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 01/09/2026

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 01/09/2026, Surveyor conducted 1 verification visit at Cottages Of Madison Applewood. One deficiency was identified. The deficiency was a repeat violation. 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, SOD OCCY13, dated 02/24/2025, SOD OCCY14, dated 09/16/2025. One of 2 deficiencies from SOD OCCY14, dated 09/16/2025 was substantially corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 11	{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 for 3 of 7 residents reviewed.	{N 352}		

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

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{N 352}	Continued From page 1 Staff documented administration of medication when the medication remained in the bubble packs for Resident 15, Resident 19 and Resident 20. This requirement is being cited for the 8th 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, SOD OCCY13, dated 02/24/2025, SOD OCCY14, dated 09/16/2025. 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 01/09/2026 was 11. On 01/09/2026 at 11:58 AM, Surveyor inspected the medication cart and requested resident records for Resident 13, Resident 19 and Resident 20. On 01/09/2026 at 11:58 AM, Surveyor inspected the medication cart with Med Passer III and House Manager GGG and observed the following scheduled medication's bubble packs: Example 1 - Resident 15 Bubble Pack label identified: Bedtime Famotidine 20 MG 1 tablet once daily at bedtime Dispensed 12/01/2025 (date delivered from pharmacy) 15 tablets remained in the bubble pack (Photo 1)	{N 352}		

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{N 352}	Continued From page 2 Resident 15 was admitted 12/30/2019. Diagnoses included Alzheimer's disease, late onset and gastro-esophageal reflux disease (GERD). Physician orders included famotidine 20 MG, 1 tablet daily at bedtime. Medication Administration Record (MAR) dated 12/16/2025-01/08/2026: From 12/16/2025-01/08/2026, staff documented famotidine 20 MG administration 22 times and 2 refusals (total 24). Observation notes dated 12/16/2025-01/09/2026: No documentation why famotidine 20 MG remained in the bubble pack when staff documented it was administered. Individual Service Plan (ISP) dated 08/25/2025: In the area of Resident Daily Task- " ...Staff to complete any tasks needed ...daily ...will receive assistance with crushing medications ..." Example 2- Resident 19 Bubble pack label identified: Bedtime Atorvastatin 20 MG 1 tablet once daily Dispensed 12/16/2025 20 tablets remained in the bubble pack (Photo 2) Resident 19 was admitted 12/12/2025. Diagnoses included vascular dementia, lipid metabolism disorder and cerebrovascular accident (stroke) due to thrombosis of left anterior cerebral artery. Physician orders included atorvastatin 20 MG 1 tablet once daily. (MAR) dated 12/16/2025-01/08/2026:	{N 352}		

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{N 352}	Continued From page 3 From 12/16/2025-01/08/2026, staff documented atorvastatin 20 MG administration 22 times, and not administered twice due to out of building. Observation notes dated 12/16/2025-01/09/2026: No documentation why atorvastatin remained in the bubble pack when staff documented it was administered. ISP dated 12/12/2025- In the area of Medications- " ...Staff to administer all medications as prescribed by the health care provider ...will receive medications as prescribed, without missed doses or errors ..." Example 3- Resident 20 Bubble pack label identified Bedtime Acetaminophen 500 MG 2 tablets 3 times daily Dispensed 12/01/2026 2 tablets remained in each of 14 slots (Photo 3). Resident 20 as admitted 08/04/2021. Diagnoses included traumatic ischemia of muscle, subsequent encounter. Physician orders included acetaminophen 500 MG 2 tablets 3 times daily. (MAR) dated 12/16/2025-01/08/2026: From 12/16/2025-01/08/2026, staff documented administration of bedtime acetaminophen 23 times. Observation notes dated 12/16/2025-01/09/2026: No documentation why acetaminophen remained in the bubble pack when staff documented it was administered. ISP dated 11/01/2025-	{N 352}		

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{N 352}	Continued From page 4 In the area of Resident Daily Task - "All resident's cares/tasks are completed daily ...Staff to complete any tasks needed daily for the resident ..." On 01/09/2026 at 11:58, Surveyor interviewed Medication Passer III and House Manager GGG. Medication Passer III stated staff administered medications to all residents residing at facility. House Manager GGG stated the PM cycle fill started on 12/16/2025 (date tablet 1st removed from bubble pack) and staff were to remove tablet(s) from the bubble pack slot number corresponding to the date, with the 1st tablet removed from bubble pack slot #16 on 12/16/2025. House Manager GGG stated 7 tablets should have remained in the PM/bedtime bubble packs on 01/09/2026 unless the medication was not administered for some reason. House Manager GGG stated extra tablets remaining in Resident 15's bubble pack may have been due to his/her refusing the medication. On 01/09/2026 at 2:41 PM, Surveyor discussed concern of medications remaining in the bubble packs when staff documented they were administered with House Manager GGG and Float Administrator JJJ. House Manager GGG retrieved concerning bubble from the medication cart for 7 residents and Surveyor, House Manager GGG and Float Administrator JJJ compared the number of medications remaining in bubble packs to the December 2025 and January 2026 MARs. During the comparison it was verified that 5 extra famotidine 20 MG tablets remained in Resident 15's bubble pack, 11 extra atorvastatin 20 MG tablets remained in Resident 19's bubble pack and 5 extra acetaminophen tablets remained in Resident 20's bubble pack.	{N 352}		

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{N 352}	Continued From page 5 House Manager GGG stated s/he did not know why extra medications remained in Resident 15's, Resident 19's and Resident 20's bubble packs. House Manager GGG stated since cited for same medication issues in the most recent SOD (Note: SOD OCCY14, dated 09/16/2025 and issued 10/30/2025), all staff who administered medications were retrained in medication administration. Float Administrator JJJ stated it appeared from the comparison of MARs to bubble packs 2 staff were not consistently passing medications as trained despite both having been re-education multiple times. House Manager GGG stated they would update Administrator FFF and talk to staff.	{N 352}		