STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011775	A. BUILDING: _____ B. WING _____	C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	325 W COTTAGE GROVE ROAD 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 From 09/03/2024 to 09/04/2024, Surveyor conducted a complaint investigation at Kindredhearts of Cottage Grove, a CBRF in Cottage Grove. Three deficiencies were identified. The complaint was substantiated. Census: 12	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed received prompt and adequate treatment. Resident 1 did not receive treatment for pain after sustaining a fall that resulted in a hip fracture. Findings include: From 09/03/2024 to 09/04/2024, Surveyor conducted a complaint investigation alleging the provider did not assist with a resident's pain management after an injury. On 09/03/2024 at approximately 10:00 a.m., Surveyor reviewed Resident 1's facility record and hospice record, obtained by Surveyor. Resident 1 was admitted to the provider's facility on	N 353		

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

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04/11/2024. Resident 1's record included the following incident reports:

- 08/15/2024 10:15 a.m.: "Resident was trying to transfer to bed & chair slipped and fell on to the floor." The document stated Resident 1 rated his/her pain at a "7." The incident report indicated first aid was not given and vitals were not taken. The report indicated the supervisor was notified of the fall, but no further notifications were made.
- 08/16/2024 6:30 a.m.: "[Resident 1] had pulled [his/her] alarm and as I walked in [Resident 1] was laying on the floor with all of [his/her] blankets and pillows on the ground. [S/he] was on the side of [his/her] bed." The document stated Resident 1 rated his/her pain at a "9." The incident report indicated first aid was not given, vitals were taken and hospice was notified.

Resident 1's hospice record included the following notes:

- Visit 08/15/2024 from 2:57 p.m. to 4:38 p.m.: "Responded to fall per facility request. [Resident 1] already in bed again. Staff stated they found [him/her] on the floor and that [s/he] may have had a change in condition. "Excruciating pain" reported by [hospice]. Resident unable to bear weight on L leg. Grabbing hip. L leg turned outwards. No visible bruising other than L bicep hematoma. Contacted [family] regarding significant decline recently. Increased falls, restlessness reported by staff ... [Resident 1] is open to x-ray of hip and pain medication." *Based on incident report, fall occurred greater than 4 hours prior to visit from hospice.
- Visit 08/16/2024 from 8:35 a.m. to 11:31 a.m.: "Writer responded to additional fall this morning around 0630 ... [Resident 1] up in [his/her] reclining chair. Reporting pain 4-5/10 in L hip and

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N 353	Continued From page 2	N 353		

buttocks ... Resident able to recline electric chair in increments due to pain in L hip. L leg continues to be notably turned outwards. Able to pump ankles/flutter feet. Unable to bear weight."
- 08/17/2024 11:24 a.m.: "Called to check on [Resident 1]'s pain, still states that it is a 10/10. Advised facility to give PRN Tylenol, PRN Morphine, in addition to the scheduled Tramadol.
- 08/17/2024 8:10 p.m.: "Received phone call from facility that [Resident 1]'s family had come to visit and requested [s/he] be sent to [emergency department] to be evaluated. We have not received results from [his/her] x-ray. Facility staff stated [s/he] was still in pain after administering additional meds this morning when writer called to check in. Will wait to receive update from [emergency department]."

Resident 1's record indicated s/he had the following physician orders for pain management on 08/15/2024: Acetaminophen 500 mg (Start Date: 06/26/2024) - 1 tablet every 6 hours as needed and Tramadol Hcl 50 mg (Start Date: 07/24/2024) - 2 tablets every 6 hours as needed.

Resident 1's record indicated the following medications were ordered on 08/16/2024: Tramadol Hcl 50 mg scheduled every 6 hours for pain, Morphine Sulfate Ir 15 mg .5 tablet every 3 hours as needed for pain or shortness of breath and Lorazepam .5 mg every 3 hours as needed for agitation, anxiety, restlessness, nausea and/or vomiting.

Resident 1's medication administration record (MAR), dated 08/01/2024 to 08/17/2024, indicated Resident 1 was not administered any as needed medications for pain management or restlessness from 08/15/2024 to 08/17/2024. The MAR documented Resident 1's Tramadol Hcl 50

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mg scheduled to be administered at 2:00 a.m., 8:00 a.m., 1:00 p.m. and 8:00 p.m. was administered twice on 08/17/2024 at 10:05 a.m. and 7:52 p.m. (No note indicating why the 8:00 a.m. dose was not given within the prescribed interval or why the 1:00 p.m. dose was not administered) prior to Resident 1 discharging to the hospital on 08/17/2024.

On 09/03/2024 at approximately 10:30 a.m., Surveyor interviewed Caregiver B. Surveyor asked Caregiver B about Resident 1's 08/15/2024 fall. Caregiver B stated s/he went into Resident 1's room and found him/her in a lot of pain. Caregiver B stated Resident 1's body was on the bed, but his/her legs were hanging off. Caregiver B stated s/he didn't consider it a "fall" and wasn't sure if the pain Resident 1 was experiencing was due to a fall the night before or week prior. Caregiver B stated s/he contacted hospice to complete an assessment and later learned that Resident 1 had sustained a hip fracture. Surveyor asked Caregiver B what was done to help with Resident 1's pain management, identified on the fall report completed by Caregiver B as a "7." Caregiver B replied, "Nothing. I was waiting to be told what to do." Surveyor asked Caregiver B if s/he had considered administering medication for pain. Caregiver B replied, "I gave [him/her] the scheduled medications. That should have helped." Surveyor then asked Caregiver B to review Resident 1's medications and identify which scheduled medication would assist with pain control. Caregiver B reviewed the medications and stated, "I don't know what these are for. It isn't listed like the [as needed medications]." Caregiver B then stated, "I guess I should have given [him/her] something for pain."

