STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017703	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON APPLEWOOD	5565 BURKE RD MADISON, WI 53718

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 04/24/2024, with information gathered through 04/30/2024, the Bureau of Assisted Living, Southern Regional Office conducted 2 complaint investigations at Cottages of Madison Applewood, located at 5565 Burke Rd in Madison, WI. Seven citations of noncompliance were issued, including 4 repeat citations of noncompliance. Both complaints were substantiated. Census: 16	N 000		
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: Based on record review and interview, the provider did not ensure that Resident 2's individual service plan (ISP) was updated to reflect his/her needs and physical condition regarding bathing, bowel monitoring, and skin monitoring.	N 389		

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

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N 389	Continued From page 1 This requirement is being cited for the fifth time. See Statement of Deficiency (SOD) UDWF11, issued 02/19/2021, SOD UDWF12, issued 06/17/2021, SOD 54DT11, issued 03/24/2023, and SOD FT8K12, issued on 06/16/2023. Findings include: On 04/24/2024, at approximately 10:15 a.m., Surveyor interviewed Resident 2. Resident 2 reported that it had been approximately 2-3 weeks since s/he had been offered an opportunity to shower. Resident 2 reported that s/he was supposed to get the assistance of staff for showers once per week but wasn't sure if s/he should just try to shower him/herself. On 04/24/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 01/08/2024 with diagnoses including vascular dementia, repeated falls, and type 2 diabetes. Resident 2 was documented as being his/her own legal representative. Resident 2's prescriptions included docusate sodium 100 mg capsules prescribed for constipation, with a start date of 01/08/2024 and instructions to, "Take 1 capsule by mouth twice daily as needed." Surveyor observed Resident 2's observation notes from 03/01/2024 through 04/24/2024 and observed the following entry: - 04/09/2024 (6:00 p.m.): "Resident returned from the hospital. Has cellulitis upper thigh, Has[sic] Miconazole Nitrate Powder to be applied twice daily and antibiotic to be completed." There were no observation notes after this entry, and there were no observation notes prior to that mentioned Resident 2's skin. The observation note immediately prior to this entry was dated	N 389		

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04/01/2024 (9:45 a.m.) and was a brief entry about his/her morning blood sugar value.

Surveyor reviewed Resident 2's current individual service plan (ISP), last signed as reviewed on 01/03/2024, which documented the following:

- Under the "Medications" section: "Resident requires staff to manage/administer medications."
- Under the "Illnesses" section: "Resident has chronic illness(es) that require proper treatment and management...Resident has recurring illness(es) that require proper treatment and management. Reoccurring falls with injuries."
- Under the "Bathing" section: The box indicating "partial assistance" was checked. A note documented, "Resident requires partial assistance from staff to complete bathing tasks." The frequency was set to "Daily @ As Needed."
- Under the "Toileting" section: Under the question, "Does resident require bowel movement monitoring?" the box indicating "Yes" was checked. A note documented, "Resident requires staff to monitor and document bowel movements."
- Under the "Communication" section: "Resident is quiet most of the time, answers when spoken to."

Surveyor also observed an "Oral Health" section, which documented, "[Describe resident's oral health status/history]. Has some missing teeth. Resident's Desired Outcome & Goals: To maintain proper oral health and hygiene. Responsible Persons: Staff/resident." No specific information of the type of assistance required by staff was documented.

Surveyor reviewed "Skin Check" documents for Resident 2, provided by House Manager B. There

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were 16 checks total from 01/10/2024 - 04/24/2024. The documented frequency ranged from approximately 2x/week - 1x/week with occasional gaps of 1 week or longer in between checks. Every check record documented that the skin assessment was to occur weekly.

Surveyor reviewed medical records for Resident 2, provided by House Manager B, which included the following:

- An "After Hospital Care Plan" document, dated 04/09/2024. The record documented that Resident 2 was hospitalized from 04/07/2024 - 04/09/2024 due to a "skin infection in left thigh." The record documented that Resident 2 was treated with antibiotics, wound care, and lab monitoring, and that Resident 2 was instructed to follow up with his/her primary care provider for monitoring further progression of any symptoms. A heading in the record, titled, "How Should You Care for Your Wound?" instructed for cares to be provided to Resident 2's left groin wound two times a day and as needed. Additional instructions provided a detailed wound care regimen of cleansing, powder use, and barrier cream use; as well as signs of infection to monitor.

- An "After Visit Summary" document, dated 04/22/2024. The record documented that Resident 2's fungal dermatitis was addressed in the visit and a new prescription for miconazole powder to be administered twice daily was initiated.

Surveyor again reviewed Resident 2's ISP. There was no evidence of any skin monitoring needs documented.

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N 389	Continued From page 4 At approximately 2:15 p.m., Surveyor interviewed Resident 2. When asked about his/her hospitalization, Resident 2 reported that s/he had a left groin/lower extremity skin condition, where his/her skin turned red and itchy. Resident 2 reported that this persisted for a few days and became "raw." Resident 2 reported that his/her skin began draining pus that was white/brown in color and smelled bad. Resident 2 reported that while hospitalized s/he was provided intravenous antibiotics for his/her infected skin. At approximately 2:55 p.m., Surveyor interviewed House Manager B. House Manager B reported that Resident 2 is expected to be showered twice weekly and that this was the standard frequency for all residents. Surveyor requested Resident 2's bowel movement monitoring documentation, as referenced in his/her ISP, from House Manager B. Nothing further was provided. At approximately 3:20 p.m., Surveyor interviewed Administrator A. Administrator A reported that Resident 2 didn't need bowel movement monitoring and so staff were not monitoring or documenting his/her bowel movements. When reviewing the bowel movement monitoring section of Resident 2's ISP, Administrator A replied that that must have just been part of the regular care plan template and the person who made the ISP didn't change it. Surveyor reviewed the as-needed constipation medication and Administrator A confirmed Surveyor's observation that there didn't appear to be monitoring guidance outlined in Resident 2's ISP that would cue staff for the needed use of that medication. Administrator A reported that a previous licensed practical nurse (LPN) had been responsible for managing the ISPs. Administrator A reported that Resident 2's shower schedule was 2x/week, on	N 389		

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N 389	Continued From page 5 Wednesdays and Saturdays. When reviewing Resident 2's ISP, which documented daily showers, Administrator A reported that no one receives daily showers and that this must have been in the initial care plan template that was overlooked. Administrator A reported that Resident 2's ISP didn't look fully individualized to him/her. Surveyor reviewed Administrator A's signature on Resident 2's ISP, signed and dated for 02/08/2024. Administrator A reported that s/he "just signed it." Cross Reference: N0425 DHS 83.38(1)(a) Personal Care	N 389		
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 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 observation, interview, and record review, the provider did not ensure Resident 1	N 425		

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and Resident 2 were provided with personal care services adequate to meet their individual needs.

Resident 1 was not provided with personal care services related to bathing, including daily cares and showers.

Resident 2 was not provided with personal care services related to showering.

The findings include:

On 04/24/2024, Surveyors conducted a complaint investigation alleging concerns with personal care services.

Definitions:
DHS 83.02(37) "Personal care" means assistance with activities of daily living, but does not include nursing care.
DHS 83.02(3) "Activities of daily living" means bathing, eating, oral hygiene, dressing, toileting and incontinence care, mobility, and transferring from one surface to another such as from a bed to a chair.

