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N 000	Initial Comments From 09/08/2025 to 09/10/2025, Surveyor conducted 2 complaint investigations at Kindred Hearts Cottage Grove. Four deficiencies identified. One complaint was substantiated. One complaint was unsubstantiated. Census: 12	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed received medication as prescribed. Resident 1 did not receive his/her Divalproex as prescribed. Findings include: On 09/08/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 resided at the provider's facility when the provider took over ownership on 08/01/2025. Resident 1 had a diagnosis of dementia. Resident 1's current ISP documented that the provider was responsible for medication administration. The ISP stated, "Resident has shown symptoms of verbal and physical aggression toward staff and	N 352		

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other residents. Resident yells, slams stuff on tables, slam and throws [his/her] walker, etc. Resident will also elope when staff is not looking. Resident needs constant one on one." Resident 1's physician orders included Divalproex 500 mg 2 times daily (affiliated diagnosis not listed). Resident 1's Medication Administration Record (MAR), dated 08/01/2025 to 08/31/2025, documented his/her Divalproex 500 mg was unavailable for administration 16 times from 08/01/2025 through 08/08/2025.

"Depakote tablets and capsules are used to treat seizures in people with epilepsy ... Depakote tablets are also used in adults to prevent migraine headaches, or to treat manic episodes related to bipolar disorder (manic depression)." (Source: Drugs.com Website, Depakote Generic Name: Divalproex Sodium, September 10, 2025, https://www.drugs.com/depakote.html#uses (retrieval date - September 10, 2025).)

On 09/08/2025 at 4:20 p.m., Surveyor interviewed Pharmacist B. Pharmacist B clarified that Resident 1 had an active order for Divalproex 500 mg 2 times daily at the time of the provider taking over ownership on 08/01/2025. Pharmacist B stated Resident 1 did not have Divalproex available to him/her from 08/01/2025 to 08/08/2025 because the medication was not eligible for refill until 08/09/2025. Pharmacist B explained that Resident 1 was temporarily discharged from the pharmacy's services due to a hospitalization, which affected medication refills. Pharmacist B stated the provider was faxed a letter on 07/29/2025 indicating the Divalproex was not eligible for a refill until 08/09/2025. Surveyor asked Pharmacist B what the provider could have done to obtain medication prior to 08/09/2025. Pharmacist B explained that the provider could

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N 352	Continued From page 2 have worked with Resident 1's discharging hospital and/or responded to the pharmacy's 07/29/2025 letter to come up with an alternate option such as cash payment or early fill to ensure Resident 1 continued to receive medications as prescribed.	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 individual service plans (ISP) reviewed were updated when there was a change in resident's needs. Resident 4's ISP was not updated regarding his/her interventions related to behaviors, his/her need for separation from another resident and his/her involvement with home health services. Resident 1's ISP was not updated to indicate the level of supervision s/he required.	N 389		

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N 389	Continued From page 3 Findings include: From 09/08/2025 to 09/10/2025, Surveyor conducted 2 complaint investigations. Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 4: On 09/08/2025 at 8:00 a.m., Surveyor reviewed a home health note, dated 08/15/2025, obtained by Surveyor. The note, completed by Home Health RN D, stated a caregiver at the facility was observed insisting that Resident 4 sit next to a resident s/he had threated to punch in the past. The note stated the other resident was shouting and irritating all the other residents. The note stated Resident 4 was backing away from the table, stating "I can't sit here. I can't sit here. I'm going to punch [him/her] in the face. I can't sit here;" yet the caregiver continued to insist Resident 4 sit next to the irritated resident that was sitting down. The note stated the facility's caregiver was giggling and smiling, as if s/he found Resident 4's fear amusing. The note stated Home Health RN D informed Assistant Director E that Resident 4 could not sit next to the resident that was sitting under any circumstances as Resident 4 was verbally stating s/he would punch the resident in the face because they had issues in the past. The note stated Home Health RN D had reported the threats in the past and Assistant Director E was aware of the threats. The note stated Assistant Director E responded, "It doesn't matter because they are going to fight no matter what." On 09/08/2025 at 10:00 a.m., Surveyor reviewed Resident 4's record. Resident 4 resided at the	N 389		

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provider's facility at the time of their change of ownership on 08/01/2025. Resident 4's current ISP stated, "The resident has a history of aggressive behaviors medications [sic]. During episodes of escalation, the resident may exhibit verbal aggression and may attempt to make physical contact with staff or other residents. Intervention Plan: Staff should proactively engage the resident in preferred activities and offer food, beverages, or other calming strategies to help de-escalate the situation and redirect attention." Resident 4's ISP was not updated to indicate s/he should remain separate from any particular resident at the facility, was not updated to include Resident 4's preferred activities to engage in and was not updated to include his/her home health services.

