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 07/24/2024

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 07/23/2024 to 07/24/2024, Surveyors conducted a complaint investigation at Kindredhearts of Cottage Grove, a CBRF in Cottage Grove. Two deficiencies were identified. One deficiency is a repeat deficiency. See Statement of Deficiency (SOD) G0WL14, dated 02/23/2023. The complaint was substantiated. Census: 12	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 2 of 2 residents reviewed received all medications in the dosage and at intervals prescribed by a practitioner. Resident 2 did not receive his/her medications as prescribed on 07/10/2024. Resident 1 did not receive his/her medications as prescribed on 07/22/2024. This is a repeat deficiency. See Statement of Deficiency (SOD) G0WL14, dated 02/23/2023. Findings include: From 07/23/2024 to 07/24/2024, Surveyor	N 352		

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
	0011775	A. BUILDING: _____ B. WING _____	C 07/24/2024

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 352	Continued From page 1	N 352		

conducted a complaint investigation regarding medication errors. Surveyor reviewed Resident 1 and Resident 2's records, which identified the following concerns:

Example 1 - Resident 1:

Resident 1 admitted to the provider's facility on 06/24/2021 with diagnoses including dementia, depression and seizures. Resident 1's physician orders included the following 8:00 a.m. medications:

- Vitamin D25 mcg 1 tablet (Start Date: 07/02/2024)
- Vitamin B-12 1000 mcg 2 tablets (Start Date: 06/05/2024)
- Magnesium Oxide 400 mg 1 tablet (Start Date: 07/03/2024)
- Certavite tablet 1 tablet (Start Date: 06/05/2024)
- Levetiracetam 250 mg .5 tablet 2 times (Start Date: 06/06/2024)
- Tramadol Hcl 50 mg .5 tablets 3 times (Start Date: 07/08/2024)
- Sertraline Hcl 50 mg 1 tablet (Start Date: 06/06/2024)

Resident 1's Medication Administration Record (MAR), dated 07/01/2024 to 07/23/2024, documented Resident 1 had blank entries for his/her 8:00 a.m. medications on 07/22/2024.

On 07/23/2024 at approximately 2:30 p.m., Surveyor interviewed Administrator A and Caregiver E. Caregiver E confirmed s/he completed 8:00 a.m. medication pass on 07/22/2024. Caregiver E stated s/he did not pass Resident 1's 8:00 a.m. medications because the medications for 07/22/2024 were already punched out of Resident 1's medication punch

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 07/24/2024

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 352	Continued From page 2	N 352		

cards. Caregiver E stated s/he informed Administrator A. Administrator A sighed and stated there was a miscommunication. Administrator A stated Resident 1's punch cards were off by a day to a medication error on 07/10/2024 and Administrator A had not been able to order replacement medications yet due to the pharmacy's billing cycle. Administrator A stated Resident 1's medications should have been administered on 07/22/2024 using a different date/number in the punch card.

Example 2 - Resident 2:

On 07/23/2024 at approximately 2:45 p.m., Surveyors reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 07/30/2021 with diagnoses including dementia, chronic kidney disease and epilepsy. Resident 2's record included a progress note, dated 07/10/2024 at 8:00 a.m., that stated Resident 2 took Resident 1's medications in error on 07/10/2024. Resident 2's MAR documented the following medications were not administered at 8:00 a.m. on 07/10/2024 as prescribed: Docusate Sodium 100 mg, Lidocaine 5% patch, Tamsulosin .4 mg, Escitalopram 10 mg, Vitamin D-2 1.25 mg, Levetiracetam 750 mg, Lamotrigine 25 mg, Bisoprolol-Hct 10-6.25 mg, Duloxetine 30 mg, Vitamin B-2 100 mg, Polyethylene Glycol 3350 17 grams, Gabapentin 100 mg, Lisinopril 20 mg and Amlodipine 5 mg. The MAR indicated Resident 2 received his/her Hydrocodone -Apap at 9:45 a.m. Resident 2's record did not list Resident 1's 8:00 a.m. medications that were ingested; however, Resident 1's MAR indicated the following for 8:00 a.m. medications: Vitamin D 25 mcg, Vitamin B-12 1000 mcg, Magnesium Oxide 400 mg, Certavite tablet, Levetiracetam 250 mg, Tramadol Hcl 50 mg and Sertraline Hcl

