STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015621	A. BUILDING: _____ B. WING _____	C 03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON POINTE SENIOR LIVING	705 ZIEGLER RD 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 On 03/18/2025, with information gathered through 03/24/2025, conducted a complaint investigation at Madison Pointe Senior Living. One deficiency was identified. Complaint was substantiated. Census: 36	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 changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

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

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed received appropriate health monitoring to meet his/her needs.

Resident 1, who required assistance with bathing/showering and toileting, was not monitored for skin breakdown.

Findings Include:

On 02/26/2025, the department received a concern that residents were experiencing wounds and not receiving appropriate cares.

On 03/18/2025, at approximately 12:45 PM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 was on hospice and receiving wound care. Administrator A informed Surveyor Resident 1's wound care nurse was currently in the building.

On 03/18/2025, at approximately 1:00 PM, Surveyor interviewed hospice Registered Nurse (RN) D. RN D stated when Resident 1 moved into the facility, s/he did not have a skin breakdown on his/her buttock area. Resident 1 developed a pressure wound and was now unresponsive and septic. Resident 1 passed away 03/23/2025.

On 03/22/2025, Surveyor reviewed Resident 1's

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record.

Resident 1 moved into the facility, 02/06/2025, with diagnoses including heart failure, chronic obstructive pulmonary disease (COPD), and Type 2 diabetes and was on hospice.

Resident 1's "Admission Assessment Guide," dated 01/21/2025, documented:
Incontinence Needs: Total Care; Bathing takes 1-2 hours.

Resident 1's "Progress Notes," documented:
Type of Incident, Date & Time: 02/17/25 1800 (6:00 PM)
Summary of Incident: noted that resident has a opened wound to the left lower cheek, wound bed noted to have granulated tissue, and active bleeding noted, area cleansed with wound cleanser, and boarded dressing applied.
Findings (vs [vital signs], change in orientation, injury): open wound
Immediate Actions Taken and Outcome: Hospice notified of the wound, [Hospice RN D] out for a visit, wound care orders in place for 3x a week and as needed. Hospital bed received. The writer has requested an air mattress for the bed and cushion for recliner.
What Interventions were added to the service plan, if any?: wound care orders in place for 3x a week and as needed. Hospital bed received. The writer has requested an air mattress for the bed and cushion for recliner.

Resident 1's "Individual Service Plan (ISP)," dated 02/06/2025, documented:
-Mobility: Transfers 1-2 person assist. Date Initiated: 02/06/2025. Requires assist of 2 for transfers. Date Initiated: 03/10/2025.
-Toileting: Incontinent of bladder and bowel.

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N 431	Continued From page 3 Requires assist from staff. Date Initiated: 02/06/2025. The resident requires assistance for incontinence change. Q2 (every 2 hours) Check and Change. Date Initiated 02/06/2025. Revision on 03/10/2025. Will develop no skin breakdown due to incontinence through the review date. Date Initiated: 02/18/2025. -Skin Maintenance: If resident has a change in skin condition (i.e. infection, open areas, pressure sores, or other injuries) then the caregiver will notify clinical/wellness lead, family, and medical practitioner in a timely manner. Date Initiated: 02/19/2025. Residents skin is clean and dried after each episode of incontinence. Date Initiated: 02/19/2025. Wound care to bottom area completed by RN [Hospice] on MWF (Monday, Wednesday, Friday). Date Initiated: 02/19/2025. Location of Wound: Multiple areas on [his/her] bottom - Hospice to add locations and measurements through progress notes. On 03/24/2025, Surveyor reviewed Resident 1's hospice documentation provided by the hospice provider, which documented: "02/17/2025 - On Call RN received update on patient wound. Per staff, [Caregiver E], sacral wound is "black and had an odor to it." [S/he] reports [s/he] changed bandage. ... Black may indicate unstageable eschar. No other signs or symptoms of infection were reported. Advised staff to keep it clean and change as needed. Staff verbalized understanding. Note: Facility director called back and were wondering if we had any documentation of wounds other than the recent skin tears in our charting. Upon reading notes; I was not able to see any previous documentation of a sacral wounds."	N 431		

