STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015533	A. BUILDING: _____ B. WING _____	C 11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MADISON WEST AL	429 S YELLOWSTONE DR MADISON, WI 53719

(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 11/11/2024 to 11/18/2024, Surveyors conducted a complaint investigation and standard survey at Brookdale Madison West AL, a CBRF in Madison. Seven deficiencies were identified. One deficiency was a repeat deficiency -See Statement of Deficiency (SOD) GY5L11, dated 02/12/2021 The complaint was unsubstantiated. Census: 57	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility did not take immediate steps to ensure the safety of all residents after an allegation of caregiver abuse on 07/15/2024. Findings include: The facility is licensed to serve up to 74 residents in the client groups of irreversible dementia/Alzheimer's and advanced aged. On 11/11/2024 at approximately 11:00 a.m., Surveyors reviewed Resident 2's record. Resident 2 was admitted on 11/03/2021. Resident 2's record documented an incident occurring on 07/15/2024 that involved Resident 2 being pushed into his/her wheelchair by a caregiver. Resident 2 also reported that candy bars go missing from his/her room. On 11/11/2024, at approximately 1:30 p.m., Surveyors interviewed Executive Director II C regarding what steps the facility took after the allegation of caregiver abuse was received by the facility on 07/15/2024. Executive Director II C stated s/he would need to follow up with Surveyors because the allegations occurred prior to his/her hire. On 11/12/2024, at 8:19 a.m., Surveyors reviewed documentation from Executive Director II C of an investigation, dated 7/15/2024 through 07/19/2024, that indicated the following: -On 07/15/2024 Caregiver E was interviewed and stated that Resident 2 was upset because Resident 2 was in his/her wheelchair too early for dinner. -On 07/15/2024 Caregiver F was interviewed and	N 158		

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N 158	Continued From page 2	N 158		

stated that Resident 2 pushed his/her pendant around 4:20 p.m. Caregiver F stated that Caregiver E assisted Resident 2. Resident 2 was in the dining room around 4:45 p.m.
-On 07/15/2024 Nurse G was interviewed and stated that Resident 2 reported to him/her that a female staff pushed Resident 2 back in their wheelchair. Resident 2 did not state the name of the caregiver. Resident 2 was upset because s/he felt it was too early to be in wheelchair for dinner.
-On 07/19/2024, at 3:00 p.m., Caregiver E was reinterviewed. Caregiver E stated that Resident 2 often feels like staff are pushing him/her when staff are assisting him/her because s/he can't hear or see. Caregiver F stated that s/he is always cautious with Resident 2 because s/he misinterprets interactions. Caregiver E said s/he encouraged a second staff to assist.
-On 07/19/2024, the investigation was concluded and did not substantiate any abuse had occurred.
* Surveyors noted there was no action taken from 07/16/2024 to 07/18/2024.

On 11/12/2024, at 11:47 a.m., Surveyors asked the facility to provide what immediate steps the facility took to ensure the safety of all residents during the investigation time frame. Executive Director II C said, "Upon learning of the allegation, the CBRF immediately started an investigation in an effort to identify the alleged perpetrator." Surveyors observed that the 07/15/2024 interviews did not provide a conclusion regarding whether the allegation was substantiated.

On 11/12/2024, at 12:30 p.m., Surveyors reviewed timecards and noted both Caregiver E and Caregiver F, who worked when the allegation of abuse occurred, continued to work during the

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N 158	Continued From page 3 investigation. Timecards indicated the following: -Caregiver E worked 07/16/2024 from 3:07 p.m. to 9:46 p.m., 07/17/2024 from 2:58 p.m. to 10:57 p.m., and 07/19/2024 from 3:01 p.m. to 10:00 p.m. -Caregiver F worked 07/16/2024 from 7:00 a.m. to 3:00 p.m., 07/16/2024 3:00 p.m. to 9:16 p.m., 07/18/2024 7:14 a.m. to 12: 26 p.m., 07/18/2024 12:58 p.m. to 3:26 p.m., and 07/19/2024 7:20 a.m. to 2:01 p.m. On 11/12/2024, at 2:51 p.m., Surveyors interviewed Executive Director II C. Executive Director II C acknowledged there was no documented interventions that safeguarded Resident 2 while his/her allegation remained under investigation. Surveyors observed the report did not include thorough documentation, including times and action taken by the provider to ensure resident's health, safety, and well-being. Upon receiving a report of an allegation of abuse, the provider did not take immediate steps to ensure the safety of all residents.	N 158		
N 176	83.13(1)(d) Maintain records heating system maintenance. The CBRF shall maintain documentation of all of the following: Maintenance of the heating system as required under s. DHS 83.46(1)(c). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation of their sensitivity testing was maintained.	N 176		

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N 176	Continued From page 4 Findings include: On 11/11/2024 at approximately 10:00 a.m., Surveyor reviewed the facility's environmental records. Surveyor was unable to locate documentation of a sensitivity test having been completed in the past 5 years. On 11/11/2024 at approximately 1:30 p.m., Surveyor interviewed Executive Director II C and asked if the facility had a sensitivity test completed in the past 5 years. Executive Director II C stated s/he would have an individual with the maintenance department contact the facility's smoke detection system contractor. The provider was given until 12:00 p.m. on 11/12/2024 to provide follow up documentation. On 11/12/2024 at approximately 1:30 p.m., documentation had been provided indicating the facility had a sensitivity test completed within the past 5 years.	N 176		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the	N 220		

