documented the following administrations:

- 10/03/2023 7:35 p.m. - Reason and follow up not documented.
- 10/03/2023 11:37 p.m. - Follow up not documented.
- 10/04/2023 1:00 p.m. - Reason not documented.
- 10/05/2023 2:35 p.m. - Reason and follow up not documented.
- 10/05/2023 9:04 a.m. - Follow up not documented.
- 10/06/2023 1:14 a.m. - Follow up not documented.
- 10/06/2023 12:26 p.m. - Reason not documented.
- 10/07/2023 3:37 a.m. - Reason and follow up not documented.
- 10/07/2023 1:14 p.m. - Reason not documented.
- 10/07/2023 4:15 p.m. - Follow up not documented.
- 10/08/2023 9:35 p.m. - Follow up not documented.
- 10/09/2023 6:59 p.m. - Follow up not documented.

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N 415	Continued From page 18 - 10/10/2023 2:42 p.m. - Follow up not documented. - 10/10/2023 8:12 a.m. - Follow up not documented. - 10/12/2023 11:52 a.m. - Reason not documented. - 10/13/2023 3:34 a.m. - Follow up not documented. - 10/15/2023 11:04 a.m. - Reason and follow up not documented. - 10/16/2023 12:50 p.m. - Reason not documented. - 10/18/2023 2:29 p.m. - Follow up not documented. - 10/20/2023 12:37 p.m. - Reason not documented. - 10/22/2023 12:47 p.m. - Reason not documented. - 10/23/2023 11:04 a.m. - Reason not documented. On 11/16/2023 at approximately 8:40 a.m., Surveyor requested information regarding the reason and/or effectiveness of Resident 8's PRN administrations. On 11/16/2023 at approximately 12:45 p.m., Director A followed up with Surveyor and stated s/he had no follow up documentation to provide.	N 415		
N 425	83.38(1)(a) Personal care. 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	N 425		

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N 425	Continued From page 19 residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 8 received personal care services. Findings include: From 11/02/2023 to 11/21/2023, Surveyor conducted a complaint investigation alleging the personal care needs of residents were not met. Surveyor reviewed the records of Resident 8, who admitted to the facility on 09/24/2023, and identified the following concerns: Example 1 - Incontinence Cares: On 11/02/2023 at approximately 10:30 a.m., Surveyor reviewed Resident 8's individual service plan (ISP). The ISP, not dated, indicated s/he was incontinent of bowel and bladder and required toileting assistance every 2 hours. On 11/03/2023 at approximately 11:00 a.m., Surveyor reviewed hospice records, which documented the following: - 10/02/2023: "Patient was saturated in urine." - 10/12/2023: " ...Patient was saturated in urine from upper thigh to back of neck. Patient is in	N 425		

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same gown that writer put on [him/her] 6 days ago. Patient had dried stool on [his/her] buttocks, on [his/her] hands and [his/her] hands had not been washed as evidenced by dried food.

On 11/06/2023 at approximately 1:00 p.m., Surveyor interviewed Hospice Nurse I. Hospice Nurse I stated s/he had worked with Resident 8 since approximately July 2023. Hospice Nurse I stated Resident 8 was frequently found incontinent - Soiled from his/her mid thighs all the way to his/her pillows. Hospice Nurse I stated Resident 8's paper chucks, cloth chucks, sheet and mattress would be wet and on several occasions Resident 8 was found with dry feces on him/her.

On 11/17/2023 at approximately 4:00 p.m., Surveyor received Resident 8's "Task Administration Record," dated 09/01/2023 to 10/23/2023, from Director A. The record indicated caregivers were to assist Resident 8 with toileting needs at 3:00 a.m., 6:00 a.m., 8:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m. and 10:00 p.m. Documentation indicated the following:

- 3:00 a.m. toileting needs were not documented as complete 42 times.
- 6:00 a.m. toileting needs were not documented as complete 50 times.
- 8:00 a.m. toileting needs were not documented as complete 22 times.
- 10:00 a.m. toileting needs were not documented as complete 23 times.
- 12:00 p.m. toileting needs were not documented as complete 26 times.
- 2:00 p.m. toileting needs were not documented as complete 26 times.
- 4:00 p.m. toileting needs were not documented

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as complete 30 times.
- 6:00 p.m. toileting needs were not documented as complete 33 times.
- 8:00 p.m. toileting needs were not documented as complete 34 times.
- 10:00 p.m. toileting needs were not documented as complete 34 times.