On 09/08/2025 at 1:00 p.m., Surveyor interviewed Regional Director A and Administrator F regarding Resident 4's care and behaviors at the facility. Regional Director A stated s/he had heard about the 08/15/2025 incident, but was informed the concern came from the Managed Care Organization (MCO) RN and attempted to follow up with the MCO with no success. Regional Director A stated Resident 4 liked to be in charge of the house and Resident 1 (the other resident identified in the 08/15/2025 incident) had a history with everyone, so staff just tried to keep him/her calm and offer things to do. Surveyor asked Regional Director A and Administrator F if they were aware of Resident 4's home health services, to which both Regional Director A and Administrator F denied.

On 09/10/2025 at 12:10 p.m., Surveyor interviewed Home Health RN D, who confirmed Resident 4 was on service with his/her agency for pain management. Home Health RN D stated

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s/he visited Resident 4 once every 2 weeks. Home Health RN D stated s/he had brought concerns regarding Resident 4 and Resident 1's interactions to Assistant Director E's attention well before the 08/15/2025 incident and then again on 08/15/2025. Home Health RN D was unsure why the provider's staff would have thought Home Health RN D was with the MCO.

On 09/10/2025 at 2:15 p.m., Regional Director A stated s/he understood there was a miscommunication regarding Resident 4's 08/15/2025 incident and the involvement of home health services. Regional Director A stated Resident 4's intervention/preferred activities included watching television, coloring, games and chatting with others.

Example 2 - Resident 1:

On 09/08/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 resided at the provider's facility when the provider took over ownership on 08/01/2025. Resident 1 had a diagnosis of dementia. Resident 1's current ISP stated, "Resident has shown symptoms of verbal and physical aggression towards staff and other residents. Resident yells, slams stuff on tables, slams and throws [his/her] walker etc. Resident will also attempt to elope when staff is not looking. Resident needs constant one on one."

On 09/08/2025 from approximately 10:00 a.m. to 11:04 a.m., Surveyor observed Resident 1 sitting outside on the provider's unenclosed patio without staff present. For approximately 30 minutes of this duration, Resident 1 was sitting with Resident 2, who had been observed by Surveyor being verbally aggressive to Resident 1

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N 389	Continued From page 6 minutes prior to going outside. On 09/08/2025 at 11:04 a.m., Surveyor interviewed Regional Director A and asked who was providing supervision to Resident 1 while s/he was on the patio and shared that the ISP stated Resident 1 required constant one on one. Regional Director A stated the ISP was incorrect and needed to be updated to state Resident 1 only required one to one supervision during active aggression. Regional Director A stated the provider did not provide one on one supervision.	N 389		
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	N 431		

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N 431	Continued From page 7 changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the health of 1 of 4 residents reviewed was monitored and changes documented. Resident 2's pulse was not monitored 2 times daily prior to the administration of his/her Metoprolol. Findings include: On 09/08/2025 at 10:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 09/02/2025. Resident 2's temporary individual service plan (ISP), documented that the provider's staff were responsible for medication administration. Resident 2's physician orders included Metoprolol 75 mg (Start Date: 09/02/2025) - Take 2 times daily for congestive heart failure; hold if systolic blood pressure is less than 110 or heart rate is less than 60. Resident 2's Medication Administration Record (MAR), dated 09/02/2025 to 09/08/2025, documented Resident 2's Metoprolol had been administered 2 times daily since 09/03/2025. Resident 2's record did not include any documentation of pulse recordings. On 09/10/2025 at 12:30 p.m., Surveyor requested Resident 2's documentation of pulse checks from Regional Director A. On 09/10/2025 at 1:10 p.m., Regional Director A provided Surveyor with documentation of 1 pulse check on 09/04/2025 at 9:00 a.m. Surveyor did not receive documentation of any additional pulse	N 431		

