STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 09/09/2025 with information gathered through 09/16/2025, Surveyors conducted 1 verification visit at Cottages Of Madison Applewood. Two deficiencies were identified. The deficiencies were repeat violations. See Statement of Deficiency (SOD) UDWF11, dated 01/29/2021, UDWF12, dated 05/18/2021, SOD 54DT11, dated 12/02/2022, SOD FT8K11, dated 02/16/2023, SOD FT8K12, dated 06/05/2023, SOD OCCY12, dated 10/02/2024, and SOD OCCY13, dated 02/24/2025. Fifteen of 16 violations from Statement of Deficiency (SOD) OCCY13, dated 02/24/2025, were substantially corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 6	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner.	{N 352}		

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

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{N 352}	Continued From page 1 During July 2025, August 2025 and September 2025, 6 of 6 total residents residing at facility had not received all scheduled prescription medications as prescribed. This requirement is being cited for the seventh time. See Statement of Deficiency (SOD) UDWF11, dated 01/29/2021, UDWF12, dated 05/18/2021, SOD 54DT11, dated 12/02/2022, SOD FT8K12, dated 06/05/2023, SOD OCCY12, dated 10/02/2024, and SOD OCCY13, dated 02/24/2025. Findings include: The facility is licensed as a Class CNA CBRF able to serve up to 16 residents in the client groups of advanced aged, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, and physically disabled. Census on 09/09/2025 was 6. On 09/09/2025, Surveyors inspected the medication cart, requested resident records including current individual service plans (ISP) for Resident 4, Resident 5, Resident 7, Resident 11, Resident 15, and Resident 18, and reviewed their records. On 09/09/2025 at 9:03 AM, Surveyor inspected the medication cart with Med Passer HHH after s/he had finished the AM med pass and observed the following scheduled medication's bubble packs: Example 1- Resident 5 -AM acetaminophen Pharmacy labeled identified: acetaminophen 325 MG	{N 352}		

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{N 352}	Continued From page 2 take 2 tablets once daily 62 tablets dispensed 08/01/2025 From 08/17/2025-09/09/2025, 2 tablets remained in the 09/01/2025 slot (Photo 1). -AM aspirin Pharmacy label identified: aspirin 81 MG take 1 tablet once daily 31 tablets dispensed 08/01/2025 From 08/17/2025-09/09/2025, 1 tablet remained in the 09/01/2025 (Photo 2). -AM furosemide Pharmacy label identified: furosemide 20 MG take 1 tablet once daily 31 tabs dispensed 08/01/2025 From 08/17/2025-09/092025, 1 tablet remained in the 09/01/2025 slot (Photo 3). -AM spironolactone Pharmacy label identified: spironolactone 25 MG take 1 tablet once daily 31 tabs dispensed 08/01/2025 From 08/17/2025-09/09/2025, 1 tablet remained in the 09/01/2025 slot (Photo 4) -Bedtime carvedilol 3.125 MG Pharmacy label identified: carvedilol 3.125 MG take 1 tablet twice daily 62 tablets dispensed 08/01/2025 (31 in AM bubble pack and 31 in PM bubble pack) One tablet was removed from each the 09/14/2025 and 09/15/2025 slots. From 08/17/2025-09/08/2025, 1 tablet remained in each the 08/23/2025, 08/24/2025, 08/25/2025, 08/29/2025, 09/05/2025 and 09/06/2025 slots	{N 352}		

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{N 352}	Continued From page 3 (Photo 5). If the 09/14/2025 and 09/15/2025 tablets were inadvertently removed in place of 2 of the remaining tablets, 4 extra tablets remained. -Bedtime melatonin 3 MG Pharmacy label identified: melatonin 3 MG take 1 tablet daily at bedtime 31 tablets dispensed 08/01/2025 1 tablet was removed from each the 09/13/2025 and 09/15/2025 slots. From 08/17/2025-09/08/2025, 1 tablet remained in each the 08/23/2025, 08/24/2025, 08/25/2025, 08/29/2025, 09/05/2025 and 09/07/2025 slots. If the 09/13/2025 and 09/15/2025 tablets were inadvertently removed in place of 2 of the remaining tablets, 4 extra tablets remained (Photo 6). Resident 5 was admitted 01/12/2021. Physician orders included: acetaminophen 325 MG take 2 tablets once daily; aspirin 81 MG take 1 tablet once daily for coronary artery disease (start 02/26/2025); furosemide 20 MG take 1 tablet once daily for edema (start 02/26/2025); spironolactone 25 MG take 1 tablet once daily for heart failure (start 02/26/2025); carvedilol 3.125 MG take 1 tablet twice daily for heart failure (start 02/25/2025); and melatonin 3 MG take 1 tablet daily at bedtime for sleep (start 02/25/2025). Medication Administration Record (MAR): On 09/01/2025, staff documented administration of AM acetaminophen 325 MG aspirin 81 MG, furosemide 20 MG, and spironolactone 25 MG. From 08/17/2025-09/08/2025, staff documented administration of bedtime carvedilol 3.125 MG	{N 352}		