Example 1: Resident 1

On 04/24/2024 at 7:50 A.M., Surveyors entered the facility and observed House Manager B and Caregiver C present in the facility. House Manager B told Surveyor s/he came in to the facility to help related to the facility being short staffed.

On 04/24/2024 at 8:00 A.M., Surveyor observed Caregiver E arrive at the facility and enter the kitchen. Caregiver E told Surveyor s/he was "pulled from a different facility" on the premises to work at this facility. Caregiver E told Surveyor

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s/he did not normally work at this facility.

On 04/24/2024 at 8:54 A.M., Surveyor conducted an interview with House Manager B about Resident 1's personal care needs. House Manager B told Surveyor Resident 1 was incontinent of bowel and bladder, required caregiver assistance with incontinence care, and utilized a wheelchair for mobility. House Manager B told Surveyor Resident 1 required caregiver assistance with bathing, oral hygiene, dressing, and transfers. House Manager B told Surveyor Resident 1 would be capable of participating in an interview and providing appropriate information.

On 04/24/2024 at 9:19 A.M., Surveyor observed Caregiver C assist Resident 1 from Resident 1's bed to Resident 1's wheelchair utilizing a pivot transfer before Caregiver C left Resident 1's room. Surveyor observed Resident 1 to be fully clothed during Resident 1's transfer from bed. Resident 1 told Surveyor s/he had been awake in bed for awhile and had just gotten out of bed for the first time on this morning. Surveyor observed no evidence Resident 1 had been provided with oral care or morning cares, including bathing. Resident 1 told Surveyor Caregiver C had just assisted him/her with incontinence care with disposable wipes and provided Resident 1 with a clean incontinence brief. Resident 1 told Surveyor s/he preferred not to utilize the facility's shared bathroom room to use the toilet or receive daily personal cares. Resident 1 told Surveyor s/he did not mind utilizing the facility's shared shower room to receive assistance with showers. Resident 1 told Surveyor Caregiver C did not provide Resident 1 with wash cloths, soap, water, and/or disposable wipes to cleanse Resident 1's face and upper body and did not provide

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assistance with oral care on this morning. Resident 1 told Surveyor s/he did not receive set up and/or physical assistance with morning cares, including oral care, on a daily basis. Resident 1 told Surveyor s/he had not had a shower in several weeks, including having his/her hair washed. Resident 1 told Surveyor Caregiver D would take time to provide Resident 1 with shower assistance during the evening shift (3:00 P.M. to 11:00 P.M.), but Caregiver D had been off of work for several weeks. Resident 1 told Surveyor Caregiver D was the last caregiver to provide Resident 1 assistance with a shower. Resident 1 told Surveyor s/he did not like feeling "unclean" and felt s/he had no choice but to "put up with it." Resident 1 told Surveyor the facility often had one caregiver on duty.

On 04/24/2024, Surveyor reviewed the facility's staffing schedule for March 2024 and April 2024, as provided by House Manager B. The facility's March 2024 schedule included Caregiver D's last documented shift on duty was 03/14/2024, an evening shift. The facility's April 2024 schedule included Caregiver D's next scheduled shift to be 04/24/2024, an evening shift.

On 04/24/2024 at 10:16 A.M., Surveyor conducted an interview with Caregiver C. Caregiver C told Surveyor s/he did not provide set up and/or physical assistance with morning cares, including oral care, this morning. Caregiver C told Surveyor Resident 1 did not ask for morning cares, so Caregiver C did not set up and/or assist Resident 1 with morning cares. Caregiver C told Surveyor s/he provided Resident 1 with incontinence care and a transfer out of bed this morning, but provided no other personal cares to Resident 1. Caregiver C told Surveyor s/he worked at the facility during the day shift, 7:00

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N 425	Continued From page 9 A.M. until 3:00 P.M., and did not provide Resident 1 with shower assistance during his/her shifts. Caregiver C told Surveyor Resident 1 was to receive assistance with showers during the evening shift, 3:00 P.M. to 11:00 P.M. Caregiver C told Surveyor s/he was the only caregiver on duty at times. Caregiver C told Surveyor the last time s/he was the only caregiver on duty during the day shift was Monday, 04/22/2024, and House Manager B provided help with duties during that shift. Caregiver C said "it was a lot of work when short-staffed and 15 residents in-house." On 04/24/2024, Surveyor reviewed Resident 1's record, as provided by House Manager B. Resident 1 was admitted to the facility on 11/01/2022 and had diagnoses including dementia, mental illness, and muscle weakness. Resident 1's individual service plan (ISP) dated 01/11/2024 included, "[Resident 1] requires partial assistance from staff to complete oral care. Staff are to gather oral care supplies and assist [Resident 1]; Daily @ [at] morning [and] evening." Resident 1's ISP included, "[Resident 1] needs set-up and assistance [with grooming]" and "[Resident 1] needs reminders to get the task done. Once [Resident 1] starts the task, [s/he] can complete it (washing face, comb hair, shave, use deodorant)." Resident 1's ISP included, "[Resident 1] needs 1 assist with all transfers. [Resident 1] uses the walk-in shower with a shower chair. [Resident 1] needs supervision while in the shower and needs assistance with legs/feet/back/hair; Weekly (Mon [Monday] and Thu [Thursday] @ [at] 10:00 A.M. [and] as needed." Resident 1's ISP included, "[Resident 1] requires full assistance from staff to complete bathing tasks. Resident will at times refuse showers."	N 425		

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House Manager B told Surveyor Resident 1 was to be provided assistance with personal cares every morning, including oral care. House Manager B told Surveyor Resident 1 did not routinely refuse personal cares, including shower assistance.
Surveyor reviewed Resident 1's "Observations for [Resident 1] (03/01/2024 - [through] 04/24/2024." The only note regarding shower assistance offered and/or provided to Resident 1 was documented on 03/04/2024 at 10:00 A.M. by House Manager B. The note included, "[Resident 1] had a shower today, got room cleaned and bedding change [sic]." The "observations" during this time frame did not include documentation of Resident 1 refusing any personal cares, including shower assistance.
Surveyor was provided several documents titled, "Skin Check" dated between 02/26/2024 and 04/22/2024 from House Manager B when Surveyor asked if the facility documented when Resident 1 was provided with shower assistance. The "Skin Check" documents received including Resident 1's name and specific dates did not include any documentation of whether Resident 1 was provided with and/or refused shower assistance. House Manager B verbally agreed the "Skin Check" documents did not include any task or care provided other than the results of a skin check. House Manager B and Surveyor reviewed Resident 1's "Skin Check" document dated 04/15/2024. House Manager B told Surveyor his/her initials were documented on the "signature" line of the document. House Manager B told Surveyor s/he provided Resident 1 with a "bed bath" on 04/15/2024 including washing Resident 1's upper body and incontinence care, but did not include washing Resident 1's hair. House Manager B told Surveyor s/he did not provide Resident 1 with a shower on 04/15/2024

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because the facility was short-staffed on that day and s/he was at the facility to help with cares. House Manager B told Surveyor resident showers were not being provided as scheduled related to staffing issues and the facility did not want a caregiver in the shower room providing a resident shower when the facility was short-staffed.

