STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021203	A. BUILDING: _____ B. WING _____	C 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON ELMWOOD	5575 BURKE ROAD 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 07/21/2026, Surveyor conducted a complaint investigation at Cottages of Madison Elmwood, a CBRF located in Madison, WI. As a result of the investigation, 3 violations of Chapter DHS 83 were issued. The complaint was substantiated. Census: 15	N 000		
N 357	83.32(3)(m) Rights of Residents: Recording and filming In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Recording, filming, photographing. Not be recorded, filmed or photographed without informed, written consent by the resident or resident ' s legal representative. The CBRF may take a photograph for identification purposes. The department may photograph, record or film a resident pursuant to an inspection or investigation under s. 50.03(2), Stats., without his or her written informed consent. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 1 provided informed written consent for the facility to film the resident for purposes other than identification, as required. This resulted in Resident 1 being recorded by facility staff while exhibiting behaviors described as disruptive or inappropriate, without evidence that Resident 1 had provided informed written consent for the recording.	N 357		

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

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N 357	Continued From page 1	N 357		

Findings included:
On 07/21/2026 at 9:30 AM, the Surveyor reviewed Resident 1's medical record. Resident 1 was admitted to the facility on 02/23/2026 with diagnoses that included, but were not limited to: major depressive disorder, anxiety, and bilateral above-knee amputations.

There was a document that consents to photographing of Resident 1 for identification purposes dated 02/23/2026. There was no document that indicated consent for filming/video of residents. Surveyor discussed with Adminsitrator A that filming a resident's behavior is not for identification and therefore not permitted.

Resident 1's Individual Service Plan (ISP) indicated that Resident 1 could demonstrate challenging or disruptive behaviors in the community, including raising their voice, using profanity, speaking disrespectfully to staff, or becoming demanding when expressing needs. The ISP also indicated that Resident 1 could involve themself in the personal matters of other residents, which could lead to verbal conflicts with staff or residents.
The ISP directed staff to approach Resident 1 in a calm, respectful, and professional manner and to establish boundaries when Resident 1 became inappropriate or disruptive.

On 07/21/2026 at 10:30 AM, the Surveyor interviewed Resident 1. Resident 1 stated, "I get yelled at all the time here by staff. I yell back sometimes, but I don't initiate it. I was told by several residents that I was filmed when I was yelling at staff not too long ago." When asked whether Resident 1 had given staff permission to

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N 357	Continued From page 2	N 357		

record them, Resident 1 stated, "Hell no! I don't want them filming me! That's ridiculous!"
On 07/21/2026 at 11:00 AM, the Surveyor interviewed Resident 2. Resident 2 stated that Resident 1 could become disrespectful when speaking with staff. Resident 2 further stated that approximately two weeks earlier, staff had recorded Resident 1 while Resident 1 was yelling at staff and using racial slurs. Resident 2 stated, "I don't know if they are supposed to do that, but they did. I hope they don't film me!"
On 07/21/2026 at 11:30 AM, the Surveyor interviewed Resident 3. Resident 3 stated that Resident 1 could become disrespectful when speaking with staff. Resident 3 further stated that approximately two weeks earlier, staff had recorded Resident 1 while Resident 1 was yelling at staff and using racial slurs. Resident 3 stated that staff reported they recorded the incident to show management what Resident 1 was like.
The interviews of Residents 2 and 3 independently corroborated that Resident 1 had been recorded by facility staff during an incident involving alleged disruptive behavior and that the recording was made to demonstrate Resident 1's behavior to management.

On 07/21/2026 at 12:30 PM, the Surveyor interviewed Administrator A. Administrator A acknowledged that Caregiver B had sent Administrator A a video of Resident 1 berating staff and using racial slurs. Administrator A stated that each resident signed a consent upon admission that permitted the facility to film or photograph the resident.

The Surveyor reviewed the purpose of the facility's filming/photographing consent with Administrator A and explained that the regulatory provision permitting photographs or recordings

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N 357	Continued From page 3 without additional informed consent applied to identification purposes. Administrator A acknowledged that they had not understood the limitation and stated that they would communicate this information to staff.	N 357		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not provide behavior-management services adequate to manage Resident 1's behaviors that presented a risk of harm to Resident 1 and others. Resident 1's Individual Service Plan (ISP) identified disruptive behaviors and directed staff to use specific interventions; however, corroborating interviews with Resident 1, multiple residents, a caregiver, and the administrator established that Resident 1 continued to engage in behaviors involving the motorized wheelchair that resulted in, or posed a risk of, physical injury to others. The administrator acknowledged that the interventions identified at admission were not effective and that Resident 1 continued to drive the wheelchair at excessive speeds and intentionally strike or attempt to strike others.	N 433		

