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 06/09/2025

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 06/09/2025, Surveyor conducted a verification visit at Kindredhearts of Cottage Grove, a CBRF in Cottage Grove. One deficiency was identified. This is a repeat deficiency. See Statement of Deficiency (SOD) VH4Z18, dated 03/03/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 6	{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 2 of 6 residents. Resident 8 and Resident 19 did not have all prescribed medications available for administration. This is a repeat deficiency. See Statement of Deficiency (SOD) VH4Z18, dated 03/03/2025.	{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 06/09/2025

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 Findings include: On 06/09/2025 at approximately 10:15 a.m., Surveyor reviewed the provider's medication cart and physician orders for 6 of 6 residents residing at the facility with Assistant Administrator LL and Regional Director KK. The following concerns were identified: Example 1 - Resident 8: Resident 8 admitted to the provider's facility on 01/18/2016. Resident 8 had physician orders for the following medications which were unavailable in the provider's medication cart: Muscle Rub 15%-10% cream - Apply to affected area 3 times daily as needed (Start Date: 05/22/2018), Bisacodyl 10 mg suppository - Insert daily as needed for constipation (Start Date: 05/22/2018), Milk of Magnesia - Take 30 ml daily as needed for constipation (Start Date: 11/26/2018), Bisacodyl 5 mg - Take 1 tablet daily as needed for constipation (Start Date: 11/26/2018) and Senexon-S 50-8.6 mg - Take 2 tablets daily as needed for constipation (Start Date: 06/12/2021). On 06/09/2025 at approximately 11:00 a.m., Regional Director KK stated s/he had reached out to Resident 8's hospice agency on 04/23/2025 to refill Resident 8's PRN medications; however, at the same time Resident 8 switched hospice agencies. Regional Director KK stated s/he hadn't followed up on PRN medications since 04/23/2025. Regional Director KK then followed up with Resident 8's hospice RN, who was visiting the facility at that time. Regional Director KK stated the RN informed him/her that Resident 8's PRN prescriptions were sent to pharmacy on 05/12/2025, but allegedly not received and not followed up on until Surveyor's visit on	{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 06/09/2025

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 06/09/2025. Example 2 - Resident 19: Resident 19 admitted to the provider's facility on 05/07/2025. Resident 19 had physician orders for the following medications which were unavailable in the provider's medication cart: Milk of Magnesia - Take 30 ml daily as needed for constipation (Start Date: 05/19/2025) and Bisacodyl 10 mg suppository - Insert daily as needed for constipation (Start Date: 05/19/2025). On 06/09/2025 at approximately 11:00 a.m., Regional Director KK informed Surveyor that Resident 19's order for Bisacodyl suppositories was overlooked upon admission because it was a "standing order" from the physician. Regional Director KK stated Resident 19's Milk of Magnesia was pending authorization from the managed care organization. Regional Director KK was unable to provide documentation related to the Milk of Magnesia pending authorization. Two of 6 residents did not have all medications available to them for administration.	{N 432}		