STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 07/20/2023, Surveyor completed a complaint investigation and verification visit at Kindredhearts of Cottage Grove, a CBRF in Cottage Grove. Nine deficiencies were identified. Six deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) S8M611, dated 12/13/2018, SOD S8M612, dated 07/10/2019, SOD VH4Z11, dated 08/08/2022 and SOD VH4Z12, dated 12/20/2022. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 10	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the facility complied with all laws governing the CBRF. Findings include: On 07/18/2023, Surveyor completed a complaint investigation and verification visit. The following concerns related to licensee responsibilities and repeat deficiencies were identified:	N 196		

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
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 196	Continued From page 1 Employment/Personnel: - Licensee S did not notify the department of the facility's change in administrator. Department records indicated Administrator N was the administrator of the facility. Administrator L, Administrator N, Caregiver O and Caregiver P all identified Administrator L as the administrator while Surveyor was onsite. When Surveyor asked Licensee S if s/he updated the department regarding the change in administrator, Licensee S stated s/he thought Operations Coordinator I, who left the company approximately 1 week ago, was the administrator on record. Licensee S was unaware Administrator N was listed as the administrator on record with the department and stated s/he planned to submit him/herself as the administrator on record. - Three of 3 caregiver records reviewed did not have complete background checks. Licensee S stated this task can easily "slip by." *This is a repeat deficiency (See SOD VH4Z11, dated 08/08/2022 and VH4Z12, dated 12/20/2022). Environment: - The facility had food that was not labeled or dated and expired food in the refrigerator. *This is a repeat deficiency (See SOD VH4Z12, dated 12/20/2022). - The facility had toxic chemicals available in the maintenance closet, linen/cleaning closet and laundry room. Licensee S was unaware if these rooms had the ability to lock and was unaware toxic chemicals needed to be secured. *This is a repeat deficiency. (See SOD VH4Z12, dated 12/20/2022). - Four of 4 exits were obstructed by latched gates on the exterior. Licensee S was unaware this was a concern and stated, "That's how [exits] were	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 196	Continued From page 2	N 196		

when we got the building."
- The provider had a sprinkler system inspection on 02/23/2023, which resulted in deficiencies that were not addressed as of 07/18/2023. *This is a repeat deficiency (See SOD VH4Z12, dated 12/20/2022).

Resident Care:
- Resident 12 had a documented weight loss of 26 lbs in 4 months and had not had his/her weight recorded in 2 months. *This is a repeat deficiency. See SOD S8M611, dated 12/13/2018, SOD S8M612, dated 07/10/2019 and SOD VH4Z11, dated 08/08/2022.

On 07/18/2023 at approximately 4:00 p.m., Surveyor reviewed concerns related to licensee responsibilities and repeat deficiencies with Licensee S. Surveyor asked Licensee S if s/he reviewed the previous SOD with current staff and followed up to ensure corrections were made. Licensee S stated s/he reviewed the SOD with the previous administrator and that it would have been the role of Operations Coordinator I to ensure corrections were made. Licensee S stated some of the concerns were tasks easy to "slip by" and others were difficult to have staff follow through on the corrections for. Surveyor asked Licensee S what type of training was provided for Administrator L, who identified him/herself as the current administrator. Licensee S stated Administrator L received some training when s/he was assistant administrator prior to becoming administrator. Licensee S stated "in better times" there was a mentor for new administrators, but the company had too much turnover to provide a mentor at this time. Licensee S stated Administrator L did not currently meet administrator qualifications and Licensee S did not have plans to enroll Administrator L in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 196	Continued From page 3 administrator course at this time. Cross Reference: N0200 DHS 83.14(2)(e) Notify Within 7 Days Of Administrator Change N0219 DHS 83.17(1)(a) Licensee Conduct Caregiver Background Check N0431 DHS 83.38(1)(g) Health Monitoring N0452 DHS 83.41(3)(b) Food Safety N0499 DHS 83.45(3) Toxic Substances N0558 DHS 83.48(8)(b) Sprinkler System Installation And Maintenance N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways	N 196		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not notify the department within 7 days after there was a change in administrator. Licensee S was unaware that Administrator N was the administrator on record. Four of 4 employees present on 07/13/2023 identified Administrator L as the administrator. Findings