On 09/03/2024 at approximately 11:00 a.m.,

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N 353	Continued From page 4 Surveyor reviewed concern with Administrator A and Consultant C that Resident 1 sustained a fall resulting in a hip fracture on 08/15/2024 but did not receive assistance with his/her pain management until receiving scheduled Tramadol on 08/17/2024. Surveyor reviewed the provider's record and hospice records that indicated a delay in pain management. Consultant C replied, "I don't disagree" in response to Surveyor's concerns. Consultant C then explained s/he and Administrator A had made a lot of staffing changes in the past few weeks since becoming involved with the facility. On 09/04/2024 at approximately 5:00 p.m., Surveyor reviewed hospital records, obtained by Surveyor. The record indicated Resident 1 was admitted to the hospital on 08/17/2024 with extreme pain with any movement or adjustment of his/her left hip, diagnosed with a left hip fracture and passed away on 08/19/2024. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 353		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities.	N 358		

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N 358	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents were safeguarded from environmental hazards. The electrical socket used for Resident 1's bed was in disrepair. Findings include: On 09/03/2024, Surveyor conducted a complaint investigation alleging Resident 1's electrical socket, used for his/her bed, was in disrepair. On 09/03/2024 at approximately 10:45 a.m., Surveyor observed the electrical socket in Resident 1's former room, used for Resident 1's bed, with Administrator A. Surveyor observed half of the inner plastic portion of the outlet was broke off with no outer face plate, exposing the electrical (Photo 1). Surveyor asked Administrator A how long the outlet had been in disrepair. Administrator A replied, "Based on the looks of it, a while." Surveyor asked Administrator A how Resident 1's bed was plugged into the outlet. Administrator A replied, "Not safely." On 09/03/2024 at approximately 11:00 a.m., Surveyor reviewed concern with the electrical socket exposing wires with Administrator A and Consultant C. Both Administrator A and Consultant C acknowledged there were areas of the facility that needed repairs and explained new maintenance personnel would be starting 09/09/2024.	N 358		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental	N 381		

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condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the needs, abilities and physical condition were assessed for 1 of 2 residents reviewed when there was a change in needs. Resident 1's physical condition and/or needs were not reassessed after sustaining falls.

Findings include:

From 09/03/2024 to 09/04/2024, Surveyor conducted a complaint investigation alleging the provider did not properly respond to falls.

On 09/03/2024 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 04/11/2024. Resident 1's record included the following incident reports, dated 06/17/2024 to 08/17/2024:

- 06/25/2024 5:20 p.m.: "Resident paged staff to [his/her] room once [s/he] fell. When we got there [s/he] was on the floor and mentioned that [s/he] had fell and hit [his/her] head. Staff took a set of vitals. Hospice nurse was still on site and did an exam and retook vitals. [Resident 1] stated [s/he]

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did not want to be sent out but would follow up with staff if pain got worse or [s/he] felt [s/he] needed to be sent out. The report documented Resident 1's pain at a "4." *The report did not include any further assessment/intervention to prevent further falls.
- 07/06/2024 4:30 p.m.: "Aides went in to remind [him/her] to come out for dinner. [S/he] then stated [s/he] would like to stay in [his/her] room because had taken a pretty hard fall and hit [his/her] head. Asked if [s/he] notified or called for help, and [s/he] said no." The report indicated Resident 1 rated his/her pain at a "6", vitals were not taken, first aid was not given and range of motion was not performed. *The report did not include any further assessment of Resident 1's physical condition or assessment/intervention to prevent further falls.
- 08/15/2024 10:15 a.m.: "Resident was trying to transfer to bed & chair slipped and fell on to the floor." The document stated Resident 1 rated his/her pain at a "7." The incident report indicated first aid was not given and vitals were not taken. *The report did not include any further assessment of Resident 1's physical condition or assessment/intervention to prevent further falls.
- 08/16/2024 6:30 a.m.: "[Resident 1] had pulled [his/her] alarm and as I walked in [Resident 1] was laying on the floor with all of [his/her] blankets and pillows on the ground. [S/he] was on the side of [his/her] bed. The incident report indicated first aid was not given, vitals were taken, and pain level was rated at a "9." *The report did not include any further assessment/intervention to prevent further falls.

Resident 1's individual service plan (ISP), dated May 2024, stated Resident 1 had no past history of falls and required no alternative safety measures. The ISP indicated Resident 1

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N 381	Continued From page 8 ambulated with standby assistance with a 4 wheeled walker. On 09/03/2024 at approximately 10:30 a.m., Surveyor interviewed Administrator A. Surveyor shared observation that Resident 1's ISP indicated s/he had no history of falls and had no alternative safety measures in place. Surveyor shared that of the 4 falls reviewed, 2 physical assessments were incomplete and all 4 did not include an intervention to prevent further falls. Administrator A, who started with the provider 08/19/2024, confirmed s/he had no further assessments to provide and agreed that assessments should have been completed and the ISP updated for Resident 1. On 09/03/2024 at approximately 11:00 a.m., Surveyor reviewed concern with Resident 1's lack of assessments following falls with Administrator A and Consultant C. Consultant C stated s/he and Administrator A had recently started with the provider and were starting to work on getting resident records reviewed and updated. On 09/04/2024 at approximately 5:00 p.m., Surveyor reviewed a hospital record, obtained by Surveyor. The record indicated Resident 1 was admitted to the hospital on 08/17/2024 with extreme pain with any movement or adjustment of his/her left hip after sustaining falls at the facility, diagnosed with a left hip fracture and passed away on 08/19/2024. Cross Reference: N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment	N 381		