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N 431	Continued From page 8 checks. On 09/10/2025 at approximately 2:15 p.m., Regional Director A followed up with Surveyor and stated s/he now saw that Resident 2's Metoprolol included pulse parameters. Regional Director A stated s/he would fix the provider's directions regarding Metoprolol administration.	N 431		
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 ensure services were provided to manage residents' behaviors. Resident 2, Resident 1 and Resident 4 exhibited aggression. Findings include: From 09/08/2025 to 09/10/2025, Surveyor conducted a complaint investigation alleging the provider did not manage residents' behaviors appropriately. OBSERVATIONS	N 433		

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On 09/08/2025 at 9:15 a.m., Surveyor observed Resident 1, Resident 2 and Resident 4 present in the facility's living room watching television.

On 09/08/2025 at 9:33 a.m., Surveyor heard Resident 2 yell, "You little [expletive]. I'll [expletive] you up. You running your mouth. You act like you run the God [expletive] TV. Sit your [expletive] down." Surveyor then observed Regional Director A run to the living room to redirect Resident 2. Surveyor observed Resident 4 had gotten up from his/her chair and was approaching Resident 2. Surveyor observed Resident 4 be redirected by Caregiver C. All 3 residents in the living room where then offered a snack.

On 09/08/2025 at 9:39 a.m., Surveyor heard Resident 2 yelling on his/her cell phone in the living room. Resident 2 was heard saying, "I need to tell you what the [expletive] to do and do it."

On 09/08/2025 at 10:55 a.m., Surveyor heard Resident 2 yell, "I'll [expletive] you up. [Expletive, expletive]. Shut the [expletive] up. You don't bully me. I will straight up kick your [expletive]." Surveyor observed Resident 4 had gotten up from his/her seat and walked towards Resident 2. Surveyor observed staff intervene.

On 09/08/2025 from approximately 10:00 a.m. to 11:08 a.m., Surveyor observed Resident 1 out on the provider's unenclosed patio unsupervised. For approximately 30 minutes of that time, Resident 2 was also out on the patio.

INTERVIEWS

On 09/08/2025 at 10:42 a.m., Surveyor interviewed Resident 4. Resident 4 stated

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Resident 2 needed to be thrown in jail. Resident 4 stated a lot of people at the facility were afraid of Resident 2. Resident 4 stated Resident 1 was "just a pain." Resident 4 stated Resident 1 would get face to face with him/her, but Resident 1 would just walk away and not get physical.

On 09/08/2025 at 11:30 a.m., Surveyor interviewed Resident 3. Resident 3 stated Resident 2 was mean and called him/her "[expletive]" and "[fat, [expletive], [expletive]]"every time s/he walked past. Resident 3 stated s/he no longer felt safe at the facility and had called law enforcement on Resident 2 twice. Resident 3 stated Resident 1 also had aggressive behaviors, but that s/he had worked his/her own way through dealing with this by working on his/her approach with Resident 1.

On 09/08/2025 at 11:45 a.m., Surveyor interviewed Caregiver C. Caregiver C stated Resident 1 would get upset about the television. Caregiver C stated Resident 1 had behaviors when people were rude and that Resident 1 required supervision when outside but stated that was difficult to provide at times. Caregiver C gave the example of earlier that morning when Resident 1 was out on the patio unsupervised. Caregiver C explained that s/he and his/her coworker were putting away recently delivered groceries when management instructed them to ensure Resident 1 was supervised. Caregiver C voiced frustration that management didn't help provide the supervision.

On 09/08/2025 at 12:05 p.m., Surveyor interviewed Regional Director A. Regional Director A stated after talking with his/her staff, s/he could confirm that Resident 3 had called law enforcement on 09/07/2025 due to the way

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Resident 2 looked at him/her.