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{N 352}	Continued From page 4 and melatonin 3 MG daily. Observation notes dated 08/17/2025-09/09/2025 did not address why medications were documented as administered but left in bubble packs. ISP (not signed or dated): In the area of Medication Management: " ...Staff to perform all medication administration tasks as prescribed by physician ..." Example 2- Resident 7 -AM acetaminophen Pharmacy label identified: acetaminophen 500 MG take 2 tablets 3 times daily 186 tablets dispensed 08/01/2025 (2 tablets 3 times daily for 31 days = 186 tablets). From 08/18/2025-09/09/2025, 2 tablets remained in 09/01/2025 slot (Photo 7). -AM omeprazole DR 20 MG Pharmacy label identified: omeprazole DR 20 MG take 1 capsule twice daily 62 capsules dispensed 08/01/2025 (1 capsule 2 times daily for 31 days = 62 capsules) From 08/18/2025-09/09/2025, 1 tablet remained in 09/01/2025 slot (Photo 8). -AM folic acid Pharmacy label identified: folic acid 1 MG take 2 tablets once daily 62 tablets dispensed 08/01/2025 From 08/18/2025-09/09/2025, 1 tablet remained in 09/01/2025 slot (Photo 9). -AM duloxetine HCL	{N 352}		

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{N 352}	Continued From page 5 Pharmacy label identified: duloxetine HCL DR 60 MG take 1 capsule once daily 31 capsules dispensed 08/01/2025 From 08/18/2025-09/09/2025, 1 tablet remained in 09/01/2025 slot (Photo 10). -AM aspirin 81 MG Pharmacy label identified: aspirin 81 MG take 1 tablet once daily 31 tablets dispensed 08/01/2025 From 08/18/2025-09/09/2025, 1 tablet remained in 09/01/2025 slot (photo 11). Resident 7 was admitted 12/30/2023. Physician orders included: acetaminophen 500 MG take 2 tablets 3 times daily for pain (start date 06/11/2025); omeprazole DR 20 MG take 1 capsule twice daily for gastro esophageal reflux disease (start 03/40/2025); folic acid 1 MG take 2 tablets once daily for supplement (start 08/01/2025); duloxetine HCL DR 60 MG take 1 capsule once daily for fibromyalgia (start 08/01/2025); and aspirin 81 MG take 1 tablet once daily for normal pressure hydrocephalus (start 07/18/2025). MAR: From 08/18/2025 - 09/09/2025, staff documented daily administration of AM acetaminophen 500 MG, duloxetine HCL 60 MG, folic acid 1 MG, omeprazole DR 20 MG, and aspirin 81 MG. On 09/01/2025, Caregiver F documented administration of AM (8:00 AM) medications at 2:33 PM and 2:36 PM. Observation notes dated 08/18/2025-09/09/2025 did not address why medications were documented as administered when left in bubble	{N 352}		

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{N 352}	Continued From page 6 packs or why 09/01/2025 8:00 AM medications were documented as administered at 2:33 PM and 2:36 PM. ISP dated (not signed or dated, was received via email from House Manager GGG on 09/15/2025 5:17 PM.): In the area of Medication Management: " ... All medications are to be administered by trained staff in accordance with all physician orders ..." On 09/09/2025 at 10:05 AM, Surveyor interviewed Administrator FFF and showed him/her Resident 5's and Resident 7's bubble packs in the medication cart. Administrator FFF stated the cycle fill started on 08/17/2025 or 08/18/2025 depending on the resident and medication. Administrator FFF stated s/he could not account for extra medication left in the bubble packs unless staff were punching them out of the wrong slots. On 09/09/2025 at 10:53 AM, Surveyor interviewed Caregiver F and reviewed 09/01/2025 AM MAR documentation him/her. Caregiver F stated s/he worked 09/01/2025 but did not know why Resident 7's AM medications were signed out at 2:33 PM- 2:36 PM. Example 3- Resident 11 -AM stimulant laxative plus Pharmacy label identified: stimulant laxative plus 3 tablets twice daily 186 tablets dispensed 08/01/2025 (3 tablets twice daily for 31 days = 186 tablets) From 08/17/2025- 09/09/2025, 3 tablets remained in each the 08/24/2025 (per MAR not administered due to loose stools) and 09/01/2025 slots (Photo 12).	{N 352}		