On 04/24/2024 at 2:00 P.M., House Manager B and Surveyor reviewed the facility's staffing schedule for March 2024 and April 2024, including a sample of the facility's evening shifts from 04/01/2024 through 04/24/2024. The following dates included 1 caregiver scheduled on duty to work from 3:00 P.M. until 11:00 P.M.: 04/01/2024, 04/02/2024, 04/06/2024, 04/08/2024, and 04/15/2024. House Manager B told Surveyor the facility's scheduling program was a new, electronic application and management was still getting used to the information and it may not be entirely accurate. House Manager B said s/he or Administrator A could have "helped out" at the facility on these dates, but their time did not show up on the schedule because they were management. House Manager B told Surveyor Caregiver D's leave-of-absence since March 2024 had impacted the facility's evening schedule and evening caregiver availability. House Manager B told Surveyor s/he was looking forward to Caregiver D's return to work this week. House Manager B told Surveyor the facility's goal was to have 2 caregivers on duty during the day shift, 2 caregivers on duty during the evening shift, and 1 caregiver on duty during the night shift. House Manager B told Surveyor a "float" caregiver between the 3 licensed facility's on the premises could be utilized during the evening shifts and nights shifts, as needed.

On 04/30/2024 at 12:09 P.M., Surveyor

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conducted an interview with Resident 1's funding agency Case Manager L. Case Manager L told Surveyor Resident 1 was a reliable reporter and had verbalized to Case Manager L his/her with personal cares, including not receiving showers on a regular basis. Case Manager L told Surveyor Resident 1's concerns were on-going and as a result, Resident 1 would be moving out of the facility within the week.

Example 2: Resident 2

On 04/24/2024, at approximately 10:15 a.m., Surveyor interviewed Resident 2. Resident 2 reported that it had been approximately 2-3 weeks since s/he had been offered an opportunity to shower. Resident 2 reported that s/he was supposed to get the assistance of staff for showers once per week but wasn't sure if s/he should just try to shower him/herself.

On 04/24/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 01/08/2024 with diagnoses including vascular dementia, repeated falls, and type 2 diabetes. Resident 2 was documented as being his/her own legal representative. Surveyor reviewed Resident 2's current individual service plan (ISP), last signed as reviewed on 01/03/2024, which documented the following:

- Under the "Bathing" section: The box indicating "partial assistance" was checked. A note documented, "Resident requires partial assistance from staff to complete bathing tasks." The frequency was set to "Daily @ As Needed."

Surveyor reviewed medical records for Resident 2, provided by House Manager B, which included the following:

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N 425	Continued From page 13 - An "After Hospital Care Plan" document, dated 04/09/2024. The record documented that Resident 2 was hospitalized from 04/07/2024 - 04/09/2024 due to a "skin infection in left thigh." The record documented that Resident 2 was treated with antibiotics, wound care, and lab monitoring, and that Resident 2 was instructed to follow up with his/her primary care provider for monitoring further progression of any symptoms. A heading in the record, titled, "How Should You Care for Your Wound?" documented that cares were instructed to be provided to Resident 2's left groin wound two times a day and as needed. Additional instructions provided a detailed wound care regimen of cleansing, powder use, barrier cream use; as well as signs of infection to monitor. - An "After Visit Summary" document, dated 04/22/2024. The record documented that Resident 2's fungal dermatitis was addressed in the visit and a new prescription for miconazole powder to be administered twice daily was provided. At approximately 1:51 p.m., Surveyor interviewed House Manager B. House Manager B reported that skin check documents were completed with every shower given to residents and that was how s/he could ensure staff were both monitoring residents' skin and completing showers as scheduled. Surveyor then reviewed skin check documents for Resident 2, provided by House Manager B. There were 16 checks total from 01/10/2024 - 04/24/2024. The documented frequency ranged from approximately 2x/week - 1x/week. Surveyor observed occasional gaps of 1 week or longer in between checks, including the following:	N 425		

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- No check between 01/27/2024 - 02/07/2024 (11 days)
- No check between 02/14/2024 - 02/21/2024 (7 days)
- No check between 02/21/2024 - 03/02/2024 (10 days)
- No check between 03/06/2024 - 03/23/2024 (17 days)
- No check between 03/23/2024 - 04/06/2024 (14 days)
- No check between 04/16/2024 - 04/13/2024 (7 days)
- No check between 04/13/2024 - 04/20/2024 (7 days)

Every check record documented that the skin assessment was to occur weekly. While reviewing the records, Surveyor continued to interview House Manager B. House Manager B reported that Resident 2 was known to be quiet and s/he had not heard of him/her refusing showers or cares. House Manager B reported that the signature for the staff who documented the check on 04/20/2024 was that of Caregiver K. Surveyor then reviewed the staff schedule for April 2024 with House Manager B, which did not show Caregiver K working that day. House Manager B reported that Caregiver K maybe wasn't scheduled to work but picked up an extra shift or got called in and that was why it didn't show on the schedule provided. House Manager B reported that Caregiver K's timecard would show if Caregiver K worked that day.

At approximately 2:15 p.m., Surveyor interviewed Resident 2. Resident 2 reported that Caregiver K had never given him/her a shower. Resident 2 reported that s/he had asked staff once for a shower since his/her hospitalization earlier in the

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month but had gotten no response and so s/he gave up asking staff because they never seemed to follow up with residents' care needs. When asked about his/her hospitalization, Resident 2 reported that s/he had a left groin/lower extremity skin condition, where his/her skin turned red and itchy. Resident 2 reported that this persisted for a few days and became "raw." Resident 2 reported that his/her skin began draining pus that was white/brown in color and smelled bad.

At approximately 2:55 p.m., Surveyor interviewed House Manager B. House Manager B reported that Resident 2 is expected to be showered twice weekly and that this was the standard frequency for all residents. While reviewing the gaps in shower checks, House Manager B reported that these were maybe not getting done due to the provider being short staffed. While interviewing House Manager B, Surveyor reviewed the timecard for Caregiver K for 04/14/2024 - 04/24/2024, which was provided by him/her. The timecard showed that Caregiver K did not work on 04/20/2024. House Manager B confirmed Surveyor's observations that the timecard did not show Caregiver K working that day, and reported that maybe Caregiver K just incorrectly dated the skin check but completed it with his/her shower a different day. When relaying the information that Resident 2 reported s/he had never been showered by Caregiver K, House Manager B replied, "Okay."

