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 03/06/2026

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 03/04/2026, with information gathered through 03/06/2026, Surveyor conducted 1 complaint investigation at Caring Hands Assisted Living in New Holstein. One (1) of 1 complaint was substantiated. As a result of the survey, 1 deficiency will be issued. The deficiency is a repeat violation. See SOD (Statement of Deficiency) 2QKW11, dated 08/12/2024 and SOD 2QKW12, dated 04/23/2025. Census: 40	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 1 of 1 (Resident 1) residents reviewed received all prescribed medication in the dosage and at intervals prescribed by a practitioner. Resident 1 had an order for Carbidopa/Levodopa 25/250 to take 1 tablet by mouth twice daily at 12pm and 5pm. Resident 1's MAR (Medication Administration Record) had a note under the above prescription that indicated to "give 2 1/2 tabs until supply comes from VA [Veterans	N 352		

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

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Administrator]." It was discovered Resident 1 received 2 1/2 tabs of the medication for a period of time, instead of 2 (1/2) tabs to equal the 1 tablet prescribed.

This is a repeat violation for the third time. See Statement of Deficiency (SOD) 2QKW11, dated 08/12/2024 and SOD 2QKW12, dated 04/23/2025 for additional details.

Findings Include:

On 02/03/2026, the Department received a complaint regarding medication administration

On 03/04/2026, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the record of Resident 1.

Resident 1 was admitted to the facility on 05/25/2024 with diagnoses to include Parkinson's disease, hylipidemia, and dry eye syndrome. Resident 1's most recent ISP (individualized service plan) indicates Resident 1 is able to "communicate all needs and wants to staff." The ISP also indicates Resident 1 "will continue to have staff support administering, managing and re-order all medications daily through the next annual review."

On 12/17/2025, Resident 1 had an appointment with neurology. At the appointment, Resident 1's Parkinson's medications were changed. Resident 1 received a new order which stated, "Carbidopa-levodopa 25-250mg [milligram] take 1.5 tab[tablet] at 7am, 1 tab 12pm, 1 tab 5pm, 1/2 tab 8pm." The order stated the prescription was sent to the pharmacy.

On 03/04/2026, Surveyor reviewed Resident 1's

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MAR's for December 2025 and January 2026. Both MAR's reflected the new order starting 12/17/2025, however, at 12pm and 5pm a note under the order stated, "Give 2 1/2 tabs until supply comes from VA."

On 03/04/2026, Surveyor reviewed Resident 1's "Care Notes." The following was noted:

-12/17/2025 late entry: saw neurologist, N.O. [new order] e-scripted to pharmacy

-12/30/2025 "Fax to NP[Nurse Practitioner] requesting OT[Occupational Therapy] and PT[Physical Therapy] orders r/t[related to] freq[frequent] falls..."

-01/02/2026 "Faxed response 'yes' r/t PT/OT orders to eval and tx[treat]..."

-01/09/2026 "Return from ED[emergency department] visit s/p[status post] fall; N.N.O[no new orders]"

-01/19/2026 PT at facility for start of care "Much improved transfers today. Hopefully will be able to get back to transfers w/o[without] the lift soon..."

-01/20/2026 OT at facility for start of care, will work with Resident 1 to increase strength, balance, fall prevention and staff training

-01/28/2026 "Received a phone call from nurse at [Neurology office] regarding dosing of carbidopa/levo[levodopa] at noon and 5pm"

-01/28/2026 "Received another call from [Neurology office] nurse. [S/he] stated, "I think I know what happened." "It was when [Neurology NP] wrote the order it stated Give 2 1/2 tabs at noon and 5pm. In review, it should have stated, Give 2 - 1/2 tabs (=1 tab) PO[by mouth] at noon and 5pm." "It was the way [s/he] wrote it."

On 03/06/2026, Surveyor reviewed an Office Visit note from Resident 1's Neurology visit on 01/28/2026. The office visit note stated,

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"[Resident 1] presents with [his/her][family member]. [Family member] states that [his/her] [Resident 1] has had increased weakness since mid December, so much so that [s/he] is now using a w/c[wheelchair] and needed 3-4 people to transfer [him/her] at times. [S/he] has had an increase in falls, some confusion, and new abnormal mouth movements. [S/he] has started PT/OT and states they are really working [him/her] out. [Family member] has [his/her] [Resident 1's] noon meds with [him/her] today. Of note: [s/he] has 2 1/2 tabs to take. Should be 1 tab. Review of [his/her] facility med[medication] list shows a typed in note from 12/17/2025: Give 2 1/2 tabs until supply comes from VA..."

Surveyor reviewed a "Doctor's Orders" form for Resident 1 dated 01/28/2026 which stated, "Carbidopa/Levodopa 25/250mg must be 1.5 tabs 7am, 1 tab noon, 1 tab 5pm, 1/2 tab 8pm. NOT 2 1/2 tabs at noon NOT 2 1/2 tabs at 5pm!! (highlighted in orange) This has been 3 extra doses daily!! x 6 weeks+" and signed by APNP[Advanced Practice Nurse Prescriber] at Neurologist's office.

On 03/05/2026 at 3:30 PM and 4:15 PM, Surveyor interviewed Resident 1. Resident 1 stated s/he doesn't remember the exact dates but indicated s/he was getting 2 pills instead of 1, almost double the dose for his/her Parkinson's. Resident 1 thought it was maybe the last week of December till his/her appointment with the neurologist on 1/28/2026. Resident 1 stated s/he went to the appointment with his/her medication list and noon medications that the facility gave to Resident 1. Resident 1 stated s/he showed the neurologist the pills and there were 2 1/2 pills. Resident 1 said s/he has had a decline and several falls. Resident 1 stated s/he used to be

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able to use a 4 wheeled walker by his/herself, now is using a wheelchair and has to have 2 people with him/her if walking. Resident 1 did confirm s/he is currently receiving PT/OT but its about to run out.