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{N 352}	Continued From page 7 -Noon carbidopa-levodopa Pharmacy label identified: carbidopa-levodopa 25-250 1 tablet 4 times daily 124 tablets were dispensed on 08/01/2025 (4 tablets daily for 31 days = 124). One tablet was removed from the 09/09/2025 slot. From 08/17/2025-09/09/2025, 1 tablet remained in each the 09/01/2025 and 09/02/2025 slots. If the 09/09/2025 tablet was inadvertently removed in place of 1 of the remaining tablets, 1 extra tablet remained (Photo 13). Resident 11 was admitted 12/22/2023. Physician orders included stimulant laxative plus take 3 tablets twice daily for constipation (start 04/29/2025) and carbidopa-levodopa 25-250 take 1 tablet 4 times daily for Parkinson's disease (start 08/01/2025). MAR (September 2025 MAR was received via email from House Manager GGG on 09/15/2025 5:17 PM.): From 08/17/2025, staff documented daily administration of AM stimulant laxative plus except on 08/18/2025 staff coded "4" (not given, due to loose stools). From 08/17/2025-09/08/2025 staff documented daily administration of noon carbidopa-levodopa 25-250. Observation notes dated 08/17/2025-09/09/2025 did not address why medications were documented as administered when left in bubble packs. ISP dated 05/05/2025 " ...To receive assistance from staff with	{N 352}		

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{N 352}	Continued From page 8 managing/administering medications per physician's orders ..." Example 4- Resident 15 -AM amlodipine besylate Pharmacy label identified: amlodipine besylate 5 MG 1 tablet once daily 31 tablets dispensed 08/01/2025 From 08/17/2025-09/09/2025, 1 tablet remained in the 09/01/2025 slot (Photo 14). AM levetiracetam Pharmacy label identified: levetiracetam 250 MG 1 tablet twice daily 62 tablets dispensed 08/01/2025 (1 tablet twice daily for 31 days = 62 tablets) From 08/17/2025 - 09/09/2025, 1 tablet remained in 09/01/2025 slot (Photo 15). -Bedtime donepezil Pharmacy label identified: donepezil HCL 10 MG 1 tablet once daily 31 tablets dispensed 08/01/2025 From 08/17/2025- 09/08/2025, 1 tablet remained in 08/23/2025, 08/25/2025, 08/29/2025, and 09/07/2025 slots (Photo 16). -Bedtime famotidine Pharmacy label identified: famotidine 20 MG 1 tablet once daily 31 tablets dispensed 08/01/2025 From 08/17/2025-09/08/2025, 1 tablet remained in 08/18/2025, 08/25/2025, 08/29/2025 and 09/07/2025 slots (photo 17). -Bedtime mirtazapine	{N 352}		

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{N 352}	Continued From page 9	{N 352}		

Pharmacy label identified:
mirtazapine 7.5 MG
1 tablet once daily at bedtime
31 tablets dispensed 08/01/2025 (Photo 18).
From 08/17/2025-09/08/2025, 1 tablet remained in 08/18/2025, 08/25/2025, 08/29/2025, and 09/06/2025 slots.

-Bedtime terazosin
Pharmacy label identified:
terazosin 1 MG
1 capsule once daily at bedtime
31 capsules were dispensed on 08/01/2025
From 08/17/2025-09/08/2025, 1 capsule remained in the 08/18/2025, 08/25/2025, 08/29/2025 and 09/06/2025 slots (photo 19).

Bedtime trazadone 50 MG
Pharmacy label identified:
trazadone 50 MG
take 1 tablet daily at bedtime
31 tablets were dispensed 08/01/2025
1 tablet was removed from the 09/15/2025 slot.

From 08/17/2025-09/08/2025, 1 tablet remained in each the 08/18/2025, 08/24/2025, 08/25/2025, 08/29/2025, and 09/06/2025 slots. If the 09/15/2025 tablet was inadvertently removed in place of 1 of the remaining tablets, 4 extra tablets remained (Photo 20).

