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 03/03/2025

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 03/03/2025, Surveyor conducted a verification visits at Kindredhearts of Cottage Grove, a CBRF in Cottage Grove. One deficiency was identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 5	{N 000}		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medication administration services to meet the needs of 3 of 5 residents. Resident 7, Resident 12 and Resident 8 did not have all prescribed medications available for administration. Findings include: On 03/03/2025 at approximately 8:45 a.m., Surveyor reviewed the provider's medication cart	N 432		

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 03/03/2025

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 432	Continued From page 1 and physician orders for 5 of 5 residents residing at the facility with Caregiver FF. The following concerns were identified: - Resident 7's Senexon-S 50 (Start Date: 12/25/2023 - Take 2 tablets 2 times daily as needed for constipation), Diclofenac Sodium 1% gel (Start Date: 03/11/2024 - Apply 2 to 4 grams 4 times daily as needed for pain to painful joints) and Promethazine-DM 6.25-15 mg (Start Date 12/14/2023 - Take 5 mls every 6 hours as needed for cough) were not available for administration. - Resident 12's Diclofenac Sodium 1% gel (Start Date: 02/22/2023 - Apply 2 grams to wrists and ankles 3 times daily as needed), Artificial Tears (Start Date: 02/22/2023 - Instill 1 drop in each eye 4 times daily as needed), Triamcinolone .1% ointment (Start Date: 02/22/2023 - Apply to affected spots on scalp and face 2 times daily as needed), and Ketoconazole 2% shampoo (Start Date: 02/22/2023 - Use 2 times weekly on Mondays and Fridays) were unavailable for administration. - Resident 8's Triamcinolone .1% cream (Start Date: 10/07/2024 - Apply to affected areas 3 times daily for itching), Albuterol Sul 2.5 mg (Start Date: 10/07/2024 - Inhale via nebulizer every 4 hours as needed for shortness of breath or wheezing), Siltussin cough syrup (Start Date: 01/22/2025 - Take 10 ml every 6 hours as needed for cough) and Ondansetron 4 mg (Start Date: 02/09/2024 - Take 1 tablet every 6 hours as needed for nausea/vomiting) were unavailable for administration. On 03/03/2025 at approximately 9:00 a.m., Surveyor asked Caregiver FF if the above medications were available elsewhere in the facility. Caregiver FF replied, "No. I've never seen them."	N 432		

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 03/03/2025

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 432	Continued From page 2 On 03/03/2025 at approximately 9:10 a.m., Surveyor reviewed the list of unavailable medications with Administrator II. Administrator II stated s/he had recently cleared the cart of expired medications and placed a reorder through pharmacy. On 03/03/2025 at approximately 9:35 a.m., Surveyor interviewed an individual with the pharmacy, Pharmacy JJ. Surveyor reviewed each of the above residents and their unavailable medications and asked if the pharmacy had a "reorder" on file. Pharmacy JJ stated there was not reorder/refill requests for the above residents and corresponding medications. On 03/03/2025 at approximately 9:45 a.m., Surveyor interviewed Administrator II and Chief Operating Officer HH and shared concern that 3 of 5 residents did not have all prescribed medications available for administration. Administrator II stated s/he had left his/her reorder request on a voicemail and heard the pharmacy had issues with their voicemail. Surveyor then shared concern that the provider attested to compliance, including compliance with medications on 02/04/2025, but appeared to not be in compliance by having medications unavailable. Chief Operating Officer HH confirmed the provider had attested to compliance, yet did not have medications available for administration. On 03/03/2025 at approximately 1:15 p.m., Surveyor received documentation from Chief Operating Officer HH that stated the provider's pharmacy had experienced intermittent voicemail outages from 02/11/2025 to 02/13/2025 and 02/17/2025 to 02/19/2025, indicating if a	N 432		

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 03/03/2025

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 432	Continued From page 3 voicemail outage affected the status of medication reorders, the provider would have had from 02/19/2025 to 03/03/2025 to follow up on the status of the reorders.	N 432		