include: On 07/13/2023 at approximately 12:00 p.m., Surveyor reviewed department records, which documented Administrator N as the facility's administrator. On 07/13/2023 at approximately 12:30 p.m., Surveyor met with Administrator N, who stated	N 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 200	Continued From page 4 s/he was the administrator of the affiliated facility next door. Administrator N stated Administrator L was the new administrator for the facility. On 07/13/2023 at approximately 12:40 p.m., Surveyor met with Administrator L. Administrator L, who had previously been a caregiver, stated s/he became the administrator on 06/01/2023. Administrator L reported Administrator A left the facility at the end of May and Administrator L became the administrator. Surveyor asked if the provider updated the department regarding the change in administration. Administrator L replied, "I don't know." On 07/18/2023 at approximately 12:50 p.m., Licensee S stated s/he would notify the department of the change in administrator and planned to submit him/herself as the requirement. On 07/18/2023 at approximately 4:00 p.m., Surveyor informed Licensee S that Administrator N was currently the administrator on record with the department. Licensee S stated s/he thought Operations Coordinator I was the administrator on record, but that Operations Coordinator I was no longer with the company.	N 200		
{N 219}	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or	{N 219}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 219}	Continued From page 5 offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct and document a caregiver background check following the procedures in s. 50.065, Stats;, and ch. DHS 12 upon the hire of 3 of 3 caregivers reviewed. The provider did not conduct a complete background check for Caregiver O, Caregiver Q or Caregiver R upon hire. This is a repeat deficiency. See Statement of Deficiency (SOD) VH4Z11, dated 08/08/2022 and VH4Z12, dated 12/20/2022. Findings include: On 07/13/2023 at approximately 1:30 p.m., Surveyor conducted a review of 3 employees to verify compliance with background checks. Surveyor requested training records from Administrator L for Caregiver O, Caregiver Q and Caregiver R. On 07/13/2023 at approximately 2:00 p.m., Surveyor reviewed documentation which indicated the following: - Caregiver O, hired 06/22/2023, did not have background checks completed upon hire. The file did not contain a background information disclosure (BID), criminal history search form	{N 219}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 219}	Continued From page 6 from the Department of Justice (DOJ) or information maintained by the Department of Safety and Professional Services (IBIS) - Caregiver R, hired 06/05/2023, did not have background checks completed upon hire. The file did not contain a BID, DOJ report, or an IBIS letter. - Caregiver Q, hired 06/21/2023, did not have background checks completed upon hire. The file did not contain a BID, DOJ report, or an IBIS letter. On 07/13/2023 at approximately 2:30 p.m., Surveyor reviewed concern with Administrator L that 3 of 3 caregivers reviewed did not have background checks completed upon hire. Administrator L acknowledged concern. Administrator L stated s/he had limited to no time to conduct administrative tasks because s/he was busy working the floor and once s/he was able to find new hires Administrator L had an unexpected 2-week hospitalization. Administrator L stated s/he just returned to work that week and would take care of having background checks completed. On 07/18/2023 at approximately 4:00 p.m., Surveyor reviewed concern regarding background checks not being completed for new employees with Licensee S. Licensee S stated, "This stuff can easily slip by."	{N 219}		
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	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 431	Continued From page 7 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 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 physical health of Resident 12 was monitored. Resident 12 had a documented weight loss from January to May 2023 and had not had a weight check in the past 2 months. This is a repeat deficiency. See Statement of Deficiency (SOD) S8M611, dated 12/13/2018,	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 431	Continued From page 8 SOD S8M612, dated 07/10/2019 and SOD VH4Z11, dated 08/08/2022. Findings include: On 07/17/2023 at approximately 2:00 p.m., Surveyor reviewed Resident 12's record. Resident 12 was admitted to the facility on 08/02/2022 with diagnoses including dementia and anxiety. Resident 12's individual service plan (ISP), not dated, stated "Wellness monitoring as needed every day - Goal to maintain present wellness monitoring and to intercede with care providers as needed." Surveyor then reviewed Resident 12's vitals history, dated 01/01/2023 to 07/17/2023, with Administrator L which documented the following: - 01/04/2023: 195.2 lbs - 01/09/2023: 195.4 lbs - 