STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110509	A. BUILDING: _____ B. WING _____	R-C 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL LAKES TERRACES	345 W MAIN ST MADISON, WI 53703

(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 10/01/2025, the bureau of assisted living southern regional office conducted a verification visit at Capitol Lakes Terraces a CBRF located in Madison, WI. As a result of the survey, 1 violation of DHS Chapter 83 was identified. Two violations from previous statement of deficiency (SOD) Y2EC11 dated 06/18/2025 were corrected. One violation was a repeat from SOD Y2EC11 dated 06/18/2025 was re-cited. Under statutory provisions of Wis. Stat. Chap 50, a $200 revisit fee is being assessed. Census: 33	{N 000}		
{N 386}	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.	{N 386}		

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
	110509	A. BUILDING: _____ B. WING _____	R-C 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL LAKES TERRACES	345 W MAIN ST MADISON, WI 53703

(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 386}	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individualized service plan (ISP) was comprehensive. On 10/01/2025, Surveyor reviewed Resident 7's ISP. The ISP didn't contain documentation of the following: behavioral plan, administration of psychotropic PRN (as needed) medication, previously reported symptoms of urinary tract infections or the established interventions for UTI treatment. Surveyor reviewed Resident 8's ISP. The ISP didn't contain documentation of the following: anti-coagulant therapy or the related interventions/special precautions. This is a repeat from previous statement of deficiency (SOD) Y2EC11 dated 06/18/2025. FINDINGS INCLUDE: On 10/01/2025, Surveyor arrived at facility for a verification visit. RECORD REVIEW: EXAMPLE 1: Resident 7 On 10/01/2025, Surveyor reviewed Resident 7's face sheet. Resident 7 was admitted to the facility on 06/21/2024. Resident 7 was his/her own person. Resident 7 was diagnosed with but not limited to: history of urinary tract infection, stress incontinence, urge incontinence, and urgency of urination.	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110509	A. BUILDING: _____ B. WING _____	R-C 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL LAKES TERRACES	345 W MAIN ST MADISON, WI 53703

(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 386}	Continued From page 2 On 10/01/2025, Surveyor reviewed Resident 7's observations note from 09/01/2025 to 10/01/2025: 1.) On 09/12/2025 at 3:17 PM, Practical Nurse L documented the following, "Urine sample obtained at 15:50 PM. Called to [Name Of Hospice Provider] and will pick it up." 2.) On 09/15/2025 at 2:31 PM, Practical Nurse M documented the following, "call placed to [Name Of Hospice Provider] per [Family Members] request as resident is still having incontinence episodes and [s/he] feels that [Resident 7] is having difficulty with sitting and standing ..." 3.) On 09/19/2025 at 3:46 PM, Practical Nurse L documented the following, "Urine specimen obtained and called to [Name Of Hospice] for pick it (sic.) up at 15:30." On 10/01/2025, Surveyor reviewed Resident 7's September 2025 medication administration record (MAR). Resident 7's allergies were listed at the top. Surveyor reviewed the following orders: 1.) Cefpodoxime 200 mg tablet - take 1 tablet by mouth 2 times daily for the next 5 days to treat infection. The start date of the antibiotic was 09/12/2025. 2.) Ciprofloxacin Hcl 250 mg tablet - take 1 tablet by mouth 2 times daily for the next 3 days to treat infection. The antibiotic start date was 09/16/2025. 3.) Ciprofloxacin Hcl 500 mg tablet - take 1 tablet by mouth 2 times daily for the next 7 days to treat infection. The antibiotic start date was 09/20/2025. 4.) Methenamine 1 gram tablet - take 1 tablet by mouth 2 times daily. The indication was to prevent recurring UTIs. 5.) Sertraline Hcl 50 mg tablet - take 1 tablet by mouth once daily. The indication: anxiety.	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110509	A. BUILDING: _____ B. WING _____	R-C 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL LAKES TERRACES	345 W MAIN ST MADISON, WI 53703

