

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  CCC of West Green Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</b></p> <p>Based on observation, staff and resident interview, and record review, the facility did not ensure 3 Residents (R) (R3, R1, and R4) of 6 sampled residents who required assistance with activities of daily living (ADLs) were provided care in a timely and consistent manner.</p> <p>The facility did not ensure R3, R1, and R4 received scheduled showers/baths.</p> <p>Findings include:</p> <p>The facility's Bathing-Shower and Bed Bath policy, dated May 2024, states that a shower or bed/sponge bath will be offered weekly. The resident may inform the facility if they want a shower on the AM or PM shift. The resident has the right to refuse showers or bed/sponge baths.</p> <p>1. On 9/4/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including morbid obesity, transient cerebral ischemic attack, type 2 diabetes, and history of urinary tract infections (UTIs) and mixed incontinence. R3's Minimum Data Set (MDS) assessment, dated 8/3/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R3 had intact cognition.</p> <p>On 9/4/24 at 11:36 AM, Surveyor interviewed R3 who stated R3 had not received a shower for some time and it might have been since before Christmas. R3 stated staff told R3 that R3 refused or declined showers. R3 stated R3 didn't refuse showers, but sometimes didn't want a shower at the moment it was offered. R3 stated staff did not offer an alternate time or reapproach R3 at a later time. R3 stated R3 had skin issues and motioned to R3's left shoulder, neck, back, chest and hairline. R3 showed Surveyor an area on R3's upper left shoulder with what appeared to be blotchy red marks. R3 stated R3 saw a Nurse Practitioner (NP) a week prior who ordered ointment for the area. R3 stated R3 felt the itching and reddened areas were due to being dirty.</p> <p>Surveyor reviewed R3's shower/bathing documentation from 11/3/23 to the present which indicated R3 last received a shower on 4/26/24. Of the 43 weeks reviewed, R3 received 9 showers, 8 bed/sponge baths, 1 tub bath, had 6 documented refusals, and had 4 entries that stated not applicable. The documentation indicated 19 weeks were unaccounted for.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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:  525232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  CCC of West Green Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/4/24 at 2:45 PM, Surveyor interviewed Anonymous Staff (AS)-D who stated showers rarely get done due to staffing. AS-D stated management is aware of the inability to complete showers and do not assist when the facility is short staffed. AS-D stated AS-D has been asked to sign off on shower sheets that showers were completed when AS-D did not give showers.</p> <p>On 9/4/24 at 3:00 PM, Surveyor interviewed AS-E who stated completing showers is an issue because the acuity is high and staff aren't able to get them done. AS-E stated AS-E has been asked to sign off on shower sheets when AS-E did not provide showers.</p> <p>On 9/4/24 at 3:52 PM, Surveyor interviewed Nurse Practitioner (NP)-F who verified NP-F saw R3 on 8/29/24 and R3 had dermatitis on the shoulder and chest. NP-F stated NP-F prescribed triamcinolone ointment twice daily for 14 days and then daily as needed. NP-F stated it was possible the dermatitis was due to not showering.</p> <p>38793</p> <p>2. On 9/4/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including stroke with a traumatic brain injury and anxiety. R1's MDS assessment, dated 7/16/24, had a BIMS score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 discharged from the facility on 8/8/24.</p> <p>On 9/4/24 at 11:21 AM, Surveyor interviewed R1's Power of Attorney for Healthcare (POAHC) who verified R1 did not receive showers on a weekly basis while at the facility.</p> <p>Surveyor reviewed R1's shower/bathing documentation for July and August of 2024. The documentation indicated R1 received showers on 7/23/24 and 8/4/24, but the other two weeks of R1's stay were unaccounted for.</p> <p>On 9/4/24 at 2:42 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated shower sheets were not filled out as often as they should be. DON-B verified R1 was missing two weeks worth of shower sheets/documentation.</p> <p>49010</p> <p>3. On 9/4/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including hip dislocation, chronic pain syndrome, type two diabetes, and bipolar disorder. R4's MDS assessment, dated 6/25/24, had a BIMS score of 14 out of 15 which indicated R4 had intact cognition.</p> <p>On 9/4/24 at 12:04 PM, Surveyor interviewed R4 who stated R4 did not receive showers on a weekly basis. R4 stated R4 was supposed to receive a shower every Tuesday but it had been two and a half weeks since R4 was last bathed. R4 stated staff did not wash R4 which made R4 unhappy because R4 had cracks and cervices that needed regular cleaning. R4 stated R4 had to ask staff for a wash cloth and towel so R4 could wash R4's self. R4 stated R4 wanted to be bathed daily and expressed that to staff. R4 stated R4 should at least receive pericare every shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  CCC of West Green Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed R4's shower/bathing documentation from 6/19/24 to the present and noted R4's shower sheets indicated R4 received showers on 7/9/24, 7/23/24, 7/30/2, 8/13/24, and 8/20/24 with one refusal on 8/6/24. The documentation did not indicate the shower was offered again on another day. Based on the documentation, showers due on 6/25/24, 7/2/24, 7/16/24, 8/27/24, and 9/3/24 were unaccounted for.