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 06/20/2025

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 06/17/2025 with additional information gathered through 06/20/2025, Surveyor conducted a complaint investigation at Carrington Assisted Living. As a result, 1 of 1 complaints was substantiated and 2 deficiencies were identified. Census: 19	N 000		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not update the individual service plan (ISP) to identify Resident 2's needs and interventions related to wandering. On 05/05/2025, Resident 2 wandered into Resident 1's room during the night and got into Resident 1's bed, causing Resident 1 to feel scared. Resident 2 also had other incidents of intrusive wandering. The provider did not update	N 389		

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
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N 389	Continued From page 1	N 389		

Resident 2's ISP to identify needs or interventions associated with wandering.

Findings include:

On 06/12/2025, the Department received a complaint alleging residents going into other resident rooms.

On 06/17/2025 at approximately 9:30 AM, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the record of Resident 1 and Resident 2.

Surveyor reviewed Resident 1's progress notes from 05/05/2025 and observed the following:

"At 215am a call light was going off when staff member went to answer call light it was saying room 4 [a vacant room], when entering room 4 there was no one in there. Staff member then began doing room checks to see if anyone was walking around as [another resident] had been walking around staff member was unsure if resident had entered a room and pulled the call light or if the pendant was pushed, but the resident was walking around the halls. In doing so staff member discovered that [Resident 2] was not in [his/her] room [his/her] walker was but [s/he]wasnt [sic]. Staff member checked [his/her] livibng [sic] room are [s/he] was not there either, staff member started looking in all open rooms around [his/her] room with no luck. Staff member called on call explained what was going on and continued looking for the resident. another call light was ringing upon answering the call light staff member discovered [Resident 1] had [Resident 2] in [his/her] bed. Resident was very frightened and angry that it took a while for staff member to answer [his/her] call light due to the

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N 389	Continued From page 2	N 389		

pendant ringing for another toom [sic] that was not [his/hers]. Whike [sic] on the phone with on call looking in every room, once the emergency wall light was pulled I went into [his/her] room to answer the call light and found [Resident 2] in [his/her] bed. [Resident 1] s very angry I tried to deescalate the situation got [Resident 2] back in [his/her] bed than resident rang again ...staff member called on call back and informed [him/her] that [s/he] found [Resident 2] naked in [Resident 1's] bed and how angry [s/he] was at staff member and the situation [sic all]."

An additional progress note created by ED D on 05/20/2025 stated, "On 5/5/25 ED [Executive Director] was informed of incident where [Resident 2] was found naked in [Resident 1's] bed, staff member had herd [sic] time figuring out who was ringing because the call light for [Resident 1] was saying room 4. Staff member did what [s/he] was taught to look in al [sic] rooms till [s/he] found who was ringing ...ED received a call from [Family H] about the situation ED talked with [Family H] and told [him/her] [s/he] was aware of situation and will follow up with resident. ED met with resident and talked about [his/her] concerns and that [s/he] will address them with staff."

A review of Resident 1's call light log indicated on 05/05/2025 a "pull switch: bed" was activated by Resident 1 at 2:55 AM and 3:07 AM.

Surveyor reviewed Resident 2's record and the following was noted:

Resident 2 admitted to the facility on 07/10/2024 with diagnoses to include Parkinson's Disease. Resident 2's most recent ISP with a print date of 06/20/2025 identified s/he uses a walker to

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 06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 389	Continued From page 3	N 389		

ambulate and requires staff assistance for bathing, incontinence care, dressing and medication administration. Resident 2 is independent with transfers but requires staff assistance with sitting in chairs and furniture due to perception issues. Resident 2 also "needs escort while out of community due to cognitive dysfunction." Under "Personal Safety r/t [sic] Cognitive Impairment" the ISP reflects "Frequent safety checks ...Resident is visually checked on frequently through the day and night to promote safety ..." In addition, under "Behavior Care" the ISP notes, "The residents known triggers for violent towards staff, rams walker into things, bangs on tables, yells are [sic] certain team members. The residents resistive behavior is de-escalated by redirection ...behavior monitoring."

A review of Resident 2's progress documented an additional wandering incident from 6/17/2025 at 5:03 AM which stated, "Resident was found roaming around with nothing on at around 2AM ..."

There was no additional documentation in Resident 2's ISP to identify his/her risk with wandering. There was also no documentation in Resident 2's progress notes pertaining to the wandering incident on 05/05/2025.