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N 431	Continued From page 4 "Pressure injuries start as red, blue, or purplish patches on the body that don't turn white when touched and get worse over time. These patches can quickly turn into blisters and open sores. The sores can then become infected and grow deeper until they reach muscle, bone, or joints. Pressure injuries are found on parts of the skin that are closest to bone and have little fat to pad them. This includes the heels, hips, elbows, ankles, back, base of the spine, and shoulders. The affected skin may feel warm, smell bad, and look swollen. A fever, chills, or confusion can develop if the infection spreads to the bloodstream. If untreated, a very serious condition called septic shock can occur. In the worst cases, pressure injuries can become life-threatening. That's why it's vital to contact a healthcare provider at the first sign of a pressure injury. This is often a soft, red patch of skin that stays red for 30 minutes even after the pressure is eased. ... Pressure injuries are organized into different categories. They range from an early warning signal to the most severe: -Stage 1. A red, blue, or purplish area first appears like a bruise on the skin. It may feel warm to the touch and burn or itch. -Stage 2. The bruise becomes an open sore that looks like an abrasion or blister. The skin around the wound can be discolored. The area is painful. -Stage 3. The sore deepens and looks like a crater. There are often dark patches of skin around the edges. -Stage 4. The damage spreads to the muscle, bone, or joints. It can cause a serious bone infection called osteomyelitis. It can also lead to a possibly life-threatening blood infection called sepsis. -Unstageable full thickness pressure injury. A stage 3 or 4 injury that is covered with black dead tissue (eschar) or creamy yellow, gray/black, or	N 431		

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white, thick slimy tissue (slough). It is difficult to see the severity of the injury because of the covering.
-Deep tissue pressure injury. A very dark red, maroon, or purple colored area of the skin that doesn't disappear when pressed on or a dark deep wound or blister filled with blood that is seen through a separation in the skin."
(Source: Hopkins Medicine website, Bedsores, 2025, https://www.hopkinsmedicine.org/health/conditions-and-diseases/bedsores#:~:text=A%20stage%203%20or%204,Deep%20tissue%20pressure%20injury. (retrieval date - March 24, 2025).)

"Purulent drainage (pus or exudate) is a symptom of infection. This thick, milky fluid oozes from a wound that isn't healing properly. It contains a mixture of dead cells and bacteria, as well as white blood cells, which rush to the site at the first sign of injury. Pus from an infected wound might be white, yellow, green, pink or brown in color - and it usually smells bad. Changes in purulent drainage color or odor usually mean the infection is getting worse.
Your skin is a protective barrier. Any time it breaks - whether from injury or surgery - you'll see blood and watery clear or tinted fluids (serous drainage) around the wound. Serous drainage is normal - a sign of your body's innate healing power. These fluids carry proteins and white blood cells to your wound to jumpstart the recovery process.
But if you notice thick, milky pus coming from your wound instead, it probably means you have an infection - and it's important to tell a healthcare provider right away. Treating purulent drainage quickly can reduce your risk for serious (and sometimes, life-threatening) conditions like sepsis."

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N 431	Continued From page 6 (Source: Cleveland Clinic website, What is purulent drainage?, January 19, 2024, https://my.clevelandclinic.org/health/symptoms/purulent-drainage (retrieval date - March 24, 2025).) On 03/24/2025 at 1:00 PM, Surveyor conducted the exit interview with Administrator A, Clinical Market Leader B, and Clinical Market Leader C. Surveyor discussed the concern that Resident 1's wound was not documented as being identified until 02/17/2025 when the wound was black and odorous. Clinical Market Leader B that the hospice RN had been onsite 02/10/2025, and a wound was not reported to staff. Clinical Market Leader C explained the wound must have occurred between 02/10/2025 and 02/17/2025 and staff should have recognized and reported the skin breakdown. Clinical Market Leader C stated Resident 1 often refused cares and did not want to get out of his/her recliner, so staff attempted to provide cares while Resident 1 remained in his/her chair, but additional training will be provided to staff on how to do proper cares when a resident refuses or is chair/bedbound, along with the importance of documentation.	N 431		