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N 220	Continued From page 5 screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 caregivers reviewed, were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment. Caregiver A was not screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment. Findings include: On 11/11/2024, Surveyor conducted a review of 3 employees to verify compliance with all employee training requirements. Surveyor requested records of Caregiver A from Business Office Manager D. Caregiver A was hired on 09/21/2022. The provider did not have documentation indicating Caregiver A had a communicable disease screen within 90 days before 09/21/2022. On 11/11/2024 at approximately 1:30 p.m., Surveyor interviewed Executive Director II C and Business Office Manager D. Surveyor stated they were unable to locate documentation of Caregiver A's communicable disease screening in the employee records. Executive Director II C acknowledged that documentation of the communicable disease screen could not be found in the employee file.	N 220		

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N 239	Continued From page 6	N 239		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees reviewed, obtained all department approved training as required. Caregiver A did not have training in fire safety within 90 days after starting employment. This is a repeat deficiency. See Statement of	N 239		

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N 239	Continued From page 7 Deficiency, SOD GY5L11, dated 02/12/2021. Findings include: On 11/11/2024, Surveyor conducted a review of 3 employees to verify compliance with department approved training requirements. Surveyor requested training records from Business Office Manager D and Executive Director II C for Caregiver A. Fire Safety The record for Caregiver A, hired 04/21/2024, did not contain evidence of training or evidence of meeting an exemption for fire safety training. On 11/11/2024, at approximately 1:30 p.m., Surveyor interviewed Business Office Manager D and Executive Director II C. Business Office Manger D confirmed the provider did not have evidence Caregiver A completed or met an exemption for fire safety training. On 11/11/2024, Surveyor verified Caregiver A was not on the Community-Based Care and Treatment training registry for fire safety.	N 239		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all	N 407		

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N 407	Continued From page 8 resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3 was reassessed at least quarterly for the desired responses and possible side effects of his/her Quetiapine and Mirtazapine prescriptions. Findings include: On 11/11/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 07/22/2020. Resident 3 has a diagnosis of depression and dementia like behaviors. Resident 3's physician orders included: - Quetiapine 25 mg, give1x daily (Start Date: 09/07/2022) -Mirtazapine 15 mg, give 1x daily (Start Date: 05/09/2023) On 11/11/2024 at approximately 11:00 a.m., Surveyor requested Resident 3's quarterly psychotropic reviews from Executive Director II C. The record indicated that psychotropic reviews were completed on 09/14/2023, 12/18/2023 and 06/17/2024. On 11/11/2024 at approximately 1:30 p.m., Surveyor interviewed Executive Director II C. Surveyor shared concern that documentation indicated psychotropic reviews were not completed quarterly. Executive Director II C stated that there were some concerns with the former nurse completing certain tasks. Executive	N 407		

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N 407	Continued From page 9 Director II C was given until 11/12/2024 at 12:00 p.m. to provide follow up documentation. No documentation related to psychotropic reviews was received.	N 407		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a weekly menu was prepared and available to residents. Findings include: On 11/11/2024 at approximately 11:00 a.m., Surveyor toured the provider's facility. Surveyor was unable to locate a menu to indicate what meals would be served for the day or week. Surveyor did observe an induvial writing the daily menu on a board. On 11/11/2024 at approximately 11:15 a.m., Surveyor interviewed Resident 1 and s/he indicated that s/he was unaware of what was for lunch that day or the remainder of the weekly meals. On 11/11/2024 at approximately 11:30 a.m., Surveyor observed a board outside the	N 450		

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N 450	Continued From page 10 lunchroom with lunch and dinner menu listed. On 11/11/2024 at approximately 1:00 p.m., Surveyor interviewed Executive Director II C. Executive Director II C explained that the chef had been with the company only two months and was still learning the computer program to post weekly menus. Executive Director II C also stated that the food delivery truck was late that day, so staff had to change the menu.	N 450		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure every interior floor and wall were clean and in good repair. Resident 1's bathroom had damaged dry wall and stained flooring and his/her room carpeting had several stains. Findings include: On 11/11/2024 at approximately 11:30 a.m., Surveyor toured Resident 1's room and observed the following concerns: - The drywall near Resident 1's shower was scraped off - Several feet in length (Photo 1). - The carpeting in Resident 1's room had red, gray and brown stains scattered throughout the floor. Stains in many areas were greater than 10 inches in diameter (Photo 2, Photo 3, Photo 4). - The flooring in Resident 1's bathroom had a strip of green tape extending 2/3 the length of the bathroom that was crumbled up at the ends and	N 491		

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N 491	Continued From page 11 the flooring had brown and gray markings scattered through the floor (Photo 5). On 11/11/2024 at approximately 11:35 a.m., Surveyor interviewed Resident 1. Resident 1 stated s/he had resided at the facility for several years and some of the stains were greater than 1 year old. Resident 1 stated his/her bathroom was too small for him/her to navigate, resulting in marks throughout the bathroom. On 11/11/2024 at approximately 1:00 p.m., Surveyor interviewed Executive Director II C. Surveyor shared pictures of Resident 1's room. Executive Director II C stated s/he was aware of the condition of Resident 1's room. Executive Director II C stated the carpeting had been shampooed with no success and s/he needed approval prior to replacing the carpeting. Executive Director II C stated s/he was going to have an architect look at Resident 1's bathroom to see if changes could be made to make the bathroom more accommodating.	N 491		