STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019492	A. BUILDING: _____ B. WING _____	C 03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON ASSISTED LIVING	2626 FINGER RD GREEN BAY, WI 54302

(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 03/13/2024 with additional information gathered through 03/18/2024, Surveyor conducted a complaint investigation at Carrington Assisted Living. As a result, the complaint was substantiated and 1 deficiency was identified. Census: 13	N 000		
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 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 accurate documentation of medication administration. There was one entry in Resident 1's Medication Administration Record (MAR) that was missing documentation related to the administration of Hyoscyamine. Findings include: On 03/08/2024, the Department received a complaint alleging Resident 1 received another resident's secretion medication in error on	N 415		

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

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N 415	Continued From page 1 02/07/2024. On 03/13/2024 at approximately 9:35 AM, Surveyor reviewed Resident 1's closed record. Resident 1 was admitted 11/02/2023 with diagnoses that included congestive heart failure and weakness. Resident 1 was admitted to hospice on 01/25/2024 and passed away on 02/07/2024. Surveyor reviewed Resident 1's MAR for February 2024 and there was no documentation or medication listed for Hyoscyamine on 02/07/2024. There was also no documentation/ in Resident 1's observation notes. Surveyor observed a standing order from hospice that indicated Resident 1 was admitted onto hospice with a start date of 01/25/2024 and an end date of 04/25/2024. Within the hospice standing order, Surveyor observed Hyoscyamine was listed as a PRN and 0.125 mg was to be given every 4 hours as needed. Surveyor observed a signature by Resident 1's physician on 02/23/2024 which was signed 16 days after his/her death. On 03/13/2024 at 10:24 AM, Surveyor interviewed Administrator A who confirmed the secretion medication was called Hyoscyamine. S/he reported Caregiver B administered Hyoscyamine to Resident 1 on 02/07/2024 as Resident 1 appeared to be "gurgling." Administrator A reported when Caregiver B went to enter the information into the MAR, s/he realized the medication was not listed. Administrator A stated Caregiver B immediately notified him/her and they both double checked the MAR and observed it was not listed. Administrator A confirmed the facility processed	N 415		

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N 415	Continued From page 2	N 415		

this as a medication error and Caregiver B was removed from the cart and has since been re-educated.

On 03/13/2024 at approximately 11:00 AM, Surveyor interviewed Resident Care Coordinator (RCC) C who reported Caregiver B thought the hospice aide in the room on 02/07/2024 was the hospice registered nurse. RCC C stated the aide told Caregiver B Resident 1 sounded "gurgly" and suggested s/he could use something for his/her secretions. RCC C stated Caregiver B took the Hyoscyamine from Resident 2's medications when s/he noticed it was not in the medication cart and administered it to Resident 1. RCC C stated Caregiver B reported s/he was told in the past from hospice nurses comfort medications can be used if needed from another hospice patient and can be replaced. RCC C reported once Caregiver B went to enter it into Resident 1's MAR s/he realized it was not listed. RCC C stated since this happened Caregiver B was pulled off the medication cart, re-trained, re-delegated and shadowed prior to assuming his/her duties back on the cart.

On 03/14/2024 at approximately 3:05 PM, Surveyor received an email from Chief Operating Officer (COO) D that included a physician order for Hyoscyamine starting 01/26/2024 and ending 02/08/2024. COO D stated, "We had the other orders and had faxed them to [pharmacy] to be filled, so I am not sure how we didn't have the other order in our records."

On 03/15/2024 at 4:16 PM, Surveyor contacted COO D via phone to inquire about the documentation of the medication administration of the Hyoscyamine as Surveyor did not see any documentation in Resident 1's MAR or

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N 415	Continued From page 3 observation notes. COO D reported s/he would double check their records and let Surveyor know by 10 AM on 03/18/2024. On 03/17/2024 at 6:37 PM, Surveyor received a follow up email from COO D that included an attachment of an observation note dated 03/15/2024 at 4:15 PM. The observation note stated, "Late entry: [Resident 1] received Hyoscyamine dose at 12:00 pm on 2/7/2024..." COO D confirmed s/he put the documentation in Resident 1's file on 03/15/2024 relating to the medication being administered. COO D also confirmed the facility never received the hospice comfort pack which included Hyoscyamine for Resident 1 as it was delivered in error to Family F's address rather than the facility address which was reflected on the physician order.	N 415		