(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 386}	Continued From page 3 6.) "Monitor Behavior related to anxiety/restlessness/irritability Record (sic.) the # of times behavior exhibited then, record the corresponding Non-Pharm Interventions(s): NPIs (non-pharmacological interventions) that work best are: a. offer snack/drink, b. redirection, d. 1:1 reassurance/conversation, f. remove from conflict, g. check for basic needs: comfort, hunger, thirst, restroom, tired, other, h. explain care prior to doing it or 0. No intervention needed. Document ?E? if intervention effective. Document ?N? if intervention Not every shift for medication monitoring - Start Date- 08/12/2025 1400." A total of 8 incidents of anxious behavior documented for the month of September. 7.) "Monitor Behavior related to depressive statements ..." A total of 6 incidents of depressive statements were documented for the month of September. 8.) Lorazepam 0.5 mg tablet - take 1 tablet by mouth every 4 hours as needed for anxiety. On 10/01/2025, Surveyor reviewed Resident 7's ISP. The ISP was signed on 07/25/2024. Under the subsection titled, "Behavior," the following was documented, "NO MONITORING for behavioral episodes or NO behavioral episodes ...Resident in NOT Taking Psychotropic Medications." Under the subsection titled, "Toileting Devices/Preferences/History," the following was documented, "HISTORY of Urinary Tract Infections (UTIs)." No, other documentation related to urinary health or behavioral health were reviewed. EXAMPLE 2: Resident 8 On 10/01/2025, Surveyor reviewed Resident 8's face sheet. Resident 8 was admitted to the facility on 07/09/2025. Resident 8 had an activated	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110509	A. BUILDING: _____ B. WING _____	R-C 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL LAKES TERRACES	345 W MAIN ST MADISON, WI 53703

(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 386}	Continued From page 4 power of attorney. Resident 8 was diagnosed with but not limited to: dementia with agitation, Alzheimer's disease and paroxysmal atrial fibrillation. On 10/01/2025, Surveyor reviewed Resident 8's September 2025 MAR. Resident 8 was prescribed the Eliquis (Apixaban) 5 mg tablet twice daily. According to Pearson Nurse's Drug Guide, "APIXABAN (Eliquis)... CLASSIFICATION: ANTICOAGULANT, ANTITHROMBOTIC...ADVERSE EFFECTS Hematological (increased bleeding) ...Assessment & Drug Effects Report promptly suspected of overt bleeding. Patients are at higher risk for bleeding ...Report promptly to prescriber id you experience any of the following: Unexpected, prolonged, or severe bleeding: red, pink or brown urine: red or black tarry stools; coughing up blood; vomiting blood or your vomit looks like coffee grounds; unexpected pain, swelling ..." (PEARSON NURSE'S DRUG GUIDE, 2015, p. 108-109) On 10/01/2025, Surveyor reviewed Resident 8's ISP. The ISP was signed on 08/10/2025. Resident 8's ISP did not contain documentation of his/her anti-coagulant therapy Eliquis or the symptoms of increased bleeding. INTERVIEW: On 10/01/2025 at 1:00 PM, Surveyor discussed the above concerns with Administrator A and Director B. Administrator A and Director B acknowledged Resident 7's ISP didn't document a behavioral plan. Administrator A and Director B acknowledged the ISP didn't document Resident	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110509	A. BUILDING: _____ B. WING _____	R-C 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL LAKES TERRACES	345 W MAIN ST MADISON, WI 53703

(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 386}	Continued From page 5 7's psychotropic PRN for anxiety. Administrator A and Director B acknowledged Resident 7's behaviors or depressive statements an/or refusal of care had been increasing over time. Administrator A and Director B acknowledged Resident 7's ISP didn't document the symptoms, interventions and delivery of care related to his/her frequent UTI's. Administrator A and Director B acknowledged Resident 7 had been prescribed 3 courses of antibiotics to treat a UTI within the last 45 days. Administrator A stated all resident ISPs would be reviewed and cross referenced between MD orders, MARs, and face sheets to verify ISPs were being created comprehensively.	{N 386}		