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N 433	Continued From page 4 Findings included: On 07/21/2026 at 9:30 AM, the Surveyor reviewed Resident 1's medical record. Resident 1 was admitted to the facility on 02/23/2026 with diagnoses that included diabetes, major depressive disorder, anxiety, hypertension, and bilateral above-the-knee amputations. Resident 1 used a motorized wheelchair for mobility. Review of Resident 1's ISP identified challenging or disruptive behaviors that included raising their voice, using profanity, speaking disrespectfully to staff, becoming demanding when expressing needs, and becoming involved in other residents' personal matters in a manner that could result in verbal conflicts with staff or residents. The ISP directed staff to approach Resident 1 in a calm, respectful, and professional manner and to set boundaries when Resident 1 became inappropriate or disruptive. On 07/21/2026 at 10:00 AM, the Surveyor interviewed Resident 1. Resident 1 stated, "All the staff here hate me! They are racist and don't meet my needs! I have to yell, swear and sometimes drive my wheelchair too fast to get my point across. I have to pound on the med room door to get my meds in the morning." Resident 1's statement corroborated that driving the motorized wheelchair too fast was used during periods of agitation or when Resident 1 perceived that needs were not being met. On 07/21/2026 at 10:15 AM, the Surveyor interviewed Caregiver C. Caregiver C stated that Resident 1 "yells a lot" and uses racial slurs toward staff when angry. Caregiver C further reported that Resident 1 had intentionally struck Caregiver D with the motorized wheelchair and	N 433		

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that Caregiver D sustained bruising from the hip to the knee. Caregiver C stated that staff were unsure what could be done to address Resident 1's behavior.
On 07/21/2026 at 10:30 AM, the Surveyor interviewed Resident 2. Resident 2 reported that Resident 1 became verbally aggressive when Resident 1 did not get what they wanted and stated that Resident 1 drove the motorized wheelchair into people intentionally. Resident 2 reported that Resident 1 had attempted to hit them with the wheelchair on multiple occasions.

On 07/21/2026 at 11:00 AM, the Surveyor interviewed Resident 3. Resident 3 reported that when Resident 1 did not get what they wanted, Resident 1 attempted to run staff over with the motorized wheelchair. Resident 3 described an incident occurring several weeks earlier in which Resident 1 chased staff with the wheelchair while yelling at them after Resident 1 was unable to obtain medication when requested. Resident 3 also reported that Resident 1 had nearly struck them with the wheelchair.

On 07/21/2026 at 11:20 AM, the Surveyor interviewed Resident 4. Resident 4 reported that Resident 1 argued with staff, called staff names, and attempted to run over individuals with the motorized wheelchair when Resident 1 did not receive what was requested, including medication and food. Resident 4 stated that Resident 1 had nearly run them over and expressed fear of being struck because they were unable to move quickly enough to avoid the wheelchair.

On 07/21/2026 at 12:15 PM, the Surveyor interviewed Administrator A. Administrator A acknowledged awareness of Resident 1's behaviors and stated that Resident 1 drove the

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N 433	Continued From page 6 motorized wheelchair too fast and sometimes attempted to intentionally strike others with the wheelchair. Administrator A stated that Resident 1 had run over Administrator A's foot several times and had recently struck Caregiver D in the leg with the wheelchair. Administrator A further stated that interventions had been put in place at admission but "they don't work." Summary: Resident 1 demonstrated recurrent behaviors involving the motorized wheelchair that had resulted in physical contact with staff and presented an ongoing risk of injury to staff and residents. Although Resident 1's ISP identified behavioral interventions for disruptive behavior, the ISP did not identify effective interventions specific to the reported use of the motorized wheelchair as a means of aggression or identify measures adequate to mitigate the risk of injury associated with that behavior. The administrator acknowledged that the interventions implemented at admission were not effective, while interviews with Resident 1, Caregiver C, Residents 2, 3, and 4 corroborated the continued occurrence of the behaviors.	N 433		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by:	N 481		

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Based on observation and interview, the provider did not ensure a safe, clean, comfortable and homelike environment appropriate for residents. There were broken cabinets, doorways and missing silverware.

Findings include:

On 07/21/2026 at 9:00 AM, Surveyor toured the physical environment.

OBSERVATIONS:

There was a missing board from the inside door frame of Resident 1's room.

There were several gouges in the drywall inside of Resident 1's room from being struck by his/her wheelchair. The gouges were approximately 1 inch by 1 inch.

Resident 2's bedroom door was damaged from being struck by his/her motorized wheelchair.

There were 15 residents residing in the facility. Surveyor counted 4 forks and 3 spoons when lunch was served. Surveyor asked Administrator A where all the silverware was. Administrator A stated that residents take silverware back to their rooms and it never comes back. Administrator A stated that there was an order placed for more silverware and should arrive soon.

Surveyor observed Resident 3 eating lunch which was ham, corn and potatoes. Resident 3 was attempting to eat using an ice cream scoop. Resident 3 shrugged his/her shoulders and said, "well that's all they got, I gotta make do."

There was a missing cabinet door in the kitchen.

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N 481	Continued From page 8 There was a cabinet door in the kitchen that was coming out of the cabinet because the screws holding it to the cabinet were very loose. On 07/21/2026 at 11:30 AM, Surveyor interviewed Administrator A. Administrator A stated that there were a few environment concerns that need attention and that all mentioned above were, "On my list to fix."	N 481		