Resident 15 was admitted 12/30/2019.
Physician orders included: amlodipine besylate 5 MG 1 tablet once daily for hypertension (start 04/18/2025); levetiracetam 250 MG 1 tablet twice daily for seizures (start date 06/14/2025); donepezil HCL 10 MG 1 tablet once daily for dementia (start 04/28/2015); famotidine 20 MG 1 tablet once daily for gastroesophageal reflux disease (start 04/17/2025); mirtazapine 7.5 MG 1

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{N 352}	Continued From page 10 tablet once daily at bedtime for anorexia (start 04/17/2025); terazosin 1 MG 1 capsule once daily at bedtime for benign prostatic hyperplasia (enlarged prostate) (start 04/17/2025); and trazadone 50 MG 1 tablet daily at bedtime for insomnia (start 04/17/2025). MAR From 08/17/2025-09/08/2025 staff documented daily administration of AM amlodipine besylate 5 MG and levetiracetam 250 MG and PM donepezil HCL 10 MG, famotidine 20 MG, mirtazapine 7.5 MG, terazosin 1 MG, and trazadone 50 MG. Observation notes dated 08/17/2025-09/08/2025 did not address why medications were documented as administered when left in bubble packs. ISP (not signed or dated): In the area of Medication Management " ...Staff controls medication administration due to dementia diagnosis ..." Example 5- Resident 18 -AM diclofenac sodium DR Pharmacy label identified: diclofenac sodium DR 75 MG 1 tablet twice daily 48 tablets dispensed 08/25/2025 (08/26/2025-09/18/2025 twice daily= 28 tablets) One tablet was removed from 09/18/2025 slot. From 08/26/2025-09/09/2025, 1 tablet remained in each the 09/01/2025, 09/04/2025, and 09/09/2025 slots. If the 09/18/2025 tablet was inadvertently removed in place of 1 of the remaining tablets, 1 extra tablet remained (Photo 21).	{N 352}		

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{N 352}	Continued From page 11 -Evening diclofenac sodium 75 MG Pharmacy label identified: diclofenac sodium 75 MG 1 tablet twice daily 48 tablets dispensed 08/25/2025 From 08/26/2025-09/08/2025, 1 tablet remained in each the 08/26/2025 and 08/27/2025 slots, and a tablet was removed from the 09/06/2025 slot (when staff documented it was not administered when Resident 4 was out with family). If a tablet was inadvertently administered from the 09/06/2025 slot on 08/26/2025 or 08/27/2025, 1 extra tablet remained (Photo 22). Example 6- Resident 4 On 09/09/2025 at 10:00 AM, Surveyor reviewed Resident 4' medical record. Resident 18 was admitted 09/06/2024. with diagnoses that include but are not limited to: Hypo-osmolality and hyponatremia, schizoaffective disorder, transient global amnesia, chronic pain, COPD, spinal stenosis. Physician orders included: diclofenac sodium DR 75 MG take 1 tablet twice daily for pain in right hip (start date 08/25/2025), buspirone HCL 15 MG tablet and Vitamin D3 125 microgram(mcg) tablet. MAR From 08/26/2025-09/09/2025, staff documented daily administration of AM diclofenac sodium DR 75 MG except 09/04/2025 when s/he was at an appointment and 09/7/2025 and 09/08/2025 when s/he was out with family. On 08/26/2025- 09/08/2025, staff documented daily administration of PM diclofenac sodium DR	{N 352}		

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{N 352}	Continued From page 12 75 MG except on 09/06/2025, 09/07/2025 and 09/08/2025 when they documented Resident 4 was with family. Staff documented Resident 18 did not receive buspirone and vitamin D3 on the following dates: 08/12/2025 Buspirone HCL 15 mg tablet REASON: medication not available 08/24/2025 Vitamin D3 125 mcg tablet REASON: medication not available 08/25/2025 Vitamin D3 125 mcg tablet REASON: medication not available 08/26/2025 Vitamin D3 125 mcg tablet REASON: medication not available 08/27/2025 Vitamin D3 125 mcg tablet REASON: medication not available 08/28/2025 Vitamin D3 125 mcg tablet REASON: medication not available 08/29/2025 Vitamin D3 125 mcg tablet REASON: medication not available Observation notes dated 08/17/2025-09/09/2025 did not address why medications were documented as administered when left in bubble packs. ISP dated 08/25/2025 In the area of Medication Administration: " ...Medication administered by staff ..." Example 6: Resident 4 On 09/09/2025 at 10:15 AM, Surveyor reviewed Resident 4' medical record. Resident 4 was admitted 09/02/2022 with diagnoses that include but are not limited to: Insomnia, peripheral autonomic neuropathy, atrial fibrillation and flutter, GERD, cirrhosis of liver, osteoarthritis, chronic gout.	{N 352}		