At approximately 3:20 p.m., Surveyor interviewed Administrator A. Administrator A reported that a previous licensed practical nurse (LPN) had been responsible for managing the ISPs. Administrator A reported that Resident 2's shower schedule was 2x/week, on Wednesdays and Saturdays. When reviewing Resident 2's ISP, which

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N 425	Continued From page 16 documented daily showers, Administrator A reported that no one receives daily showers and that this must have been in the initial care plan template that was overlooked. Administrator A reported that Resident 2's shower days were Saturdays and Wednesdays, and that evening shift staff that day were going to shower Resident 2. Upon reviewing Resident 2's skin checks again, Surveyor observed that every skin check, of the 16 documented since his/her admission, were dated for Wednesdays or Saturdays in accordance with his/her scheduled shower days as reported by Administrator A. On 04/25/2024 at 2:58 P.M., Surveyor received an email from Administrator A. Administration A's documentation included, "I [Administrator A] have scheduled a mandatory staff meeting to cover resident's personal cares. The importance of washing up, showering, and doing oral cares with all residents daily. Between our Wellness Director, our Training Coordinator, [House Manager B], and myself [Administrator A] we will be doing additional training, hands on, with all resident assistants." Summary: The provider did not ensure Resident 1 and Resident 2 were provided with personal care services adequate to meet their individual needs. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 425		
N 445	83.41(1)(a) Food supply.	N 445		

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N 445	Continued From page 17 Food supply. 1. The CBRF shall maintain a food supply that is adequate to meet the needs of the residents. 2. Food shall be obtained from acceptable sources. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that a food supply, adequate to meet the needs of the residents, was maintained. Findings include: On 04/24/2024, Surveyors conducted a complaint investigation into concerns of the amount of food served to residents during meals. Surveyor reviewed a resident roster, which documented that the provider had 15 residents in-house. On 04/24/2024, at approximately 7:49 a.m., Surveyor observed the weekly menu posted in a glass cabinet located in the facility's dining area. The menu documented that the following was to be served on Tuesday dinner (the evening prior to the survey) and Wednesday breakfast, lunch, and dinner (the day of the survey): - Tuesday dinner: Creamy cool cucumbers, egg salad, buttery croissant, kettle chips, and "sinful" chocolate pudding parfait - Wednesday breakfast: Buttermilk pancakes, Vermont maple syrup, thick cut bacon, and strawberry yogurt - Wednesday lunch: Chopped Asian salad, crispy chicken wrap, cheesy potatoes, and old fashioned root beer floats - Wednesday dinner: Cheddar cheese and pea salad, beer brat, "Shy's Sassy Sauerkraut", cool ranch chips, and Jell-O parfait	N 445		

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At approximately 8:08 a.m., Surveyor observed breakfast, plated by Caregiver E. Caregiver E was observed scooping oatmeal from a container onto plates and preparing slices of toast. At approximately 8:10 a.m., Resident 2 was served breakfast (see Photo 1), which consisted of 1 piece of toast and approximately 1 cup of oatmeal. Caregiver E placed the plate in front of Resident 2 and walked back to the kitchen where s/he continued to plate other residents' food. Resident 2 stated to Surveyor, "This ain't much. Toast with nothing on it." No condiments were offered to Resident 2, silverware was not provided to Resident 2, and a drink was not offered to him/her. Resident 2 reported that there generally wasn't enough food served during meals, and that most of the time there wasn't enough food prepared for anyone to have second helpings. Resident 2 reported that last night's dinner consisted of a "couple slices of pizza and potato chips." Resident 2 reported that s/he thought the facility served the "cheapest food possible."

While continuing to observe breakfast, Surveyor observed that each plate prepared and served to residents consisted of approximately 1 cup of oatmeal and 1 slice of toast. A second slice of toast was given to Resident 2 by Caregiver E after s/he asked him/her for more. For approximately 75% of the residents served, Caregiver E was observed to sprinkle a spoonful of brown sugar over their oatmeal and offer grape jelly for toast, which was then provided.

At approximately 9:02 a.m., Surveyor interviewed Resident 3. Resident 3 reported that s/he was often hungry for more food after meals. When asked about whether second helpings were

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available, Resident 3 replied, "Sometimes you get it, sometimes you don't." Resident 3 reported that s/he wished more food was served with meals.

At approximately 9:17 a.m., Surveyor interviewed Resident 4. Resident 4 reported that the food was "up and down." Resident 4 reported that sometimes staff served hot dogs for meals with nothing to put on them. Resident 4 reported that it was the same for hamburgers served. Resident 4 reported that when this occurs and s/he asks for condiments, staff tell him/her that they don't have them. Resident 4 reported that the facility seemed to be frequently out of different foods and drinks, including milk and coffee. Resident 4 reported that last night for dinner pizza was served but there was only enough for each resident to have 1-2 slices and the slices were small. Resident 4 reported that 3 pizzas in total were prepared for all the residents. Resident 4 reported that chips were served as a side and water only was given to drink, with no other food served as part of the meal. Resident 4 reported that s/he asked for more but was told there wasn't enough for anyone to have more. Resident 4 reported that there was "usually just not enough" food prepared and served to residents.

At approximately 10:15 a.m., Surveyor interviewed Resident 2 again. Resident 2 reported that the food "sucked." Resident 2 reported that with last night's dinner, s/he saw Resident 5 given only 1 small slice of pizza. Resident 2 reported that Resident 5 was mad about it and that s/he encouraged him/her to talk to staff about it. Regarding drinks, Resident 2 reported that mostly water was served but every once in a while Kool-Aid was served, but that it was very diluted with water. Resident 2 reported that recently chicken nuggets were served with a

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meal, but several of them were burnt. Resident 2 reported that frequently served meals included pizza, fish patties, chicken nuggets, and some casseroles. Resident 2 reported that fruit cups used to be served but s/he hadn't seen them for awhile. Resident 2 reported that "most of the time" there was just enough food prepared for each resident to have a single helping.

At approximately 11:40 a.m., Surveyor observed lunch being prepared at Cottages of Madison Oakwood, an adjacent community-based residential facility (CBRF) also owned by the same licensee, where meals were prepared due to having a commercial kitchen. Cook F was observed cooking cheeseburgers and preparing fried onions as a topping. Cook F reported that lunch was going to be cheeseburgers with fried onions, french fries, and pickles. Cook F reported that s/he believed there were 14 residents that lived with the provider and so s/he prepared 15 burgers in case someone wanted an extra burger. Surveyor observed that 15 cheeseburgers, 1 container of french fries, approximately 10"x 6" and 5" deep, 1 jar of pickles, and 2 loaves of bread were provided to the provider's staff to prepare for lunch (see Photos 2 and 3)

At approximately 11:56 a.m., Surveyor observed Caregivers C and E plating lunch. In assembling the burgers, both were observed to spread mayonnaise on slices of regular bread and place a burger between the 2 bread slices along with a couple slices of fried onions. Caregivers C and E scooped 1 handful of french fries and placed 1 pickle spear from a jar of pickles onto each plate before serving the meals 1-2 plates at a time to residents (see Photos 4 and 5).