RECORD REVIEW

Example 1 - Resident 2:

Resident 2 was admitted to the provider's facility on 09/02/2025 with diagnoses including mild neurocognitive disorder with behavioral disturbance, anxiety, depression, impulse disorder, and Alzheimer's disease. Resident 2's temporary individual service plan (ISP) did not identify any behaviors. Resident 2's record included an incident report, dated 09/07/2025, that stated Resident 2 had an intense degree of aggressiveness towards Resident 3 and Resident 4. The report identified the television as a trigger for some of the aggressiveness and that Resident 2 was informed if s/he continued to insult others police would be called. The report stated Resident 2 created a tense environment.

Example 2 - Resident 1:

On 09/08/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 resided at the provider's facility when the provider took over ownership on 08/01/2025. Resident 1 had a diagnosis of dementia. Resident 1's current ISP stated, "Resident has shown symptoms of verbal and physical aggression towards staff and other residents. Resident yells, slams stuff on tables, slams and throws [his/her] walker etc. Resident will also attempt to elope when staff is not looking. Resident needs constant one on one." Resident 1's record, dated 08/01/2025 to 09/08/2025, documented the following:

- 08/04/2025: The resident was very upset when

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N 433	Continued From page 12 [s/he] arrived with [his/her] family member, wanting to leave, bothering the other residents, and also hitting the caregivers. Resident was screaming in the living room because s/he was unable to leave the facility. The screaming was disruptive to 2 other residents, including Resident 2, who got up and spoke to Resident 1 loudly. Resident 1 was aggressive with staff during incontinence cares. - 08/05/2025: The resident was bothering the other residents, wanting to go outside, hitting the caregivers, [s/he] didn't want to eat anything for dinner. Resident was aggressive with 2nd shift. [S/he] went straight into the street to try and play tag or get in the way. Resident was yelling and didn't want to listen to anyone. Resident 1 hit caregiver's chest and said inappropriate comments. - 08/06/2025: Verbally and physically aggressive to staff, striping, exit seeking and running into road. [Resident 1]'s behavior is dangerous to [him/herself] as well as others. Unsafe behavior. Staff called 911 to go for evaluation. - 08/09/2025: Attempted to leave. Upset today and making noises because [s/he] couldn't watch [his/her] TV channel while this was being watched by visitors. - 08/10/2025: A bit violent hitting [caregiver] in the arm, twisting [caregiver]'s fingers and trying to hit [caregiver]'s [chest]. - 08/13/2025: Woke up aggressive and chased caregiver around the kitchen to hit caregiver. Continues to insult caregiver. Went to kitchen nude to have [depend] placed on [him/her] and tried to sit at table without pants on. Restless and aggressive with staff. - 08/16/2025: Resident left through the front of the building and started hitting and insulting people when asked to return inside the facility. - 08/17/2025: Out of nowhere, got upset and	N 433		

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	0021202	A. BUILDING: _____ B. WING _____	C 09/10/2025

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started shouting.
- 08/18/2025: Hyperactive with others. Aggressive in the afternoon. Attempted to leave the building twice.
- 08/19/2025: Insulting family member, residents and staff.
- 08/22/2025: Mid-morning, Resident 1 escaped while caregivers were changing another resident. The nurse tried to stop [him/her] but Resident 1 became aggressive and crossed the street.
- 08/23/2025: In the morning, Resident 1 left the facility and crossed the street. Resident was brought back but was bothering other residents. In the afternoon, s/he has not slept, nor spent more than 10 minutes in his/her room.
- 08/25/2025: Resident had three breakfasts and was bothering other residents by wanting to eat their leftovers. Tried to leave twice, but caregivers managed to calm [him/her] down.
- 08/28/2025: Resident escaped, but caregivers managed to get Resident 1 to come back into the facility. After lunch, Resident 1 sat on the terrace that faces the street and s/he escaped again but caregivers were able to get him/her to come back in again.
- 08/30/2025: A little restless.
- 08/31/2025: A little restless.
- 09/02/2025: Very restless all afternoon.

Resident 1's record documented that Resident 1 was hospitalized 08/06/2025 for behaviors and that s/he had Memantine started on 08/21/2025 with the plan to titrate the medication.