</p> <p>On 9/4/24 at 3:15 PM, Surveyor interviewed DON-B who stated shower sheets were not filled out as often as they should be. DON-B stated R4 was pairs for cares which meant two staff completed cares together and one staff was supposed to complete the required documentation. DON-B indicated pairs for cares was part of R4's plan of care.</p> <p>Surveyor reviewed R4's plan of care, dated 8/8/24, which did not include weekly showers or R4's bathing needs or preferences. The plan of care also did not indicate the facility provided or should provide pairs for cares for R4.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  CCC of West Green Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38793</p> <p>Based on staff interview and record review, the facility did not ensure skin concerns were assessed and monitored for 1 Resident (R) (R1) of 5 residents reviewed.</p> <p>R1 sustained skin injuries on 7/16/24, 7/30/24, and 8/3/24 with no documented assessments or notification provided to R1's physician or Power of Attorney for Healthcare (POAHC).</p> <p>Findings include:</p> <p>The facility's Skin Assessment Policy and Procedure, revised May 2024, states the facility will monitor the skin integrity of residents for signs of irritation and/or injury and will have a documented weekly review of skin conditions.</p> <p>On 9/4/24, Surveyor reviewed R1's medical record which indicated R1 was admitted to the facility on [DATE] and had diagnoses including renal disease, anxiety, and stroke with a traumatic brain injury. R1's Minimum Data Set (MDS) assessment, dated 7/16/24, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 discharged from the facility on 8/8/24.</p> <p>R1's medical record contained weekly skin assessments on 7/23/24 and 7/30/24 that indicated R1 had no current skin concerns. There was no documented weekly skin assessment for the week of 7/14/24 or any admission or discharge skin assessments.</p> <p>R1's medical record contained the following progress notes:</p> <p>A progress note, dated 7/16/24, indicated R1 sustained a 5 mm (millimeter) x 5 mm skin tear on the right elbow. R1's POAHC was not updated.</p> <p>A progress note, dated 7/30/24, indicated R1 sustained a 2.5 cm (centimeter) skin tear on the left knee. R1's POAHC and Medical Doctor (MD) were not updated and an origin for the injury was not determined.</p> <p>A progress note, dated 8/3/24, indicated R1 had a 1 cm x 1.2 cm skin tear on the top of the right knee and a 2.1 cm x 1.2 cm skin tear on the side of the knee. R1's POAHC and MD were not updated and an origin for the injuries was not determined.</p> <p>On 9/4/24 at 11:21 AM, Surveyor interviewed R1's POAHC who verified they were not notified of R1's skin tears and were concerned about where the skin tears came from and how they happened.</p> <p>On 9/4/24 at 4:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding weekly skin assessments and skin tears. DON-B verified residents should have weekly documented skin checks. DON-B also verified skin tears should be monitored and assessed and the resident's MD and representative should be notified if applicable.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  CCC of West Green Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50467</p> <p>Based on staff interview and record review, the facility did not ensure they provided an environment that was as free from accident hazards as possible for 1 Resident (R) (R1) of 3 sampled residents.</p> <p>R1 had 3 unwitnessed falls while at the facility. Staff did not complete neurological checks per the facility's policy for 2 of the 3 falls noted in R1's medical record.</p> <p>Findings include:</p> <p>The facility's Neurological Assessment policy, with a revision date of 9/25/23, indicates: Residents will have a neurological assessment completed when they experience a head injury .Procedure: .2. Observe, assess, and document the resident's level of consciousness, speech, pupils, hand grasps, and vital signs. 3. Unless otherwise ordered by the physician, neurochecks will be completed along the following schedule: Every 15 minutes x 1 hour; Every 30 minutes x 1 hour; Every hour x 4 hours; and every shift x 72 hours or as ordered by the attending physician.</p> <p>On 9/4/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage, dysphagia (difficult swallowing), narcolepsy, chronic kidney disease (CKD), bipolar disorder, anxiety, and mild cognitive impairment. R1's Minimum Data Set (MDS) assessment, dated 7/16/24, stated R1's Brief Interview for Mental Status (BIMS) score was 10 out of 15 which indicated R1 had moderate cognitive impairment. R1's Power of Attorney for Healthcare (POAHC) was activated upon admission. R1 discharged home on 8/8/24.