Example 2 - Ice to left side

On 11/02/2023 at approximately 10:30 a.m., Surveyor reviewed Resident 8's ISP, not dated, which stated, "Ice pack must be put on left shoulder and left elbow 3x a day.

On 11/03/2023 at approximately 11:00 a.m., Surveyor reviewed hospice records, which documented the following:

- 10/02/2023: "Instructed staff to apply ice 3 times a day for 20 minutes. Instructed to utilize 2 people for all cares and repositioning.
- 10/12/2023: " ...Patient was at the bottom of the bed with [his/her] fractured knee pressed against the foot board. Patient reports [s/he] has not had ice applied to [his/her] elbow or [his/her] knee despite orders for ice to be applied 3 times daily. Writer talked to CNA who reports they do not have ice."

On 11/06/2023 at approximately 1:00 p.m., Surveyor interviewed Hospice Nurse I. Hospice Nurse I stated, "It was like [staff] were just done," in reference to the facility's care of Resident 8 following a fall on 10/01/2023. Hospice Nurse I stated despite his/her instructions to provide ice to resident, the facility did not do so.

On 11/17/2023 at approximately 4:00 p.m., Director A followed up with Surveyor regarding

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Resident 8's need for icing. Director A stated the facility had an ice machine and trays for ice, but they had a resident that used a lot of ice on every shift so there may not have been ice frozen.

Example 3 - Repositioning/Cares

On 11/03/2023 at approximately 11:00 a.m., Surveyor reviewed hospice records, which documented the following:

- 09/23/2023: "Patient has large bruise on right hand from staff grabbing [his/her] arm to help [him/her] turn patient
.
On 11/06/2023 at approximately 1:00 p.m., Surveyor interviewed Hospice Nurse I. Hospice Nurse I stated Resident 8, who was his/her own person, was able to tell Hospice Nurse I that the bruise observed on 09/23/2023 was from staff pulling on his/her arms. Hospice Nurse I stated staff had been observed moving Resident 8 by grabbing his/her arms in the past.

On 11/17/2023 at approximately 4:00 p.m., Director A followed up with Surveyor regarding Resident 8's 09/23/2023 bruise. Director A provided a statement, dated 09/20/2023, that stated "[Caregiver] noticed a bruise on [Resident 8]'s hand on 09/19/2023 ... [Resident 8] said it was a [caregiver] on night shift when [s/he] flips [Resident 8] around like a pancake ...".

Resident 8 did not receive proper repositioning assistance from staff, resulting in an injury.

Example 3 - Oxygen

On 11/03/2023 at approximately 11:00 a.m., Surveyor reviewed hospice records, which

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N 425	Continued From page 23 documented the following: - 09/23/2023: " ...Patient appeared short of breath on writer's arrival. O2 concentrator was set at 2L instead of the ordered 10 L. On 11/06/2023 at approximately 1:00 p.m., Surveyor interviewed Hospice Nurse I. Hospice Nurse I stated Resident 8 required 10 L of oxygen but was found at a lower rate at times. On 11/17/2023 at approximately 4:00 p.m., Director A followed up with Surveyor regarding Resident 8's oxygen use. Director A stated caregivers were supposed to check Resident 8's oxygen routinely and document they did so. Surveyor then reviewed Resident 8's "Task Administration Record," dated 09/01/2023 to 10/23/2023, received from Director A. The record indicated caregivers were to check Resident 8's oxygen at 4:00 a.m., 8:00 a.m., 12:00 p.m., 5:00 p.m., 8:00 p.m. and 11:30 p.m. Documentation indicated the following: - 4:00 a.m. oxygen checks were not documented as complete 42 times. - 8:00 a.m. oxygen checks were not documented as complete 38 times. - 12:00 p.m. oxygen checks were not documented as complete 5 times. - 5:00 p.m. oxygen checks were not documented as complete 25 times. - 8:00 p.m. oxygen checks were not documented as complete 25 times. - 11:30 p.m. oxygen checks were not documented as complete 42 times.	N 425		
N 447	83.41(1)(c) Dishwashing	N 447		