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 07/24/2024

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 352	Continued From page 3 50 mg. Resident 2's record did not include documentation indicating the medication error had been reported to a licensed practitioner, supervising nurse or pharmacist or that guidance as to what medications to hold or administer was received. Cross Reference: N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction	N 352		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an error in medication administration was reported to a licensed practitioner, supervising nurse or pharmacist immediately. The provider did not immediately notify a licensed practitioner, supervising nurse or pharmacist when Resident 2 ingested Resident 1's 8:00 a.m. medications on 07/10/2024.	N 410		

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 07/24/2024

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 410	Continued From page 4 Findings include: From 07/23/2024 to 07/24/2024, Surveyors conducted a complaint investigation alleging the provider did not follow proper protocol after a medication error occurred. On 07/23/2024 at approximately 2:30 p.m., Surveyor interviewed Administrator A. Administrator A stated Resident 1's medications were left unattended in the dining room and ingested by Resident 2 on 07/10/2024. Administrator A stated s/he was out ill at the time, but was contacted by caregivers to inform of the medication error. Administrator A stated s/he was so ill s/he barely remembered the phone call, but instructed caregivers to hold all of Resident 2's medications except Resident 2's Hydrocodone. Administrator A stated after realizing the instruction s/he had given, s/he was mad at him/herself for allowing Resident 2 to receive 2 narcotics. Administrator A stated s/he believed Director of Operations C and RN D were also notified of the error but was too ill at the time to recall details. On 07/23/2024 at approximately 2:45 p.m., Surveyors reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 07/30/2021 with diagnoses including dementia, chronic kidney disease and epilepsy. Resident 2's record included a progress note, dated 07/10/2024 at 8:00 a.m., that stated Resident 2 took Resident 1's medications, which were left unattended on a dining room table. The progress notes indicated Caregiver B took Resident 2's vitals as follow up at 11:30 a.m. and 5:15 p.m. that day. Resident 2's medication administration record (MAR), dated 07/10/2024,	N 410		

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 07/24/2024

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 410	Continued From page 5	N 410		

documented Resident 2 received his/her 8:00 a.m. Hydrocodone at 9:45 a.m., but all other 8:00 a.m. medications were held. Held 8:00 a.m. medications included Docusate Sodium 100 mg, Lidocaine 5% patch, Tamsulosin .4 mg, Escitalopram 10 mg, Vitamin D-2 1.25 mg, Levetiracetam 750 mg, Lamotrigine 25 mg, Bisoprolol-Hct 10-6.25 mg, Duloxetine 30 mg, Vitamin B-2 100 mg, Polyethylene Glycol 3350 17 grams, Gabapentin 100 mg, Lisinopril 20 mg and Amlodipine 5 mg. Resident 2's record did not list what medications were ingested in error; however, Resident 1's MAR listed the following 8:00 a.m. medications that would have been on the table unsupervised: Vitamin D 25 mcg, Vitamin B-12 1000 mcg, Magnesium Oxide 400 mg, Certavite tablet, Levetiracetam 250 mg, Tramadol Hcl 50 mg and Sertraline Hcl 50 mg. Resident 2's record did not document notification to a licensed practitioner, supervising nurse or pharmacist.

On 07/23/2024 at approximately 4:00 p.m., Surveyor asked Director of Operations C if s/he or RN D provided any guidance or took any action for Resident 2's medication error on 07/10/2024.

On 07/24/2024 at approximately 9:00 a.m., Director of Operations C stated neither she, nor RN D had any advice or guidance related to the medication error until Administrator A returned to work.

On 07/24/2024 at approximately 12:00 p.m., Surveyor interviewed Director of Operations C. Director of Operations C stated neither s/he, nor RN D were made aware of Resident 2's medication error on 07/10/2024.

On 07/24/2024 at approximately 1:45 p.m.,

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 07/24/2024

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 410	Continued From page 6 Surveyor interviewed Administrator A. Surveyor shared concern that Resident 2's record did not indicate a licensed practitioner, supervising nurse or pharmacist were notified of Resident 2's medication error and that Director of Operations C denied him/her or RN D being aware of the medication error until days later. Administrator A stated s/he could not speak to what occurred on 07/10/2024 because s/he was too ill at that time. Administrator A stated s/he was only able to share that s/he completed re-education after s/he returned to work on 07/15/2024 and put a plan in place on who to contact when concerns occurred when Administrator A was unavailable. Cross Reference: N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medications	N 410		