STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008514	A. BUILDING: _____ B. WING _____	R-C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMOMILE ASSISTED LIVING LTD	22 MILO LANE MADISON, WI 53714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments From 07/01/2024 to 07/02/2024, Surveyor conducted a verification visit at Chamomile Assisted Living LTD, a CBRF in Madison. One deficiency was identified. This is a repeat deficiency - See Statement of Deficiency (SOD) RS7915, dated 03/13/2024. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 14	{N 000}		
{N 431}	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any	{N 431}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008514	A. BUILDING: _____ B. WING _____	R-C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMOMILE ASSISTED LIVING LTD	22 MILO LANE MADISON, WI 53714

(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 431}	Continued From page 1 changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure changes in 1 of 3 residents reviewed were documented in the resident's record. The provider did not document Resident 9's weights or symptoms that resulted in 2 hospitalizations. This is a repeat deficiency. See Statement of Deficiency (SOD) RS7915, dated 03/13/2024. Findings include: On 07/01/2024 at approximately 10:00 a.m., Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider's facility on 10/17/2022. Resident 9's record included the following: - Physician Order, dated 03/08/2024, to take weekly weights and report an increase of 5 lbs. or greater to the PCP. - Physician Order, dated 04/18/2024, to take daily weights and report an increase of 5 lbs. or greater to the PCP. - Two "After Visit Summaries" that indicated s/he was hospitalized 06/03/2024 - 06/06/2024 and 06/22/2024 - 06/28/2024. - Progress note, dated 06/21/2024, that stated	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008514	A. BUILDING: _____ B. WING _____	R-C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMOMILE ASSISTED LIVING LTD	22 MILO LANE MADISON, WI 53714

(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 431}	Continued From page 2 "Education on COPD given. Instructed to do daily weights. BP 128/72." Surveyor was unable to locate documentation regarding why Resident 9 was hospitalized or daily weights. On 07/01/2024 at approximately 10:15 a.m., Surveyor interviewed Administrator A. Surveyor asked why Resident 9 had been hospitalized twice in the past month and where his/her weights were recorded. Administrator A stated Resident 9 had been "in and out" of the hospital due to COPD but was now much better after a blood pressure medication was discontinued. Administrator A stated s/he knew Resident 9's weights had been taken routinely but s/he would have to get the documentation from Caregiver I, who helped with paperwork. Administrator A stated s/he knew the facility needed to document more. On 07/02/2024 at approximately 12:10 p.m., Surveyor received documentation from Administrator A that indicated Resident 9's weights had been taken weekly from 03/12/2024 to 05/21/2024 and a note from Administrator A that stated s/he would work to get better at paperwork. Documentation did not include daily weights after the 04/18/2024 order, a discontinue order of weekly or daily weights or documentation regarding why Resident 9 was hospitalized from 06/03/2024 - 06/06/2024 and 06/22/2024 - 06/28/2024.	{N 431}		