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N 447	Continued From page 24 Dishwashing. 1. Whether washed by hand or mechanical means, all equipment and utensils shall be cleaned using separate steps for pre-washing, washing, rinsing and sanitizing. Residential dishwashers may be used in kitchens serving 20 or fewer residents. Kitchens serving 21 or more residents shall have a commercial type dishwasher for washing and sanitizing equipment and utensils in accordance with standard practices described in the Wisconsin food code. 2. A 3-compartment sink for washing, rinsing and sanitizing utensils, with drain boards at each end is required for all large facilities with a central kitchen. Washing, rinsing and sanitizing procedures shall be in accordance with standard practices described in the Wisconsin food code. In addition, a single compartment sink or overhead spray wash located adjacent to the soiled drain board is required for pre-washing. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all equipment and utensils were cleaned using separate steps for pre-washing, washing, rinsing and sanitizing. Findings include: On 11/02/2023 at approximately 12:30 p.m., while touring the facility with Director A, Surveyor observed Caregiver L washing dishes and utensils in the facility's kitchen. Caregiver L washed dishes in 1 sink with dish soap, rinsed the dishes and set the dishes aside to dry. Surveyor asked Caregiver L if s/he pre-washed or sanitized the dishes. Caregiver L replied, "No." Caregiver L was unaware of the need to pre-wash, wash, rinse and sanitize all dishes.	N 447		

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N 447	Continued From page 25 Director A was present for Surveyor's interview with Caregiver L. No instructions or guidance were provided to Caregiver L.	N 447		
{N 450}	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents were made aware of deviations from the menu. This is a repeat deficiency. See Statement of Deficiency (SOD) M20M11, dated 07/11/2023. Findings include: On 11/02/2023 at approximately 10:50 a.m., Surveyor toured the provider's facility. Surveyor observed a white board in the dining room that was blank. Surveyor observed a monthly calendar on a bulletin board in the dining room that indicated the noon meal would be Salisbury steak, mashed potatoes, gravy, seasonal vegetable, fruit and milk. On 11/02/2023 at approximately 11:05 a.m., Surveyor interviewed Resident 4 and asked if/she knew what was going to be served for lunch. Resident 4 replied, "I don't."	{N 450}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 450}	Continued From page 26 On 11/02/2023 at approximately 12:00 p.m., Surveyor observed residents served meatloaf, mashed potatoes, corn and cake. Residents were not served fruit or Salisbury steak. On 11/02/2023 at approximately 1:00 p.m., Surveyor interviewed Cook H. Cook H stated s/he did not serve Salisbury steak for the noon meal because s/he didn't have the ingredients. Cook H stated s/he updated Director A regarding the menu change. On 11/02/2023 at approximately 1:25 p.m., Director A informed Surveyor s/he was made aware of the menu change but forgot to update residents.	{N 450}		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that was safe, clean, comfortable and homelike was provided. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P12, dated 06/15/2021, EC0P15, dated 07/13/2022 and M20M11, dated 07/11/2023. Findings include:	{N 481}		