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N 445	Continued From page 21 Surveyor observed that approximately 1 handful of fries remained in the serving container after 10 residents had been served (see Photo 6). Resident 6, who was the last to be served, was provided 2 burgers and the remainder of the fries (see Photo 7). Caregiver C confirmed that after everyone had been served there was 1 burger and no fries leftover. Resident 3 was observed asking Caregiver C for something to drink. Caregiver C replied that there was no more coffee to drink. In reviewing the menu again, Surveyor observed that bacon cheeseburgers were listed as having been served for dinner on Monday (2 days prior to the survey). At approximately 12:34 a.m., Surveyor interviewed Resident 2 about lunch. Resident 2 reported that lunch was "fairly decent" but thought that the mayonnaise being provided on the bread slices was only done because Surveyor was present and observing the meal. Resident 2 reported s/he was surprised that the burgers were served on regular bread slices instead of buns and reported s/he would have preferred a bun since that's the way s/he normally eats burgers. At approximately 12:43 p.m., Surveyor observed the commercial kitchen at Cottages of Madison Oakwood with Cook F, who confirmed that the majority of the food for the licensee's 3 houses (each of them separately licensed CBRFs) used for meal preparation was stored. Surveyor observed the following in the freezer (see Photos 8 and 9): - 1 bag of frozen corn on the cob, with a label indicating that the bag contained 24 cobs - 1 bag of frozen onion rings, with the label	N 445		

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indicated that the bag was approximately 1 lb
- 1 bag of frozen buttermilk biscuits with the label indicated that the bag contained 20 biscuits
- 1 bag of frozen sausage links, approximately half full, with the label indicating that the bag originally contained 50 links
- 1 unmarked bag of what appeared to be approximately 10 frozen biscuits
- 2 slabs of meat that were individually wrapped. Cook F reported that this was chicken meat and was going to be used with tomorrow's dinner
- 1 box of frozen Texas toast, with the label indicating that the box contained 8 slices
- 1 box of frozen cookie dough
- 1 box of frozen Eggo waffles
- 2 trays of frozen chicken breasts
- 1 bag of frozen fries, with the label indicating that the bag was 5 lbs

Cook F confirmed that this was the kitchen's only freezer. Surveyor also observed the kitchen's refrigerator. Between the refrigerator and freezer, Surveyor did not observe any bacon, which was supposed to have been served with breakfast that morning, or brats, which were supposed to be served for the upcoming dinner. Regarding lunch, Cook F reported that s/he provided regular bread instead of burger buns with lunch because s/he wanted to use up the provider's bread before it went bad. Cook F later confirmed that the provider did not have any burger buns on hand. When asked about meals, Cook F reported that s/he tried to prepare a meat, a starch, and a vegetable with each meal. Cook F reported that Administrator A and House Manager B were responsible for ordering food and arranging a menu. Cook F reported that s/he wasn't sure what s/he was going to prepare for dinner that day and that s/he had to touch base with Administrator A to see what was supposed to be

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prepared.

On 04/24/2024, Surveyor reviewed Department records for the licensee's 3 CBRFs served by the same kitchen and food storage area - Cottages of Madison Applewood, Cottages of Madison Oakwood, and Cottages of Madison Elmwood. All 3 were licensed to serve up to 16 residents. A recent survey conducted at Cottages of Madison Oakwood, on 02/21/2024, documented that the that provider's census was 13 residents. A recent survey conducted at Cottages of Madison Elmwood, on 03/20/2024, documented that that provider's census was 14 residents. Surveyor observed a total approximate census, between all 3 CBRFs, of 42 residents.

At approximately 1:15 p.m., Surveyor interviewed Resident 7. Resident 7 reported that sometimes when burgers or hot dogs were served that staff served them with regular bread instead of buns. Resident 7 reported that s/he thought this was due to the provider being out of buns. Resident 7 reported s/he was upset because s/he was told by staff during lunch that there was no more coffee on hand for him/her to drink. Resident 7 reported that it was "ridiculous" that the provider ran out of coffee with lunch because him/herself and Resident 4 liked to drink coffee throughout the day.

At approximately 4:10 p.m., Surveyor interviewed Administrator A and House Manager B. Administrator A reported that s/he typically made a rotating 4-week menu and the provider's 2 cooks - Cook F and Cook G - were responsible for making a grocery list off the menu and ordering the food. Administrator A reported that the food was typically delivered to the provider. Administrator A reported that the owners decided

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on a monthly budget for meals and that it amounted to approximately $6 per resident per meal. Administrator A reported s/he didn't feel like this was enough money and that it was difficult to obtain an adequate food supply, especially with the recent inflating prices of food. Administrator A reported s/he thought s/he was able to get more food for the money with switching food sources from a food preparation/delivery service company to using local grocery stores, but it was still difficult at times. Administrator A reported that s/he has talked with the owners previously about his/her concerns regarding food supply and budget, but the concerns were not really addressed. Administrator A reported s/he was frustrated with the cooks, and in particular Cook F, because s/he felt like the provider had more food on hand than what s/he was choosing to prepare for meals. Administrator A reported that Cook F could prepare more food during meals but for some reason chooses not to. When shown a picture of the breakfast served to residents, Administrator A replied, "Oh my gosh." Administrator A reported s/he did not know oatmeal and toast were what was served for breakfast. When discussing last night's pizza concerns reported by residents, Administrator A reported s/he did not know pizza was served for dinner last night. When shown a picture of the lunch served to residents, Administrator A asked if the burgers were served on regular bread and reported s/he wasn't sure why there wouldn't have been buns on hand. Administrator A confirmed that cheeseburgers were not originally on the lunch menu. When asked about the upcoming dinner menu, Administrator A reported that s/he planned to order pizzas from a local pizza chain restaurant because s/he didn't have time to arrange for an alternate meal. When reviewing the freezer's contents with

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N 445	Continued From page 25 Administrator A, Administrator A reported that s/he was shocked because s/he knew there was more food ordered than what was in the freezer. Administrator A reported that s/he felt like s/he needed to start over with the cooks. At approximately 5:20 p.m., Surveyor observed residents in the dining area eating takeout pizza from a local pizza chain restaurant. Cross Reference: N0450 DHS 83.41(2)(c) Nutrition: Menus	N 445		
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, record review, and interview, the provider did not ensure that deviations from the planned menu were documented on the menu. This requirement is being cited for the second time. See Statement of Deficiency (SOD) 54DT11, issued 03/24/2023. Findings include: On 04/24/2024, Surveyors conducted a complaint investigation into concerns that meals served were not always listed on the menu and that	N 450		

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N 450	Continued From page 26	N 450		

items on the menu were often missing from meals.

On 04/24/2024, at approximately 7:49 a.m., Surveyor observed the weekly menu posted in a glass cabinet located in the facility's dining area. The menu documented that the following was to be served on Tuesday lunch and dinner (the day prior to the survey) and Wednesday breakfast, lunch, and dinner (the day of the survey):

- Tuesday lunch: "[Cook F]'s Famous Beef Burritos," fiesta rice, cheesy refried beans, shredded lettuce, black olives, and sour cream; and popsicles
- Tuesday dinner: Creamy cool cucumbers, egg salad, buttery croissant, kettle chips, and "sinful" chocolate pudding parfait
- Wednesday breakfast: Buttermilk pancakes, Vermont maple syrup, thick cut bacon, and strawberry yogurt
- Wednesday lunch: Chopped Asian salad, crispy chicken wrap, cheesy potatoes, and old fashioned root beer floats
- Wednesday dinner: Cheddar cheese and pea salad, beer brat, "Shy's Sassy Sauerkraut", cool ranch chips, and Jell-O parfait

At approximately 8:08 a.m., Surveyor observed breakfast, plated by Caregiver E. Caregiver E was observed scooping oatmeal from a container onto plates and preparing slices of toast. At approximately 8:10 a.m., Resident 2 was served breakfast (Photo 1), which consisted of 1 piece of toast and approximately 1 cup of oatmeal. Caregiver E placed the plate in front of Resident 2 and walked back to the kitchen where s/he continued to plate other residents' food. Resident 2 stated to Surveyor, "This ain't much. Toast with nothing on it." Resident 2 reported that last night's

