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 05/29/2025

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 05/29/2025, the bureau of assisted living southern regoinal office conducted a complaint investigation at Cottages Of Applewood a CBRF located in Madison, WI. As a result of this survey, 1 violation of DHS Chapter 83 was issued. The complaint was substantiated. Census: 8	N 000		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident was free from physical and mental abuse and neglect. On 04/29/2025 at approximately 2:00 AM, Former Caregiver B was witnessed being verbally and physically abusive to Resident 1. Findings include: On 05/06/2025, the Department received a complaint with allegations of abuse.	N 348		

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

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N 348	Continued From page 1 On 05/29/2025, Surveyors arrived at facility for a complaint investigation. RECORD REVIEW: On 05/29/2025, Surveyor reviewed the MISCONDUCT INCIDENT REPORT completed by Administrator A. Administrator A documented the incident occurred on 04/29/2025 at approximately 2:00 AM. "Today, it was brought to my attention that during the NOC shift on Saturday, [Resident 2], reported witnessing concerning behavior involving a [Former Caregiver B]. I spoke directly with [Resident 2], who stated that [s/he] was awakened from sleep by [Former Caregiver B] yelling and cursing at [Resident 1]. [Resident 2] reported hearing [Former Caregiver B] shout phrases such as, "Get the [explicative] back in bed and do not get up," and "Shut the [explicative] up and get the [explicative] in bed." According to [Resident 2], this yelling continued for approximately 20 minutes. [Resident 2] further stated that [s/he] heard [Former Caregiver B] yell, "That's it, [explicative], I've had enough of you," followed by [Resident 1] yelling for help. As [Resident 2] approached [his/her] door to intervene, [s/he] observed [Former Caregiver B] carrying [Resident 1]. [Resident 2] believes that [Former Caregiver B] may have thrown [Resident 1] into [his/her] bed, as [s/he] heard a loud noise, and noted that [Former Caregiver B] appeared back in the hallway almost immediately afterward. [Resident 2] also indicated that this type of behavior and language from [Former Caregiver B] has been repetitive. In addition, a different staff member approached me and shared that [Former Caregiver B] had admitted [s/he] was unable to change another resident, [Resident 3], and stated	N 348		

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N 348	Continued From page 2 [s/he] "had to rough [him/her] up." [Former Caregiver B] also reportedly expressed that [s/he] was frustrated with the residents and did not want to continue working at the facility." On 05/29/2025, Surveyor reviewed Former Caregiver B's staff file. Former Caregiver B's employment had been terminated following investigation on 04/29/2025. INTERVIEW: On 05/29/2025 at 10:04 AM, Surveyor interviewed Caregiver C. Caregiver C reported worked the morning following the incidents involving Former Caregiver B. Caregiver C reported that Resident 2 had told him/her that former Caregiver B had been cussing at Resident 1. Caregiver C stated s/he reported Resident 2's concerns immediately to administration. Caregiver C stated Resident 1 had been more fearful of staff since the incident. On 05/29/2025 at 10:10 AM, Surveyor interviewed Resident 2. Resident 2 stated s/he was sleeping and woke up to Former Caregiver B yelling from the main living room, "go back to your room!" Resident 2 said s/he then heard Former Caregiver B yell, "that's [explicative] it!" Resident 2 stated s/he then heard a bit of a scuffle followed by Resident 1 saying, "stop." Resident 2 stated s/he heard some stomping as Resident 1 was screaming for help. Resident 2 stated s/he then opened his/her door and saw [Resident 1] was back in [his/her] room. Resident 2 stated s/he knew Former Caregiver B had carried Resident 1 to his/her room because Resident 1 could not have ambulated that quickly from the living room to his/her room.	N 348		

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N 348	Continued From page 3 On 05/29/25 at 11:00 AM, Surveyors discussed the above concerns with Administrator A. Administrator A reported s/he called the local police and had initiated his/her own investigation. Administrator A stated s/he found substantial evidence that Resident 1 had been subjected to mistreatment. Administrator A stated s/he reported the situation to department of caregiver quality (DQA) and terminated Former Caregiver B's employment.	N 348		