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{N 481}	Continued From page 27 On 11/02/2023, Surveyor conducted a verification visit and identified the following concerns: Laundry: On 11/02/2023 at approximately 11:00 a.m., Surveyor observed 2 laundry baskets overflowing with bedding in Resident 4's room. Resident 4 stated the facility was responsible for washing his/her bedding, but it had not been completed lately. Resident 4's bed was observed with a paper chuck and no bedding on it. The facility washer was observed not in use. Resident 4 stated s/he paid a friend to complete his/her personal laundry because the facility had a history of losing his/her clothing. Environment: On 11/02/2023 at approximately 1:15 p.m., Surveyor observed Resident 10's room with drywall missing from his/her wall, approximately 10 inches in length and 2 inches in width. Director A stated s/he was unaware the wall was in poor condition. Utensils: On 11/02/2023 at approximately 12:05 p.m., Surveyor observed caregivers serve lunch. Surveyor checked in with the caregivers and asked if they had enough utensils to serve every resident. Caregiver L stated there were 2 residents left to serve and no utensils left. Surveyor observed an empty utensil drawer. Caregiver L stated s/he would pull utensils from the dishwasher, which was in the middle of a cycle, to serve the remaining residents.	{N 481}		

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{N 487}	Continued From page 28	{N 487}		
{N 487}	83.44(1)(b) Separate laundry storage areas or containers Storage and transport. The CBRF shall have separate clean and dirty laundry storage areas or containers. Storage containers shall be clean, leak-proof and have a tight fitting lid. The CBRF may not transport, wash or rinse soiled laundry in areas used for food preparation, serving or storage. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure separate storage areas or containers were provided for clean and soiled laundry. This is a repeat deficiency. See Statement of Deficiency (SOD) M20M11, dated 07/11/2023. Findings include: On 11/02/2023 at 11:15 a.m., Surveyor toured the provider's laundry room with Caregiver L, Surveyor observed a plastic container with bedding in it and a laundry basket with clothing in it. Surveyor asked Caregiver L if the container or basket contained soiled or cleaned clothing. Caregiver L stated s/he was unsure. On 11/02/2023 at 11:35 a.m., Surveyor observed Resident 9 had approximately 10 articles of clothing folded and lying on his/her floor. Director A was unsure why the clothes were on the floor, rather than in a soiled laundry basket or stowed away in his/her closet if clean. On 11/02/2023 at approximately 11:40 a.m., Surveyor observed a plastic container with soiled	{N 487}		

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{N 487}	Continued From page 29 clothing in it in Resident 2's room. Surveyor asked Resident 2 how staff handled his/her laundry. Resident 2 stated s/he put his/her soiled laundry in the container and staff would carry his/her laundry back to his/her room once clean. Resident 2 clarified no container was used for his/her clean laundry. On 11/04/2023 at approximately 12:00 p.m., Surveyor interviewed Director A regarding the facility's laundry process. Director A stated the facility purchased containers for all residents. Director A stated soiled laundry was supposed to go in the containers and after completing laundry staff were supposed to disinfect the containers and return laundry to residents using the same container. Director A was unable to locate the disinfectant spray that was supposed to be used. Surveyor shared concern that disinfectant spray was not located in the laundry room and staff were unable to identify soiled vs clean clothing. Director A nodded his/her head in response.	{N 487}		
{N 499}	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic chemicals were stored in a secured area. Cleaning agents were accessible to residents. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P12, dated 06/15/2021,	{N 499}		

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{N 499}	Continued From page 30 EC0P13, dated 10/05/2021, EC0P14, dated 03/29/2022 and M20M11, dated 07/11/2023. Findings include: On 11/02/2023 at approximately 10:50 a.m., Surveyor toured the provider's facility. Surveyor observed the provider's linen/cleaning closet, which had a sign that stated "This door needs to be locked at all times," was unlocked and accessible. The linen/cleaning closet contained toilet cleaner and all-purpose cleaner. Surveyor observed a spray bottle of unidentified cleaner on the window sill in the facility's common area. On 11/02/2023 at approximately 1:00 p.m., Surveyor toured the provider's facility with Director A. Surveyor shared concern that the linen closet, which stored toxic chemicals, was unlocked during Surveyor's initial tour of the facility. Director A replied, "Okay," and confirmed the closet should always be kept locked as indicated on the sign on the door.	{N 499}		