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N 450	Continued From page 27 dinner consisted of a "couple slices of pizza and potato chips." While continuing to observe breakfast, Surveyor observed that each plate prepared and served to residents consisted of approximately 1 cup of oatmeal and 1 slice of toast. Surveyor did not observe pancakes, bacon, or yogurt as indicated from the menu. At approximately 8:40 a.m., Surveyor observed the menu again. This time, Surveyor observed that Tuesday's lunch (the day prior to the survey) was crossed out and handwritten annotations of "cheeseburgers" and "french fries" were near the original meal listing At approximately 9:17 a.m., Surveyor interviewed Resident 4. Resident 4 reported that the facility seemed to be frequently out of different foods and drinks, including milk and coffee. Resident 4 reported that last night for dinner pizza was served but there was only enough for each resident to have 1-2 slices and the slices were small. Resident 4 reported that 3 pizzas in total were prepared for all the residents. Resident 4 reported that chips were served as a side and water only was given to drink, with no other food served as part of the meal. At approximately 10:15 a.m., Surveyor interviewed Resident 2 again. Resident 2 reported that the food "sucked." Resident 2 reported that with last night's dinner, s/he saw Resident 5 given only 1 small slice of pizza. Resident 2 reported that frequently served meals included pizza, fish patties, chicken nuggets, and some casseroles. Resident 2 reported that fruit cups used to be served but s/he hadn't seen them for awhile.	N 450		

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N 450	Continued From page 28 At approximately 11:40 a.m., Surveyor observed lunch being prepared at Cottages of Madison Oakwood, an adjacent community-based residential facility (CBRF) also owned by the same licensee, where meals were prepared due to having a commercial kitchen. Cook F was observed cooking cheeseburgers and preparing fried onions as a topping. Cook F reported that lunch was going to be cheeseburgers with fried onions, french fries, and pickles. In reviewing the menu again, Surveyor observed that bacon cheeseburgers were listed as having been served for dinner on Monday (2 days prior to the survey). At approximately 12:43 p.m., Surveyor observed the commercial kitchen at Cottages of Madison Oakwood with Cook F. When asked about meals, Cook F reported that s/he tried to prepare a meat, a starch, and a vegetable with each meal. Cook F reported that Administrator A and House Manager B were responsible for ordering food and arranging a menu. Cook F reported that s/he wasn't sure what s/he was going to prepare for dinner that day and that s/he had to touch base with Administrator A to see what was supposed to be prepared. At approximately 3:58 p.m., Surveyor observed the menu again. The menu was unchanged from the earlier observation. At approximately 4:10 p.m., Surveyor interviewed Administrator A and House Manager B. Administrator A reported that s/he typically made a rotating 4-week menu and the provider's 2 cooks - Cook F and Cook G - were responsible for making a grocery list off the menu and	N 450		

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N 450	Continued From page 29 ordering the food. When shown a picture of the breakfast served to residents, Administrator A replied, "Oh my gosh." Administrator A reported s/he did not know oatmeal and toast were was what was served for breakfast. In discussing lunch, Administrator A confirmed that cheeseburgers were not originally on the lunch menu. When asked about the upcoming dinner menu, Administrator A reported that s/he planned to order pizzas from a local restaurant because s/he didn't have time to arrange for an alternate meal. At approximately 5:20 p.m., Surveyor observed residents in the dining area eating takeout pizza from a local pizza chain restaurant. Surveyor observed the menu again, which was unchanged from the observation earlier that day and showed that cheddar cheese and pea salad, beer brats, ranch chips, and Jell-O parfaits were to be served. Cross Reference: N0445 DHS 83.41(1)(a) Food Supply	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above	N 452		

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N 452	Continued From page 30 and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the CBRF prepared and served food under sanitary conditions, including holding hot foods at 140° Fahrenheit (F) until serving. This requirement is being cited for the second time. See Statement of Deficiency (SOD) FT8K11, issued 03/17/2023. Findings include: Example 1 - Hygiene According to the Food and Drug Administration (FDA) employees that handle food should wash their hands when they enter a food preparation area, before engaging in food preparation, after handling soiled dishes, and after eating and drinking. Bare hand use with ready-to-eat food is discouraged due to the potential for food contamination. Additionally, hair restraints should be worn (Source: U.S. Food and Drug Administration, Employee Health and Personal Hygiene Handbook, 2020, https://www.fda.gov/media/77065/download (retrieval date - April 25, 2024).). According to the Wisconsin Department of Agriculture, Trade and Consumer Protection (WI	N 452		

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N 452	Continued From page 31 DATCP), food employees should wear hair restraints such as hair nets, hats, and beard nets that are effective in keeping hair under control (Source: WI DATCP, Wisconsin Food Code Fact Sheet: Employee Hygiene and Cleanliness, November 2020, https://datcp.wi.gov/Documents/EmployeeHygieneFactSheet.pdf (retrieval date - April 25, 2024).). On 04/24/2024, at approximately 8:17 a.m., Surveyor observed Caregiver E preparing breakfast plates in the kitchen with bare hands. Caregiver E was observed scooping oatmeal from a container onto plates and preparing slices of toast by placing bread in the toaster, removing heated toast, and spreading jelly onto the toasted slices as s/he held them. Caregiver E's hair, which was observed to be approximately shoulder-length, was observed to be down throughout the process. After a few plates were prepared, Caregiver E was observed leaving the kitchen area and walking towards the hallway near resident bedrooms. After a couple of minutes, Caregiver E walked back to the kitchen area and served Resident 5 a plate. When Surveyor asked where Caregiver E went, s/he replied, "I was helping [Resident 5] get down for breakfast." Caregiver E went back to the kitchen and began pouring cups of water for residents. After serving the cups to residents, Caregiver E left the kitchen and walked to Resident 8's room, where s/he was observed to hold his/her door handle with his/her right hand while offering Resident 8 breakfast. Caregiver E then walked to Resident 9's room and knocked on his/her door (which was open) while s/he alerted his/her presence and offered breakfast. Caregiver E returned to the kitchen where s/he then scooped oatmeal onto a plate and prepared a slice of toast with grape jelly. Throughout the above	N 452		

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observations, Caregiver E was not observed to conduct any hand hygiene. After preparing toast and handing it to Resident 3, Caregiver E was observed to put a pair of gloves on, and prepare another breakfast plate.

At approximately 11:40 a.m., Surveyor observed lunch being prepared at Cottages of Madison Oakwood, an adjacent community-based residential facility (CBRF) also owned by the same licensee, where meals were prepared due to having a commercial kitchen. Cook F was observed cooking cheeseburgers and preparing fried onions as a topping. Cook F's hair was observed tied back, but with no hairnet covering his/her hair. Cook F reported that s/he usually wore a hairnet when preparing foods but s/he wasn't sure where they had been since the kitchen was recently remodeled, which caused things to be moved from their normal places. Cook F reported that the kitchen was remodeled approximately 3 weeks ago.

At approximately 12:43 p.m., Surveyor interviewed Cook F in the commercial kitchen of Cottages of Madison Oakwood, where meals for the provider's community were routinely prepared. During the interview, Cook F was observed to find hairnets at the top of a shelf in the kitchen. Cook F then donned a hairnet.