On 03/04/2026 at 3:40 PM, Surveyor interviewed Family Member C. Family Member C verified s/he was the Health Care Power of Attorney (HCPOA) for Resident 1. Family Member C verified s/he accompanied Resident 1 to [his/her] neurology appointment on 1/28/2026. Family Member C stated the facility sends a medication list and because the appointment was at 11am, the facility also sent Resident 1's noon medications. During the appointment, the APNP asked Resident 1 if s/he was still taking the 1 pill at noon and 1 pill at 5pm. Family Member C stated Resident 1 looked at [him/her] "funny" and didn't reply. Family Member C stated that is when s/he suggested to look at the pills that the facility sent along with Resident 1 to the appointment. Family Member C stated s/he then took out the pills and there were 2 whole tablets and a 1/2 tablet. Family Member C stated APNP stated that this would explain why Resident 1 was having an increase in falls and change in mobility and transfers. Family Member C APNP was "angry." Family Member C stated APNP looked up the orders that s/he wrote and confirmed it was to be 1 pill at noon and 1 pill at 5pm. Family Member C said the neurology office called the facility and told them. Family Member C stated she could not talk with the facility because "I was extremely angry at the time."

On 03/05/2026 at 2:20 PM, Surveyor interviewed RN(Registered Nurse) D. RN D confirmed s/he worked at the Neurology office and was familiar with Resident 1's medication concerns. RN D

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verified the orders written on 12/17/2025 for Carbidopa/Levodopa 25/250mg was "take 1.5 tabs 7am, 1 tab noon, 1 tab 5pm and 1/2 tab 8pm." RN D confirmed the APNP did not write anywhere on the order to "Give 2 1/2 tabs until supply comes from VA." RN D stated Family Member C was present for appointment with Resident 1 on 01/28/2026. Family Member C and had Resident 1's noon medications along with a medication list that the facility provided. RN D stated APNP was reviewing the medication list and saw the note that stated, "Give 2 1/2 tabs until supply comes from VA." APNP then asked Family Member C and Resident 1 to see the medications they brought with them. Family Member C put them on the table and APNP confirmed there were 2 1/2 tablets of the carbidopa/levodopa in the package. RN D immediately called the facility and informed RN B of the medication error. RN D stated too much carbidopa/levodopa you will see an increase in tremors and falls, which was reported to have been happening with Resident 1.

On 03/05/2026 at 10:40 AM, Surveyor interviewed Med Passer E. Med Passer E stated for a brief period of time Resident 1 was receiving 2 1/2 tablets, more than previous orders but now it is going back to what it was. Med Passer E stated, "I do remember giving [Resident 1] 2 1/2 tabs" and questioning a former employee about it cause it was a lot more than usual. Med Passer E stated the former employee stated, "I'm doing what I was told." Med Passer E stated which was correct, we were doing what we were told to do. Med Passer E stated s/he didn't know it was wrong, thought it was correct, until recently when Med Passer E was told it was not correct.

On 03/04/2026 at 12:40 PM, Surveyor

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N 352	Continued From page 6 interviewed Pharmacist F. Pharmacist F verified s/he worked for the pharmacy contracted with the facility. Pharmacist F stated the pharmacy's most recent order dated 12/17/2025 for Resident 1's carbidopa/levodopa 25/250mg is take 1.5 tablets at 7am, 1 tab at noon, 1 tab at 5pm and 1/2 tab at 8pm. Pharmacist F verified the prescription from the APNP, did not contain any information to "give 2 1/2 tabs until supply comes from VA" on it. On 03/05/2026 at 11:00 AM, Surveyor interviewed Pharmacist G. Pharmacist G verified s/he worked for the VA pharmacy. Pharmacist G stated the pharmacy received a new prescription on 12/17/2025 which stated carbidopa/levodopa 25/250mg to take 1.5 tabs 7am, 1 tab noon, 1 tab 5pm and 1/2 tab 8pm. Pharmacist G verified the prescription from the APNP, did not contain any information to "give 2 1/2 tabs until supply comes from VA" on it. On 03/04/2026 at 11:05 AM and 1:30 PM, Surveyor interviewed RN B. RN B stated Resident 1 receives the Carbidopa/Levodopa from the VA pharmacy. The medication comes in a bottle from the VA to the facility and then the facility sends it to their contracted pharmacy to have it packaged in unit dose form. RN B verified s/he received a call from Resident 1's neurology office nurse (RN D) regarding the dosing of the Carbidopa/Levodopa. RN B stated RN D admitted it was the APNP's mistake in the way s/he wrote the prescription for the medication. RN B stated when writing the order, APNP needs to put a dash (-) or ( ) around the 1/2 to show separation and s/he did not do that. RN B was unable to show Surveyor the APNP's prescription where it said "give 2 1/2 tabs until supply comes from VA." RN B stated s/he was unsure where the note came from and indicated the computer system	N 352		

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N 352	Continued From page 7 was unable to tell who/when the note was written to be added to Resident 1's MAR. RN B stated the medication error occurred for 6 weeks. On 03/05/2026 at 2:00 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was able to verify that Resident 1 left at 10am on 01/28/2026 for appointment so s/he would have had noon medications with him/her. Administrator A stated s/he went all the way back to October 2024 MAR when the first order came for the carbidopa/levodopa and there is a note on each MAR since then to "give 2 1/2 tabs until supply comes from VA" Administrator A stated s/he was not involved in the situation at that time because RN B was handling it.	N 352		