STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525232	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CCC of West Green Bay	1760 Shawano Ave Green Bay, WI 54303

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 38793 Based on staff interview and record review, the facility did not ensure a resident representative was notified of a change in treatment for 1 resident (R) (R1) of 5 sampled residents. On 5/22/24, Nurse Practitioner (NP)-D gave an order to decrease R1's clonazepam (an anti-anxiety medication) from 1 mg (milligram) twice daily (BID) to 0.5 mg BID based on a pharmacy recommendation. R1's guardian was not notified of the change in treatment. Findings include: The facility's Physician-Family Notification policy, revised 1/12/24, states the facility will inform the resident's legal representative when there is a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment or to commence a new form of treatment). On 7/22/24, Surveyor reviewed R1's medical record including medication orders and pharmacy reviews. From 1/22/24 until 5/22/24, R1 was prescribed clonazepam 1 mg BID for anxiety. A monthly pharmacy review, dated 5/16/24, indicated a gradual dose reduction (GDR) should be attempted unless contraindicated. NP-D agreed to attempt a GDR and gave an order on 5/22/24 to decrease R1's clonazepam to 0.5 mg BID. On 5/24/24, Licensed Practical Nurse (LPN)-E and LPN-F transcribed NP-D's order to decrease R1's clonazepam. A progress note, dated 6/3/24, indicated NP-D was updated on R1's guardian's request to resume R1's original dose of clonazepam 1 mg BID. On 6/4/24, NP-D changed R1's clonazepam order back to 1 mg BID per R1's guardian's request. A progress note, dated 6/10/24, indicated a dose reduction was attempted for R1's clonazepam without success and R1's mood was stable at that time. On 7/22/24 at 9:50 AM, Surveyor interviewed R1's guardian regarding R1's dose reduction of clonazepam. R1's guardian indicated they were not aware of R1's dosage change until over a week later. R1's guardian stated R1 seemed to have increased anxiety and R1's guardian informed nursing staff. R1's guardian was informed of the dosage change at that time. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/24 at 10:35 AM, Surveyor interviewed NP-D who verified a pharmacy recommendation was made for a GDR of R1's clonazepam. NP-D was not sure if anyone notified R1's guardian and stated R1's guardian had been upset with nursing staff due to not being notified of the dosage change. On 7/22/24 at 2:01 PM, Surveyor interviewed Director of Nursing (DON)-B who stated R1's guardian had been upset due to a delay in notification of the change in R1's clonazepam dose. On 7/22/24 at 2:04 PM, Surveyor interviewed Regional Director (RD)-C who stated LPN-E and/or LPN-F were responsible for notifying R1's guardian of the dosage change because they processed R1's order. RD-C stated R1's GDR form indicated R1's guardian had been notified of the dosage change. On 7/22/24 at 2:35 PM, Surveyor interviewed LPN-E who did not recall if LPN-E notified R1's guardian of the dosage change and stated maybe LPN-F had done so. On 7/22/24 at 3:01 PM, Surveyor interviewed LPN-F who verified LPN-F did not notify R1's guardian of the doseage change and only entered the order in R1's medical record. LPN-F stated LPN-F told other nursing staff that LPN-F had only entered the order and hadn't done anything else regarding the order change.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on record review and staff interview, the facility did not ensure 1 resident (R) (R2) of 5 sampled residents had a medical record that contained complete and accurate information. The facility did not update R2's medical record when a visitation restriction was initiated. Findings include: The facility's Comprehensive Care Plan Policy, with a revision date of 8/10/23, indicates: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment .The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. On 7/22/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including depression, anxiety, seizure disorder, diabetes, and hypertension. R2's Minimum Data Set (MDS) assessment, dated 5/30/24, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 had intact cognition. R2's baseline care plan, dated of 5/8/24, indicated: (Family Member (FM)-H) to visit between the hours of 10:00 AM-4:00 PM per discussion with R2 and admissions. A progress note, dated 7/10/24, indicated FM-H spoke with Nursing Home Administrator (NHA)-A regarding a change in visitation. Surveyor reviewed R2's progress notes, care plan, and care conference notes which did not contain information related to a change in visitation. On 7/22/24 at 12:48 PM, Surveyor interviewed NHA-A who stated R2 and FM-H discussed with admissions staff when R2 was admitted from an acute care hospital that the visitation schedule set by the hospital would be adopted by the facility. NHA-A stated there were safety concerns regarding FM-H when FM-H visited R2 at the hospital and the facility decided to protect residents and staff by adopting the same visitation schedule. NHA-A stated during R2's stay in the facility, FM-H threatened harm to staff and threatened actions that could potentially harm residents which is why FM-H's visitation was suspended. During the interview, Surveyor requested documentation regarding the incident and the steps taken to restrict FM-H's visitation. Surveyor also requested information regarding the change in visitation, a copy of the police report, and any supporting documentation that indicated the need to suspend FM-H's visitation. NHA-A stated NHA-A would obtain the documentation and provide the information to Surveyor. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/24 at 2:15 PM, Surveyor received a document provided by NHA-A. NHA-A stated the facility did not have the police report because the officer did not return the following day to provide the report. NHA-A verified NHA-A had not requested the police report prior to Surveyor's request. NHA-A stated the document NHA-A provided contained information about why FM-H's visitation was suspended. The document, dated 7/8/24 and signed by Social Worker (SW)-G, indicated during a discharge planning care conference, FM-H became upset and voiced concerns regarding supervised visitation. FM-H indicated FM-H had a firearm in FM-H's vehicle that would be used on staff. FM-H indicated FM-H would not do anything then because R2 was in the building, but FM-H was not sure what will happen once (R2) is gone. The document did not contain actions taken by the facility, including police contact, a police report, charges filed, or visitation changes. On 7/22/24 at 3:14 PM, Surveyor interviewed SW-G who stated after a care conference, SW-G documents information regarding the care conference, including what was discussed, the resident's goals, the resident's care plan, and concerns. SW-G verified documentation was not completed following R2's care conference. SW-G also confirmed the incident was not documented in R2's medical record. SW-G stated SW-G thought the incident occurred on 7/5/24 and indicated administration was not alerted right away because the care conference occurred later in the evening. SW-G was unsure when administration was alerted and stated possibly the next day. SW-G stated police were notified the following day because administration felt it was an unsafe situation for all residents. SW-G indicated SW-G did not participate in visitation restriction conversations.