At approximately 4:10 p.m., Surveyor interviewed Administrator A and House Manager B. Administrator A reported that staff should know hygiene protocols with food preparation and that they should have been wearing gloves. Administrator A reported s/he was thinking of having more dietary training arranged for staff.

Example 2 - Breakfast and lunch food

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N 452	Continued From page 33 temperatures According to the U.S. Department of Agriculture, hot food should be maintained at or above 140°F due to the risk of bacteria growth, which "grows most rapidly in the range of temperatures between 40°F and 140°F, doubling in as little as 20 minutes," (Source: U.S. Department of Agriculture, "Danger Zone" (40°F - 140°F), June 28, 2017, https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/danger-zone-40f-140f (retrieval date - June 11, 2024).). On 04/24/2024, at approximately 8:10 a.m., Surveyor observed Resident 2 being served a breakfast plate by Caregiver E, which consisted of oatmeal and 1 slice of toast. Resident 2 reported to Surveyor that the oatmeal was "ice cold" and that many meals served by staff were cold when they were supposed to be hot. At approximately 8:17 a.m., Surveyor observed Caregiver E preparing breakfast plates in the kitchen. Caregiver E was observed scooping oatmeal from a container onto plates and preparing slices of toast by placing bread in the toaster, removing heated toast, and spreading jelly onto the toasted slices. The oatmeal was observed to be in a served from a serving tray sitting on the counter. Surveyor did not observe a heating mechanism to keep the oatmeal warm while breakfast plates were being prepared by Caregiver E. Caregiver E confirmed that the oatmeal had been prepared at and brought down from Cottages of Madison Oakwood - a community based residential facility (CBRF) next door. At approximately 8:43 a.m., Surveyor interviewed	N 452		

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Resident 7. Resident 7 reported that hot meals were usually served lukewarm or even cold.

At approximately 8:50 a.m., Surveyor observed Caregiver C prepare a breakfast plate for Resident 10. Caregiver C was observed scooping oatmeal from the serving tray on the counter and preparing 1 slice of toast. While Caregiver C left the kitchen to deliver the plate to Resident 10 in his/her room, Surveyor requested a sample of oatmeal to test. Upon being provided the oatmeal, at 8:51 a.m., Surveyor immediately took its temperature, which reached a maximum temperature of 82.4°F.

At approximately 9:02 a.m., Surveyor interviewed Resident 3. Resident 3 reported that "sometimes" hot plates were served cold.

At approximately 9:17 a.m., Surveyor interviewed Resident 4. Resident 4 reported that meals were brought down from the other building and even after they were delivered, it sometimes wasn't served to the residents until later. Resident 4 reported that because of this, the hot food served was usually pretty cold. Resident 4 reported that sometimes staff reheated the food in the kitchen after it was delivered.

At approximately 10:15 a.m., Surveyor interviewed Resident 2 again. Resident 2 reported that s/he had previously argued with staff about food "always" being cold but that s/he gave up because the staff didn't seem to pay attention to residents' needs.

At approximately 11:40 a.m., Surveyor observed lunch being prepared at Cottages of Madison Oakwood, an adjacent community-based residential facility (CBRF) also owned by the

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same licensee, where meals were prepared due to having a commercial kitchen. Cook F was observed cooking cheeseburgers and preparing fried onions as a topping. Fries were already observed in a serving tray with a plastic wrap over the top. Cook F confirmed that s/he had prepared all 3 of the provider's community CBRFs meals at the same time. At approximately 11:45 a.m. (5 minutes later), Cook F finished cooking the last burgers and placed them in pans. Cook F then put plastic wrap over the top of the burger trays. At approximately 11:47 a.m., Cook F was observed to load the trays of burgers and fries into a meal cart. Cook F confirmed that s/he was loading the food for the 2 other CBRFs at the same time. Surveyor and Cook F walked outside to Cottages of Madison Elmwood (the CBRF closest to Cottages of Madison Oakwood), approximately 15 yards away. At 11:51 a.m., Cook F delivered a tray of burgers and a tray of fries to Elmwood staff. Surveyor and Cook F then walked outside to Cottages of Madison Applewood, approximately 50 yards away. At 11:55 a.m., Cook F delivered a tray of burgers and a tray of fries to Applewood staff. At 11:59 a.m., approximately 14 minutes after the the burgers were finished cooking by Cook F, Caregiver C was observed preparing lunch plates. While lunch was being prepared, the trays of burgers and fries were observed sitting on the counter, open to the environment, with no mechanism to maintain their warmth (Photo 5). The first lunch plate was served at 12:00 p.m. After most of the meals had been served, Surveyor requested a burger sample to test. Upon being provided the burger, at 12:10 p.m., Surveyor immediately took its temperature, which reached a maximum temperature of 80.4°F. After Surveyor tested the sample burger, Resident 6 was observed to be served 2 burgers from the

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same burger tray.

At approximately 12:34 p.m., Surveyor interviewed Resident 2 about lunch. Resident 2 reported that his/her burger was "fairly" warm but not "really" warm.

At approximately 12:43 p.m., Surveyor interviewed Cook F in the commercial kitchen of Cottages of Madison Oakwood, where meals for the provider's community were routinely prepared. Cook F reported that s/he has thermometers that s/he routinely uses to test meat and hot plate temperatures. Cook F reported that s/he tested hot plate temperatures for every meal. Cook F confirmed Surveyor's observation that temperatures weren't taken with the earlier lunch meal and also denied that s/he tested the oatmeal temperature with breakfast. Cook F reported that this was because s/he had been unable to find his/her thermometers since the kitchen was remodeled, which caused things to be moved from their normal places. Cook F reported that the kitchen was remodeled approximately 3 weeks ago. Cook F confirmed that s/he currently did not know where any thermometers were for testing food temperatures.

At approximately 1:15 p.m., Surveyor interviewed Resident 7. Resident 7 reported that s/he didn't think his/her burger was cooked all the way through and so s/he stopped eating it. Resident 7 reported s/he told one of the staff about it but couldn't recall who. Resident 7 reported that when his/her burger was served it was "a little warm."

At approximately 4:10 p.m., Surveyor interviewed Administrator A and House Manager B. Administrator A reported that the provider has

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N 452	Continued From page 37 thermometers on hand and that Cook F should have known where they were. Administrator A reported that near the kitchen s/he has a binder that staff can reference for minimum food temperatures. Administrator A reported that the cart used to transport food from Oakwood to the other 2 CBRFs was insulated but wasn't heated. Administrator A reported s/he was ordering steam plates for the other homes to have to help heat up food prior to being served.	N 452		
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 that the living environment was clean and homelike. This requirement is being cited for the third time. See Statement of Deficiency (SOD) SOD 54DT11, issued 03/24/2023, and FT8K12, issued 06/16/2023. Findings include: Example 1 - Fire panel On 04/24/2024, at approximately 7:52 a.m., Surveyors arrived onsite. Upon entry to the building, a beeping tone was heard throughout	N 481		

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the common area. House Manager B reported that the beeping was related to the facility's fire panel, and had been going on and off daily since the last snow storm. House Manager B reported that the provider was having someone come out to re-wire the system. The beeping was audible throughout all the provider's common areas, including the dining area and living room, and sounded constantly from the time Surveyors arrived onsite until the time Surveyors left the building at approximately 5:20 p.m (Videos 1, 2, and 3).

