STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016710	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING	2514 WISCONSIN AVE NEW HOLSTEIN, WI 53061

(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 08/12/2024, Surveyors conducted a complaint investigation at Caring Hands Assisted Living. The complaint was substantiated. Four deficiencies were identified. Census: 42	N 000		
N 285	83.27(1)(a) Limitation of capacity as shown on license. No CBRF may have more residents, including respite care residents, than the maximum bed capacity on its license. This Rule is not met as evidenced by: Based on record review and interview, the provider had more residents than the maximum bed capacity on its license. The provider was originally licensed for 24 resident bed capacity. On 04/10/2024, the department approved the amended bed capacity from 24 beds to 44 beds. From 04/05/2024 through 04/10/2024, the provider exceeded their 24 bed capacity by having 29 residents. Findings include: On 07/24/2024, the department received complaint information alleging residents were admitted above licensed capacity. On 08/12/2024, Surveyors conducted a complaint investigation. Surveyor reviewed the department's provider electronic file and noted a correspondence letter to the provider dated 04/10/2024, amending the licensed bed capacity from 24 to 44 residents.	N 285		

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
	0016710	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING	2514 WISCONSIN AVE NEW HOLSTEIN, WI 53061

(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 285	Continued From page 1 Surveyor reviewed the provider's resident roster and noted the census of the facility on 04/09/2024 was 29 residents. Surveyor noted on 04/04/2024, the census reached full capacity of 24 residents. On 04/05/2024, Resident 1 and Resident 2 were admitted to the facility, on 04/08/2024, Resident 3, Resident 4, and Resident 5 were admitted to the facility. On 08/12/2024 at approximately 2:25 PM, Surveyors interviewed Administrator A who verified Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5 were admitted to the facility before the resident bed capacity increase on 04/10/2024, which exceeded the original licensed capacity.	N 285		
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 Resident 9 received medication in the dosage and at intervals prescribed by a practitioner. Findings include: On 07/24/2024, the department received complaint information alleging residents did not	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016710	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING	2514 WISCONSIN AVE NEW HOLSTEIN, WI 53061

(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 receive medications as prescribed. On 08/12/2024, Surveyors conducted a complaint investigation. Surveyor reviewed Resident 9's May and June 2024 Medication Administration Record (MAR). Surveyor noted an order for Tramadol HCl 50 mg tab - Take 1 tablet twice daily at 5 AM and bedtime for chronic pain. Resident 9 did not receive Tramadol HCl 50 mg on 06/17/2024 at 5:00 AM, 06/17/2024 at 7:00 PM, 06/18/2024 at 5:00 AM, and 07/04/2024 at 5:00 AM. Surveyor noted staff notation indicating "out." On 08/12/2024 at approximately 2:25 PM, Surveyors interviewed Administrator A who stated having difficulty getting the medication refilled, which is why Resident 9's MAR listed "out." Administrator A verified Resident 9 did not receive his/her medication as prescribed.	N 352		
N 370	83.34(3) More than $200 personal funds from resident Funds in excess of $200. A CBRF receiving more than $200 of personal funds from a resident shall deposit funds in excess of $200 in an interest-bearing account in the resident ' s name in a savings institution insured by an agency of, or a corporation chartered by, this state or the United States. This Rule is not met as evidenced by: Based on record review and interview, the provider maintained Resident 7's personal funds which exceeded $200.	N 370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016710	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING	2514 WISCONSIN AVE NEW HOLSTEIN, WI 53061

(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 370	Continued From page 3 Findings include: On 07/24/2024, the department received complaint information alleging resident funds were being kept in excess of $200. On 08/12/2024, Surveyors conducted a complaint investigation. On 08/12/2024 at approximately 2:20 PM, Administrator A and Surveyors observed Resident 7's lock box of personal funds in Administrator A's office. Surveyors reviewed an accounting ledger that listed as of 07/24/2024, Resident 7's cash account balance was $2,164.13. On 08/12/2024 at approximately 2:25PM, Surveyors interviewed Administrator A regarding the ledger balance. Administrator A confirmed s/he managed more than $200 for Resident 7. Administrator A acknowledged the need to assist Resident 7 with obtaining a representative payee, set up a bank account, or find other means to manage Resident 7's personal funds that exceeded $200.	N 370		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016710	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING	2514 WISCONSIN AVE NEW HOLSTEIN, WI 53061