03/22/2023: 175 lbs - 03/29/2023: 184.4 lbs - 05/06/2023: 169 lbs Surveyor shared concern with Administrator L that Resident 12 had a documented weight loss of 26 lbs from January to May 2023, but no weight recorded in the past 2 months. Administrator L acknowledged concern and stated the weight loss was likely an error in documentation. Administrator L then weighed Resident 12 and had a result of 165 lbs, concluding a 30 lb weight loss in approximately 6 months. Surveyor observed that Resident 12's pants were visibly loose on him/her. Administrator L stated this was the first s/he was learning of the weight loss. Administrator L stated caregivers should be checking vitals, including weights, monthly and notifying Administrator L of concerns so s/he can follow up. Administrator L stated s/he would follow	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 431	Continued From page 9 up with caregivers regarding weight checks and follow up with Resident 12's physician regarding the weight loss.	N 431		
{N 452}	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored under sanitary conditions for the prevention of food borne illnesses. The provider's refrigerator contained expired food and food that was not labeled or dated. This is a repeat deficiency. See Statement of Deficiency (SOD) VH4Z12, dated 12/20/2022. Findings include:	{N 452}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 452}	Continued From page 10 On 07/13/2023 at approximately 12:20 p.m., Surveyor toured the facility's kitchen and observed the following in the provider's refrigerator: - An open container of cottage cheese, not dated. - A container of stir-fried rice, not labeled or dated. Caregiver P stated the rice was his/her personal food. Surveyor shared concern that the food was not identified as a staff member's food and Surveyor observed Resident 9 eating the rice in the dining room. Caregiver P replied, "Yeah. [S/he] wanted some." - A container of sloppy joes, not labeled or dated. Caregiver P stated the sloppy joe meat was from a resident's family 2 days ago. - Italian Dressing that expired 06/10/2023. - An open container of guacamole, not labeled or dated. - An open bag of burritos, not labeled or dated. - A plastic Tupperware of applesauce, not labeled or dated. Caregiver P stated the applesauce was from the day prior. - Celery not properly sealed. - An open bag of lunch meat, not dated. "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) At approximately 12:20 p.m., as Surveyor shared concern that foods were not labeled or dated with Caregiver P, Caregiver P stated s/he was just about to clean the refrigerator.	{N 452}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 452}	Continued From page 11 At approximately 2:30 p.m., Surveyor reviewed food safety concerns with Administrator L. Administrator L stated, "We just had a meeting this morning about cleaning the refrigerator."	{N 452}		
{N 499}	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all cleaning compounds and toxic substances were stored in a secure area. The provider's laundry room, cleaning/linen closet and maintenance room, which stored toxic chemicals, were not locked. This is a repeat deficiency. See Statement of Deficiency (SOD) VH4Z12, dated 12/20/2022. Findings include: On 07/13/2023 at approximately 12:30 p.m., Surveyor toured the provider's facility with Administrator N. The provider is licensed to serve up to 20 residents with diagnoses including advanced age and irreversible dementia/Alzheimer's. Surveyor observed the following concerns: - The facility's laundry room, which contained laundry detergent, was unlocked. Surveyor observed the laundry room door was not self-closing and the lock on the door was not engaged.	{N 499}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 499}	Continued From page 12 - The facility's maintenance closet, which had sealant spray and cans of paint, was unlocked and accessible to residents. - The facility's linen/cleaning closet was unlocked and accessible to residents. The door had a keypad lock; however, the lock was not engaged. As Surveyor gained access to each area of the areas that stored toxic chemicals, Surveyor voiced concern that several toxic chemicals were accessible to residents with Administrator N. Administrator N nodded his/her head in understanding of the concern and stated s/he would follow up with caregivers to make sure doors are locked. On 07/13/2023 at approximately 12:50 p.m., Surveyor observed Caregiver O attempt to enter the laundry room. As Caregiver O turned the handle s/he stated, "It's locked? Do we got a key for this?" Caregiver O then followed up with Administrator N to obtain a key. On 07/17/2023 at approximately 1:30 p.m., Surveyor observed the facility's laundry room door completely ajar, leaving laundry detergent accessible. Caregiver P stated s/he was just doing laundry. On 07/18/2023 at approximately 4:00 p.m., Surveyor reviewed concern regarding unsecured toxic substances in the facility with Licensee S. Licensee S stated s/he was unaware that toxic substances needed to be kept locked. The provider did not ensure toxic chemicals were stored secured.	{N 499}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 558}	Continued From page 13	{N 558}		