At approximately 11:15 a.m., Surveyor interviewed Regional Director H. Regional Director H reported that approximately 2 weeks ago there was a storm which affected their fire panel system. Regional Director H reported that the issue was supposed to resolve itself but didn't. Regional Director H reported that a part of the system was then replaced which was supposed to resolve the issue within a week, but it hadn't been resolved. Regional Director H reported that Licensee I was supposed to hear back from the fire panel company but didn't, and so reached out for assistance. Regional Director H reported that the company replied they would send a technician out. Surveyor requested evidence of all communications between the provider and the fire panel company regarding the beeping concern from Regional Director H. Surveyor then reviewed the provided records, which consisted of the following:

- An e-mail from Representative J, from the provider's fire panel company, to Licensee I, dated 04/04/2024 at 4:49 p.m., which documented, "Your case [case number] is now resolved! Detailed information specific to your ticket can be found below..."

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	0017703	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON APPLEWOOD	5565 BURKE RD MADISON, WI 53718

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- An e-mail from Representative J to Licensee I, dated 04/24/2024 at 10:17 a.m. (approximately 2 hours after Surveyors were onsite), which documented, "Due to the recent storms and power outages, there were some components on [company system] that needed some attention. We got all those pieces up and running at full strength. When this first happened, we believed the issues at your sites would be resolved when these got full strength. We have a technician scheduled onsite on Thursday April 25th to troubleshoot your individual components."

At approximately 1:15 p.m., Surveyor interviewed Resident 7. Resident 7 confirmed that s/he could hear the beeping and stated, "It's been beeping so much, it's kind of annoying." Resident 7 reported that the beeping persisted throughout the entire day and that it had been going on for a long time.

At approximately 3:20 p.m., Surveyor interviewed Administrator A. Administrator A stated, "I'm about ready for it be done," regarding the beeping.

At approximately 4:10 p.m., Surveyor interviewed Administrator A and House Manager B. Administrator A confirmed that the snowstorm that initially caused fire panel issues occurred on 04/04/2024, and that the beeping had been occurring since the following day, 04/05/2024 (approximately 2.5 weeks prior to the survey). Administrator A reported that Licensee I typically handled any fire panel issues. Administrator A acknowledged Surveyor's concern that there didn't seem to be any evidence of staff attempting to troubleshoot the beeping concern until that morning during the survey with Licensee I's e-mails. Administrator A reported that maybe

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Licensee I had texted the fire panel company's staff about the issue.

On 04/26/2024, at approximately 8:44 a.m., Surveyor interviewed Representative J. Representative J reported that there were service outages after a snowstorm in early April which negatively affected the company's entire signaling abilities until approximately early last week when the issue was resolved on their end. Representative J reported that s/he had received a communication from the facility on 04/24/2024 (the day of the survey) about a fire panel issue. When asked if there were any other communications from the provider to the company, Representative J reported that Licensee I appeared to have reached out for a status update on 04/09/2024 regarding the initial fire panel problems after the storm. Representative J reported that this was during the time that the company was still trying to resolve their signaling system and so this information was relayed back to Licensee I. Representative J reported that a technician was supposed to be on site yesterday, but had emergencies that came up and so s/he was scheduled to be on site today to help resolve the issue. When asked if there was anything staff could do to resolve the constant beeping, Representative J reported that s/he was unaware that the provider's system was beeping that frequently. Representative J reported that if that information would have been relayed to him/her, a technician could have worked with them earlier to try to troubleshoot the system.

Example 2 - Coffee machine

At approximately 8:17 a.m., Surveyor observed breakfast. Surveyor observed Residents 3, 4, and

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7 drinking coffee with breakfast. Surveyor observed a coffee maker on the kitchen counter, with some coffee still in the pot. Surveyor observed that the top of the machine, where water is dispensed into, appeared to have build up and crust consistent in appearance with limescale, all around the border (Photo 10). At approximately 8:50 a.m., Surveyor interviewed Caregiver E about the coffee maker. Caregiver E confirmed that the top area was where water was dispensed into the appliance. Caregiver E reported that several of the residents drank coffee and so coffee was typically served with breakfast, lunch, and sometimes dinner.

On 04/26/2024, at approximately 12:59 p.m., Surveyor interviewed Administrator A about the coffee maker through e-mail. Administrator A replied that s/he would have someone take a look at it.

Example 3 - Toilet paper holders

At approximately 12:15 p.m., Surveyor observed the provider's 3 bathrooms while touring the facility. Surveyor observed a resident bathroom labeled as bathroom "A." A roll of toilet paper was observed sitting on the toilet tank. A toilet paper dispenser on the wall adjacent to the toilet was empty, with the roll holder missing. Surveyor then observed an unlabeled resident bathroom near room 13. A roll of toilet paper was observed sitting on the toilet tank. A toilet paper dispenser on the wall adjacent to the toilet was empty, with the roll holder missing.

At approximately 1:15 p.m., Surveyor interviewed Resident 7. Resident 7 reported that toilet paper in the resident bathrooms was only sometimes on the roll holder. At approximately 4:00 p.m.,

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N 481	Continued From page 42 Surveyor observed the provider's 3 bathrooms again. No changes were observed from Surveyor's earlier observations. At approximately 4:10 p.m., Surveyor interviewed Administrator A and House Manager B. Administrator A reported that toilet paper was usually on the roll holders. House Manager B reported that residents sometimes took the toilet paper.	N 481		
N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 3 of 3 of the provider's bathroom sink areas had dispensers being used for single use paper towels, cloth towel dispensing units enclosed for protection, or electric hand dryers. Findings include: At approximately 9:17 a.m., Surveyor interviewed Resident 4. Resident 4 reported that the bathroom near his/her room, which s/he typically used, had not had paper towels for the past month but they were put out after Surveyors arrived on site. Resident 4 reported that s/he thought it was unsanitary. At approximately 12:15 p.m., Surveyor observed the provider's 3 bathrooms while touring the	N 612		

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N 612	Continued From page 43 facility. Surveyor observed a resident bathroom labeled as bathroom "A." An empty paper towel dispenser was observed on the wall, and a roll of paper towel was observed on the counter. No other means of hand drying was observed in the bathroom. Surveyor then observed a bathroom labeled "Employees Only" which also had an empty paper towel dispenser on the wall. A roll of paper towel was observed on the counter. No other means of hand drying was observed in the bathroom. Surveyor then observed an unlabeled resident bathroom near room 13. An empty paper towel dispenser was observed on the wall, and three rolls of paper towel were observed on the counter. At approximately 1:15 p.m., Surveyor interviewed Resident 7. Resident 7 reported that only sometimes paper towels were in the bathroom dispensers. At approximately 4:00 p.m., Surveyor observed the provider's 3 bathrooms again. No changes were observed from Surveyor's earlier observations. At approximately 4:10 p.m., Surveyor interviewed Administrator A and House Manager B. Administrator A reported that s/he had directed maintenance staff yesterday to fill the paper towel dispensers with paper towel. Administrator A reported that the dispensers of the provider's other 2 CBRFs in the community were filled so s/he wasn't sure why this facility's dispensers weren't addressed.	N 612		