During an interview with Resident 1 on 06/17/2025 at 9:48 AM, s/he stated "[Resident 2] wanders a lot and one night I woke up to [him/her] laying naked in my bed." Resident 1 reported, "I kept pressing my button, but no one came. I didn't know what to do. I was scared. I didn't know what [Resident 2] was capable of doing. I then pulled my pull cord next to my bed and eventually [Caregiver F] came." Resident 1

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N 389	Continued From page 4	N 389		

stated, "[Caregiver F] got [Resident 2] up and said, 'Come on, you don't have any clothes on.'" Resident 1 discussed that since this incident s/he keeps his/her bedroom door locked at night and it is closed and often locked during the day. Resident 1 also confirmed s/he uses a wheelchair to ambulate and transfers him/herself independently.

On 06/17/2025 at 11:33 AM, Surveyor interviewed ED D who confirmed Resident 2 wandered into Resident 1's room on 05/05/2025. S/he stated the pendant for room 4 was going off that night, but that was a vacant room. ED D reported s/he was not sure how or why Resident 1's pendant was switched, but Caregiver F searched room to room when Resident 1's pull cord went off. ED D stated, "[Resident 2] wandered into [Resident 1's] room and was sleeping naked next to [him/her] in bed. [Caregiver F] brought [Resident 2] back to [his/her] room which was next door and got [him/her] situated before going back to make sure [Resident 1] was okay." ED D reported s/he spoke with Resident 1 about the incident and fixed his/her pendant right away. S/he stated Resident 1 wanted his/her door locked at all times going forward. ED D reported Resident 2 is not identified as an elopement risk and this was the first time s/he has done something like this. S/he stated Resident 2 usually sleeps through the night and staff do frequent checks. ED D reported Resident 2 can become combative during cares at night so a new medication was implemented to help with this.

During an interview with Caregiver G on 06/18/2025 at 3:27 PM, s/he confirmed s/he usually works night shift. Caregiver G reported Resident 2 has walked the halls at night before while only wearing a brief. Caregiver G reported,

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 06/20/2025

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

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N 389	Continued From page 5 "[S/he] is usually trying to find staff to help [him/her] with [his/her] brief. [S/he] gets confused sometimes and has to be redirected back to [his/her] room." On 06/19/2025 at 4:13 PM, Surveyor interviewed Caregiver F who confirmed s/he was working the night of the incident on 05/05/2025. S/he stated, "I found [Resident 2] in [Resident 1's] bed naked. [Resident 2] was on top of the covers and [Resident 1] was under the covers. [Resident 2] must have grabbed a hand towel from [Resident 1's] bathroom as [s/he] tried covering up with it. [Resident 1] was scared and upset. [S/he] said [s/he] rolled over and there was a naked [individual] in [his/her] bed. Rightfully so, I would be scared too waking up like that." Caregiver F reported this was the first time Resident 2 got out of his/her room at night. S/he stated, "During the day [s/he] walks into other resident rooms." Caregiver F reported Resident 2 is on safety checks at night and s/he was in bed during the first two checks at 10:30 PM and 12:30 AM that night. S/he reported the next check would have been around 2:00 AM and s/he was cleaning a resident bathroom when the pendant went off for room 4. Caregiver F stated nothing was relayed to him/her about the change in Resident 1's pendant. On 06/20/2025 at 10:30 AM, Surveyor interviewed WD A, Executive Director (ED) D and ED E who acknowledged Resident 2's ISP was not updated to identify needs or interventions associated with wandering.	N 389		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents	N 431		

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 06/20/2025

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

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N 431	Continued From page 6 the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed received appropriate health monitoring to meet his/her needs. Resident 1 had a physician order for weekly weight monitoring. The provider did not notify or document communication with Resident 1's physician regarding his/her weight refusals. Additionally, the provider did not make changes to Resident 1's ISP (Individual Service Plan) to	N 431		

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 06/20/2025

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

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N 431	Continued From page 7	N 431		

include information about his/her weight monitoring needs or interventions to prevent and/or manage refusals.

Findings include

On 06/12/2025, the Department received a complaint regarding care and treatment.

On 06/17/2025 at approximately 9:30 AM, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the record of Resident 1.

Resident 1 admitted to the facility on 03/07/2018 with diagnosis to include chronic pain, glaucoma and chronic ulcer of left foot. Resident 1's most recent ISP dated 03/19/2025 identified s/he uses a wheelchair to ambulate and requires staff assistance for transfers, bathing, toileting, dressing and laundry services. Additionally, Resident 1 is his/her own person and is followed by a PCP (primary care physician).