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 _____	R-C 09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{N 352}	Continued From page 13 Resident 4 was prescribed Acetaminophen 325 mg tablet and Febuxostat 40 mg tablet for gout and pain. Resident 4 did not receive either medication on the following dates: 07/13/2025 Febuxostat 40 mg tablet REASON: medication not available 07/16/2025 Acetaminophen 325 mg REASON: medication not available 07/17/2025 Febuxostat 40 mg tablet REASON: medication not available 07/21/2025 Febuxostat 40 mg tablet REASON: medication not available 07/23/2025 Febuxostat 40 mg tablet REASON: medication not available On 09/09/2025 at 1:36 PM, Surveyors discussed concern of medication administration with Administrator FFF and House Manager GGG. Administrator FFF stated the nurse was responsible for auditing medication carts and that there were problems with medications in all 3 of their buildings.	{N 352}		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the	N 387		

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N 387	Continued From page 14 development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan (ISP) was signed by the resident or the resident's legal representative acknowledging their involvement in, understanding of and agreement with the plan. ISPs were not signed for 3 of 4 residents reviewed. This is a repeat violation. See Statement of Deficiency (SOD) FT8K11 dated 02/16/2023 and FT8K12, dated 06/05/2023. Findings include: On 09/09/2025 at approximately 10:00 PM, Surveyors requested resident records, including current ISPs with signature sheets for Resident 5, Resident 7, and Resident 15 from Administrator FFF. Administrator FFF provided ISPs for Resident 5 and Resident 11. On 09/09/2025, Surveyors received Resident 5's and Resident 15's ISPs. Example 1- Resident 5 Resident 5 was admitted 01/12/2021. The ISP was void of signatures. Example 2- Resident 15	N 387		

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N 387	Continued From page 15 Resident 15 was admitted 12/30/2019. The ISP was void of signatures. Example 3 - Resident 7 Resident 7 was admitted 12/30/2023. Surveyor did not receive Resident 7's ISP or its signature sheet. On 09/12/2025 at 1:04 PM, Surveyor emailed Administrator FFF and House Manager GGG requesting Resident 7's current ISP and signature sheet, Resident 5's ISP signature sheet, and Resident 15's ISP signature sheet be sent to Surveyor that afternoon, and if ISPs were not signed to send the dates of the ISPs. On 09/15/2025 at 9:25 AM, Surveyor called facility, spoke with House Manager GGG, and requested Resident 7's current ISP and signature sheet, Resident 5's ISP signature sheet, and Resident 15's ISP signature sheet be sent to Surveyor by end of day 09/15/2025. On 09/15/2025 at 12:56 PM, Surveyor received a call from Administrator FFF who stated s/he would have House Manager GGG send Surveyor the ISP signature sheets that day. 09/15/2025 3:16 PM, Surveyor emailed Administrator FFF and House Manger GGG requesting Resident 7's current ISP and signature sheet, Resident 5's ISP signature sheet, and Resident 15's ISP signature sheet be sent to Surveyor that afternoon, and if ISPs were not signed to send the dates of the ISPs. On 09/15/2025 at 5:17 PM, Surveyor received Resident 7's current ISP and signature sheet, Resident 5's ISP signature sheet, and Resident 15's ISP signature sheet via email from House Manager HHH. None of the ISPs were signed.	N 387		

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N 387	Continued From page 16 On 09/16/2025 at 7:09 AM, Surveyor received an email from Administrator FFF stating " ...The care plan [ISP] was sent directly from ECP [electronic medical record] and emailed straight from the system ..." On 09/16/2025 at 7:11 AM, Surveyor emailed Administrator HHH and House Manager GGG requesting proof the ISPs were signed. On 09/16/2025 8:02 AM, Administrator HHH replied via email s/he had been unavailable since 09/09/2025 and would send the ISP signature sheets to Surveyor on 09/16/2025. As of 5:00 PM on 09/16/2025, no evidence was received from the provider that Resident 7's, Resident 5's, and Resident 15's ISPs were signed by the resident or the resident's legal representative.	N 387		