(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 415	Continued From page 4 PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medication administration performed by provider staff was documented in Resident 6 and Resident 8's medication administration records (MAR). Findings include: On 07/24/2024, the department received complaint information alleging resident medication administration was not documented appropriately. On 08/12/2024, Surveyors conducted a complaint investigation. RESIDENT 6 Surveyor reviewed Resident 6's sample April-July 2024 MARs and noted missing documentation. Surveyor noted 21 days where administration of medications was not initialed or documented as having been administered or not for the following medication and dates: Prednisone 5 mg - Take 1 tablet daily for chronic obstructive pulmonary disease 05/24/2024, 05/25, 05/26, 05/27, 06/01, 06/02, 06/03, 06/04, 06/06, 06/07, 06/08, 06/09, 06/10, 06/12, 06/13, 06/14, 06/15, 06/17, 06/18, 06/20, 07/07 Surveyor noted the following administration of as needed (PRN) medications to Resident 6 where the result or efficacy of the administration was not documented:	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016710	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING	2514 WISCONSIN AVE NEW HOLSTEIN, WI 53061

(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 415	Continued From page 5 04/22/2024 8:15 PM Morphine for shortness of breath 04/24/2024 8:30 PM Morphine for shortness of breath 04/27/2024 2:30 PM Morphine for shortness of breath 05/07/2024 8:00 PM Acetaminophen for pain 05/09/2024 5:00 PM Prochlorperazine for nausea 05/09/2024 6:00 PM Morphine for pain and shortness of breath 05/10/2024 1:45 PM Prochlorperazine for nausea 05/10/2024 4:00 PM Morphine for high respirations, pain, shortness of breath 05/11/2024 10:38 AM Morphine for shortness of breath 05/11/2024 12:00 PM Lorazepam - requested 05/11/2024 1:00 PM Prochlorperazine for nausea 05/22/2024 8:00 PM Acetaminophen for pain 05/22/2024 9:00 PM Lorazepam 0.5 mg for anxiety 05/22/2024 11:46 PM Lorazepam 0.5 mg for anxiety 6/11/2024 8:00 PM Acetaminophen for pain 06/14/2024 5:00 PM Albuterol sulfate for shortness of breath 06/14/2024 9:00 PM Acetaminophen for pain 06/16/2024 7:00 PM Acetaminophen for pain 07/02/2024 8:40 AM Loratadine for pain 07/02/024 8:40 AM Morphine for pain 07/02/2024 10:45 AM Morphine for shortness of breath RESIDENT 8 Surveyor reviewed Resident 8's sample June 2024 MAR and noted 5 days where administration of medications was not initialed or documented as having been administered or not for the following medications and days: Amlodipine Besylate 5 mg tab - Take 1 tablet once daily.	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016710	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS ASSISTED LIVING	2514 WISCONSIN AVE NEW HOLSTEIN, WI 53061

(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 415	Continued From page 6 Aspirin 81 mg EC tablet - Take 1 tablet daily. Ketotifen 0.025% Eye - Instill 1 drop into both eyes twice daily. Polyethylene Glycol - Mix 17 grams in 6-8 ounces of water or juice and drink daily. 06/06/2024, 06/07, 06/08, 06/09, 06/10 On 08/12/2024 at approximately 2:30 PM, Surveyors interviewed Administrator A who stated Resident 8 was in the hospital from 06/05/2024 through 06/10/2024, but staff should have documented. On 08/12/2024 at approximately 2:40 PM, Surveyors interviewed Administrator A who acknowledged lack of staff documentation in Resident 6 and Resident 8's MARs.	N 415		