On 09/08/2025 at approximately 1:00 p.m., Surveyor asked Regional Director A and Administrator F what the provider had been doing to manage Resident 1's behaviors. Regional Director A replied, "[Resident 1] has a history with everyone. We try to keep [him/her] calm and offer

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things to do." Regional Director A stated Resident 1 was provided a 30-day discharge notice in July (prior to 08/01/2025 change of ownership).

Example 3 - Resident 4:

On 09/08/2025 at 8:00 a.m., Surveyor reviewed a home health note, dated 08/15/2025, obtained by Surveyor. The note, completed by Home Health RN D, stated a caregiver at the facility was observed insisting that Resident 4 sit next to a resident s/he had threated to punch in the past. The note stated the other resident was shouting and irritating all the other residents. The note stated Resident 4 was backing away from the table, stating "I can't sit here. I can't sit here. I'm going to punch [him/her] in the face. I can't sit here;" yet, the caregiver continued to insist Resident 4 sit next to the irritated resident that was sitting down. The note stated the facility's caregiver was giggling and smiling, as if s/he found Resident 4's fear amusing. The note stated Home Health RN D informed Assistant Director E that Resident 4 could not sit next to the resident that was sitting under any circumstances as Resident 4 was verbally stating s/he would punch the resident in the face because they had issues in the past. The note stated Home Health RN D had reported the threats in the past and Assistant Director E was aware of the threats. The note stated Assistant Director E responded, "It doesn't matter because they are going to fight no matter what."

On 09/08/2025 at 10:00 a.m., Surveyor reviewed Resident 4's record. Resident 4 resided at the provider's facility at the time of their change of ownership on 08/01/2025. Resident 4's current ISP stated, "The resident has a history of aggressive behaviors medications [sic]. During

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episodes of escalation, the resident may exhibit verbal aggression and may attempt to make physical contact with staff or other residents. Intervention Plan: Staff should proactively engage the resident in preferred activities and offer food, beverages, or other calming strategies to help de-escalate the situation and redirect attention." Resident 4's progress notes and incident reports, dated 08/01/2025 to 09/08/2025, documented the following:

08/05/2025: Resident went to bed late because s/he was worried about his/her roommate, who didn't want to go to sleep and was hitting staff.
08/13/2025: Resident was upset with Resident 1's behavior.
08/15/2025: Managed Care Organization RN was present today and prior to leaving informed caregiver that Resident 4 was upset that another resident was in his/her chair. RN was informed that the facility did not have assigned seating and offered Resident 4 a seat next to the seat Resident 4 wanted. The Managed Care Organization RN stated Resident 4 would be more upset by sitting next to the other resident and potentially fight.
08/23/2025: Resident was bothered by Resident 1 sitting in his/her chair in the living room.
09/06/2025: Resident has been upset because s/he wants no one to sit in his/her chair and wanting to control the television programming.
09/07/2025: Resident was upset as Resident 1 sat on the couch to watch tv. Resident is insisting to have control over the television; however, staff are alternating programs, giving importance to Resident 2, and encouraging Resident 4 to watch television in his/her room. Resident 2 has insulted Resident 4.

On 09/08/2025 at approximately 1:00 p.m.,

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N 433	Continued From page 16 Surveyor asked Regional Director A and Administrator F what the provider had been doing to manage Resident 4's behaviors. Regional Director A replied, "[Resident 4] just likes to be in charge of the house." FINDINGS: On 09/08/2025 at approximately 1:00 p.m., Surveyor interviewed Regional Director A and Administrator F. Surveyor shared concern that based on observation, interview and record review, Resident 1, Resident 2 and Resident 4 appear to exhibit aggressive, disruptive behaviors at the facility. Surveyor shared observation of verbal aggression, Resident 4 approaching Resident 2, and Resident 1, who had a history of aggression and elopements, sitting outside without staff supervision. Regional Director A acknowledged Surveyor's observations. Regional Director A stated s/he was unsure what was going to be done regarding Resident 2's behaviors. Regional Director A stated, "[Resident 1] has a history with everyone. We try to keep [him/her] calm and offer things to do," and shared that Resident 1 was issued a 30-day discharge notice in July (prior to change of ownership on 08/01/2025). Regional Director A stated, "[Resident 4] just likes to be in charge of the house."	N 433		