STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020858	A. BUILDING: _____ B. WING _____	C 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRUMLIN RESERVE MEMORY CARE	111 E REYNOLDS ST 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 01/27/2026, Surveyor conducted a standard licensing survey and complaint investigation at Drumlin Reserve Memory Care, a CBRF located in Cottage Grove, WI. As a result of the survey, 1 violation of Chapter DHS 83 was issued. The complaint was substantiated. Census:	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 that Resident 1 received prescribed medications in the dosage prescribed by a practitioner when Resident 1 received Resident 2's medication in error. Findings include: On 11/25/2025, the Department received a complaint alleging that a resident received another resident's medication in error. On 01/27/2025 at 9:00 AM, Surveyor reviewed	N 352		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 352	Continued From page 1 Resident 1's medical record. Resident 1 was admitted 07/27/2023 with diagnoses that include but are not limited to: Parkinson's disease, extrapyramidal and movement disorder, capsular glaucoma with pseudo exfoliation of lens, GERD, Diaphragmatic hernia, Spondylosis, dysphagia, history of pulmonary embolism. On 01/27/2026 at 9:30 AM, Surveyor interviewed Nurse B. Nurse B stated that there was an incident on 11/18/2025 where Resident 1 received Resident 2's hydromorphone by staff error. Nurse B stated that Former Caregiver C had admitted s/he was going too fast and grabbed the wrong medication. Nurse B stated that Resident 1 should have received .5 milligram (mg) clonazepam but instead received 2 mg hydromorphone which was prescribed for Resident 2. Nurse B stated that Resident 2 was not affected as s/he had received his/her dose. Nurse B stated that Resident 1 was visibly lethargic and having difficulty eating breakfast the next day (11/26/2025). Nurse B consulted Resident 1's Power of Attorney (POA), who declined to have Resident 1 sent to the hospital. On 01/27/2026 at 10:00 AM, Surveyor reviewed facility investigation dated 11/18/2025. Documentation confirmed that Former Caregiver C had given Resident 1, 2 mg hydromorphone, prescribed for Resident 2. Former Caregiver C indicated in a written statement, "I wasn't paying attention, and moving too fast." On 01/27/2026 at 10:45 AM, Surveyor interviewed Administrator A and Nurse B. Administrator A and Nurse B acknowledged that Resident 1 had received a medication prescribed for Resident 2 by	N 352		

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N 352	Continued From page 2 error by Former Caregiver C. Nurse B stated that Former Caregiver C employment had been terminated as a result and other staff trained on importance of paying attention to detail when passing medications.	N 352		