{N 558}	83.48(8)(b) Sprinkler system installation and maintenance Installation and maintenance. 1. All sprinkler systems shall be installed by a state licensed sprinkler contractor. All sprinkler systems shall be maintained, inspected and tested at least annually or at intervals determined by the requirements in NFPA 25. 2. In facilities with sprinklers, sprinkler heads shall be placed at the top of each linen or trash chute and in the rooms where the chutes terminates. 3. The sprinkler system flow alarm shall be connected to the CBRF ' s fire alarm system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility's sprinkler system was maintained and inspected annually. The provider did not follow up on deficiencies identified in the sprinkler system inspection completed on 02/23/2023. This is a repeat deficiency. See Statement of Deficiency (SOD) VH4Z12, dated 12/20/2022. Findings include: On 07/13/2023 at approximately 2:00 p.m., Surveyor requested documentation of the provider's most recent sprinkler system inspection from Administrator L. Administrator L was unable to locate a sprinkler system inspection. Administrator L explained s/he had recently become the administrator of the facility in June 2023 and documentation was left in disarray from the previous administrator. On 07/14/2023 at 2:30 p.m., Surveyor received documentation of a sprinkler system inspection,	{N 558}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 558}	Continued From page 14 dated 02/23/2023, from Administrator L. The documentation listed several deficiencies and stated "[Inspection Company] will be contacting you shortly to discuss how we may help you create an action plan to correct deficiencies identified in this inspection." On 07/18/2023 at 12:50 p.m., Licensee S followed up with Surveyor regarding the sprinkler system and stated, "All the deficiencies you referenced are related to completing a 5-year inspection. I will schedule it with the contractor." The provider did not ensure the sprinkler system was maintained.	{N 558}		
{N 637}	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared	{N 637}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 637}	Continued From page 15 driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 4 of 4 emergency exits were free of obstructions. Each of the facility's emergency exits were obstructed by a latched gate at the exterior of the door. This is a repeat deficiency. See Statement of Deficiency (SOD) VH4Z12, dated 12/20/2022. Findings include: On 07/13/2023 at 1:00 p.m.., Surveyor toured the provider's facility. Surveyor observed 4 exits identified as emergency exits on the facility's posted evacuation plan. Surveyor observed each of the 4 exits had emergency exit lights to identify the emergency exit. Surveyor then observed each of the exits had an enclosed gated area on the exterior, which required an individual to unlatch the gate to exit and reach a safe area in the event of an emergency. On 07/13/2023 at approximately 2:30 p.m., Surveyor reviewed concern with Administrator L that all 4 emergency exits were obstructed by a latched gate on the exterior. Administrator L stated s/he thought that was acceptable since the facility was a memory care facility and that the gates had always been there. Administrator L stated s/he will follow up with maintenance to have the gates removed. On 07/18/2023 at approximately 4:00 p.m., Surveyor reviewed concern regarding obstructed exits with Licensee S. Licensee S replied, "That's	{N 637}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 637}	Continued From page 16 how the building was when we got it."	{N 637}		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility's laundry room door, located on the same level as resident bedrooms, was self-closing. Findings include: On 07/13/2023 at approximately 12:30 p.m., Surveyor toured the provider's facility with Administrator N. Surveyor observed the laundry room door did not self-close when left ajar. Surveyor shared observation that the door was not self-closing. Administrator N nodded his/her head in acknowledgement. On 07/13/2023 at approximately 2:30 p.m., Surveyor reviewed concern with Administrator L that the laundry room door was not self-closing. Administrator L stated s/he would follow up with the facility's maintenance personnel.	N 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011776	A. BUILDING: _____ B. WING _____	R-C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	505 W LAWN DRIVE COTTAGE GROVE, WI 53527

(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 640	Continued From page 17 On 07/18/2023 at approximately 4:00 p.m., Surveyor reviewed concern that the facility's laundry room door was not self-closing with Licensee S. Licensee S stated s/he was unaware the door needed to be self-closing.	N 640		