STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017669	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KETTLE PARK SENIOR LIVING INC	2600 JACKSON ST STOUGHTON, WI 53589

(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 10/06/2025, Surveyor conducted an abbreviated licensure survey and a complaint investigation. One deficiency was identified. Complaint was unsubstantiated. Census: 21	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 observation, record review and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 3 of 3 resident. Resident 1 did not receive his/her scheduled Eliquis (anticoagulant), acetaminophen, and Gabapentin (anticonvulsant) as prescribed. Resident 2 did not receive his/her scheduled antacid and Tamsulosin (medication for urination difficulties) as prescribed. Resident 3 did not receive his/her scheduled fiber-lax (laxative), Atorvastatin (medication for hyperlipidemia), Benefiber (prebiotic fiber supplement), oyster shell (calcium supplement), Sertraline (psychotropic medication), Pantoprazole (acid reflux medication), and Buspirone (anxiety medication) as prescribed.	N 352		

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
	0017669	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KETTLE PARK SENIOR LIVING INC	2600 JACKSON ST STOUGHTON, WI 53589

(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 352	Continued From page 1 Findings Include: On 10/06/2025, at approximately 3:30 PM, Surveyor and Director of Human Services C observed Resident 1's, Resident 2's and Resident 3's medications in the med cabinets. Example 1: Resident 1 Surveyor observed: -morning blister card of Eliquis with a start date of 09/11/2025. Four of 28 tablets remained. -afternoon blister card of Acetaminophen with a start date of 09/11/2025. Three doses of 28 doses remained. -afternoon blister card of Gabapentin with a start date of 09/11/2025. Three of 28 tablets remained. -evening blister card of Eliquis with a start date of 09/11/2025. Seven of 28 tablets remained. On 10/06/2025, Surveyor reviewed Resident 1's Medication Administration Records (MARS), dated 09/11/2025 to 10/06/2025, which documented: -Acetamin (acetaminophen) Tab (tablet) 500 MG (milligram) - Take 2 tablets by mouth. Scheduled at 2:00 PM. -Eliquis Tab 2.5 MG - Take 1 tablet by mouth twice daily. Scheduled at 8:00 AM and 8:00 PM. -Gabapentin Cap (capsule) 300 MG - Take one capsule by mouth. Scheduled at 2:00 PM. The MARS documented medication had been administered as prescribed. Based on 28 tablets/capsules in each of the above observed blister cards that started on 09/11/2025, then only 2 doses of the morning and afternoon medications and only 3 doses of the evening medication should remain.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017669	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KETTLE PARK SENIOR LIVING INC	2600 JACKSON ST STOUGHTON, WI 53589

(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 352	Continued From page 2 Example 2: Resident 2 Surveyor observed: -Evening (4:00 PM) blister card of antacid chewable with a start date of 09/11/2025. Five of 28 tablets remained. -HS (hours of sleep) blister card of Tamsulosin with a start date of 09/11/2025. Five of 28 tablets remained. On 10/06/2025, Surveyor reviewed Resident 2's MARs, dated 09/11/2025 to 10/06/2025, which documented: -Antacid 500 MG Chew (chewable) - Chew and swallow 1 tablet by mouth with meal for heartburn. Scheduled at 4:00 PM. -Tamsulosin Cap 0.4 MG - Take one capsule by mouth at bedtime. Scheduled at 8:00 PM. The MARS documented medication had been administered as prescribed. Based on 28 tablets/capsules in each of the above observed blister cards that started on 09/11/2025, then only 2 doses of afternoon medication and only 3 doses of evening medication should remain. Example 3: Resident 3 Surveyor observed: -Morning blister card of Oyster Shell with a start date of 09/11/2025. Five of 28 tablets remained. -Morning blister card of Sertraline with a start date of 09/11/2025. Three of 28 doses remained. -Morning blister card of Pantoprazole with a start date of 09/11/2025. Three of 28 doses remained. -Morning and HS blister cards of Benefiber Pre/Chew Probiotic with a start date of 09/11/2025. Four of 28 tablets remained in each	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017669	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KETTLE PARK SENIOR LIVING INC	2600 JACKSON ST STOUGHTON, WI 53589

(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 352	Continued From page 3	N 352		

blister card.
-HS blister card of Fiber-Lax with a start date of 09/11/2025. Five of 28 tablets remained.
-HS blister card of Atorvastatin with a start date of 09/11/2025. Five of 28 tablets remained.
-HS blister card of Buspirone with a start date of 09/11/2025. Five of 28 tablets remained.

On 10/06/2025, Surveyor reviewed Resident 3's MARs, dated 09/11/2025 to 10/06/2025, which documented:
-Oyster Shell Tab 500 MG - Take 1 tablet by mouth daily. Schedule at 9:00 AM.
-Pantoprazole Tab 40 MG - Take 1 tablet by mouth daily. Scheduled at 9:00 AM.
-Sertraline Tab 100 MG - Take 1.5 tablets by mouth daily. Scheduled at 9:00 AM.
-Benefiber Pre/Chw (chew) Probiotic - Chew and swallow 1 tablet by mouth twice daily. Scheduled at 8:00 AM and 8:00 PM.
-Fiber-Lax Tab 625 MG - Take 1 tablet by mouth. Scheduled at 8:00 PM.
-Atorvastatin Tab 40 MG - Take 1 tablet by mouth at bedtime. Scheduled at 8:00 PM.
-Buspirone Tab 10 MG - Take 1 tablet by mouth. Scheduled at 8:00 PM.

The MARS documented medication had been administered as prescribed.
Based on 28 tablets/capsules in each of the above observed blister cards that started on 09/11/2025, then only 2 doses of the morning medications and only 3 doses of the evening medications should remain.

On 10/06/2025, at approximately 4:30 PM, Surveyor interviewed Executive Director A, Assistant Executive Director B and Director of Health Services C. Surveyor discussed his/her observations. Director of Health Services C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017669	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KETTLE PARK SENIOR LIVING INC	2600 JACKSON ST STOUGHTON, WI 53589

(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 352	Continued From page 4 stated they were aware of the concern and had begun a quality assurance and performance improvement process.	N 352		