A list of weight recordings for Resident 1 from 11/14/2024 to 06/02/2025 noted the following:

- 11/14/2024, 120 lbs
- 12/02/2024, 120.4 lbs
- 01/15/2025, 121 lbs
- 02/03/2025, 121.5 lbs
- 03/18/2025, 116.8 lbs
- 04/29/2025, 116 lbs
- 05/02/2025, 116 lbs
- 05/09/2025, 116 lbs
- 05/30/2025, 113.8 lbs
- 06/02/2025, 115.2 lbs

A physician's order dated 04/16/2025 reflected: "Please do weekly weights. Boost drinks TID

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CARRINGTON ASSISTED LIVING	2626 FINGER RD GREEN BAY, WI 54302

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N 431	Continued From page 8	N 431		

[three times a day]." There was a handwritten note at the top of the order which stated, "Faxed and Added Order 4-21-25."

Resident 1's medication administration record (MAR) from April 2025 and May 2025 noted weight refusals on 04/25/2025, 05/16/2025 and 05/23/2025.

Review of Resident 1's progress notes from the days it was noted Resident 1 refused weight monitoring, did not show any documentation regarding the reasons for refusals. Additional dates in June, 06/06/2025 and 06/13/2025 reflected reasons for refusals as "Resident said [s/he] did not want to leave [his/her] room today," and "Resident did not want to have [his/her] weight taken."

There was no documentation in Resident 1's record to show communication with Resident 1's physician regarding his/her weight refusals. Additionally, there was also no documentation in Resident 1's ISP to include information about his/her weight monitoring needs or interventions to prevent and/or manage refusals.

On 06/17/2025 at 9:48 AM, Surveyor interviewed Resident 1 who stated, "They are supposed to be weighing me, but they don't. They say I refuse. I have never refused. I've lost a lot of weight. I weigh 112 pounds and used to weigh 120 something." Resident 1 confirmed s/he administers his/her own medication and s/he keeps nutritional supplemental drinks in his/her room. Resident 1 reported, "I am able to get them myself. I drink them between meals and sometimes before bed."

During an interview with Wellness Director (WD)

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 06/20/2025

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CARRINGTON ASSISTED LIVING	2626 FINGER RD GREEN BAY, WI 54302

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N 431	Continued From page 9	N 431		

A on 06/17/2025 at 12:50 PM, s/he stated,"If a resident has two consecutive refusals, we should be updating the doctor." WD A acknowledged they do not have much documentation from staff regarding Resident 1's weight refusals. S/he stated staff are trained to reapproach when a resident refuses.

On 06/17/2025 at 3:18 PM, Surveyor interviewed Caregiver B who confirmed Resident 1 has his/her weights taken every Friday morning. Caregiver B stated Resident 1 has said no on two occasions to getting his/her weight taken because s/he was not feeling well. Caregiver B reported, "[S/he] is pretty open to getting [his/her] weight taken. If [s/he] refuses the first time, I check in later if [s/he] will allow it. If not, I will try the next day."

On 06/18/2025 at 11:12 AM, Surveyor interviewed Caregiver C who stated, "[Resident 1] was approached two times on 05/16/2025 for weights. The first time I approached [him/her] [s/he] said [s/he] needed to eat [his/her] breakfast. When I went back in later on, [s/he] said no as [s/he] was in bed. I tried twice that day to get [his/her] weights. Not sure what happened the following day as I was not there."

On 06/20/2025 at 10:30 AM, Surveyor interviewed WD A, Executive Director (ED) D and ED E who confirmed they were having fax issues when the physician's order for weight monitoring was received for Resident 1. ED D stated they could send faxes out but could not receive them. ED D stated s/he was not sure why the doctor added weight monitoring for Resident 1. S/he reported when the family requested they follow up on the doctor's order they did. WD A confirmed any communication with the physician is done via

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 06/20/2025

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 431	Continued From page 10 fax by either the medication technicians or the wellness director. WD A stated s/he has not faxed the doctor regarding Resident 1's weight refusals as s/he did not know s/he was refusing. S/he stated there may be additional documentation in Resident 1's record, but s/he would need to check. Surveyor requested any additional documentation be emailed by the end of day on 6/20/2025. As of the end of the day on 06/20/2025, no additional information was received.	N 431		