</p> <p>R1's medical record indicated R1 had falls on 7/12/24, 7/13/24, and 7/16/24. After R1's fall on 7/12/24, R1's POAHC requested that R1 be transported to the emergency room (ER). The ER found no head trauma related to the fall.</p> <p>R1's medical record indicated the facility did not complete a full set of neurological checks per the facility's policy for R1's falls on 7/13/24 and 7/16/24. For R1's fall on 7/12/24 at 5:27 PM, neurochecks were completed on 7/13/24 at 12:00 AM, 9:30 AM, 12:00 PM, and 8:00 PM. For R1's fall on 7/14/24 at 1:20 AM, neurochecks were completed on DAYS and PM.</p> <p>Surveyor noted R1's fall on 7/16/24 occurred at 6:36 PM. A Neurological Flow Sheet provided by the facility indicated neurochecks were completed on 7/16/24 at 6:30 PM and 6:45 PM, on 7/17/24 days and PMs, on 7/18/24 at 0000 (midnight), days, and PM, and on 7/19/24 NOC (night shift) and 11:31 PM.</p> <p>On 9/4/24 at 12:22 PM, Surveyor interviewed RN-C regarding the facility's fall process. RN-C confirmed a fall was an incident if a resident had their bottom on the floor. RN-C indicated a witnessed fall was when someone saw the fall happen and stated if the fall was witnessed and the resident hit their head, neurochecks should be completed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  CCC of West Green Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 9/4/24 at 12:50 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed neurochecks should be completed if a resident had an unwitnessed fall. DON-B presented Surveyor with a Neurological Flow Sheet used for documenting neurochecks. DON-B confirmed DON-B was not aware of any undocumented falls.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  CCC of West Green Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50467</p> <p>Based on staff interview and record review, the facility did not provide pharmaceutical services to ensure the accurate dispensing and administering of all drugs and biologicals for 1 Resident (R) (R1) of 1 sampled resident.</p> <p>On multiple occasions, the administration of lorazepam (a psychotropic medication used to treat anxiety) was not reflected accurately on the Controlled Drug Record/Disposition Form (a recording form used to keep track of a controlled substance) or R1's Medication Administration Record (MAR). In addition, the medication was not administered in accordance with the physician's order.</p> <p>Findings include:</p> <p>The facility's Preparation and General Guidelines policy, with a revision date of January 2018, indicates: Administration: .2. Medications are administered in accordance with written orders of the prescriber .D. Documentation (including electronic): 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medication reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications .4. The resident's MAR is initiated by the person administering the medication in the space provided under the date on the line for the specific medication dose administered .5. When PRN medications are administered, the following documentation is provided: a) Date and time of administration, dose route and administration .d) Signature or initials of person recording administration .</p> <p>On 9/4/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage, dysphagia (difficulty swallowing), narcolepsy, chronic kidney disease (CKD), depression, bipolar disorder, anxiety, and mild cognitive impairment. R1's Minimum Data Set (MDS) assessment, dated 7/16/24, stated R1's Brief Interview for Mental Status (BIMS) score was 10 out of 15 which indicated R1 had moderate cognitive impairment. R1's Power of Attorney for Healthcare (POAHC) was activated upon admission. R1 discharged home on 8/8/24.</p> <p>Surveyor reviewed R1's July 2024 and August 2024 MARs which indicated R1 was prescribed lorazepam from 7/11/24 to 8/8/24. A physician order, initiated on 7/11/24, indicated to give lorazepam every 24 hours as needed. A physician order, initiated on 7/19/24, indicated to give lorazepam every 12 hours as needed. A physician order, initiated on 7/24/24, indicated to give lorazepam every 6 hours as needed.</p> <p>Surveyor reviewed a Controlled Drug Receipt Record/Disposition Form that indicated R1's first dose of lorazepam was signed out on 7/13/24. Surveyor compared the record sheet to R1's MAR which indicated R1's first dose of lorazepam was administered on 7/10/24.</p> <p>Further review of R1's July 2024 and August 2024 MARs and the Controlled Drug Form indicated:</p> <p>~ A physician order, initiated on 7/11/24, indicated to give lorazepam every 24 hours as needed.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  CCC of West Green Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>~ On 7/10/24 and 7/11/24, R1's MAR indicated lorazepam was administered, but it was not on the record sheet.</p> <p>~ On 7/15/24, R1's MAR indicated R1 received lorazepam at 7:05 PM, but it was not on the record sheet.</p> <p>~ A physician order, initiated on 7/19/24, indicated to give lorazepam every 12 hours as needed.</p> <p>~ On 7/20/24, two doses of lorazepam were documented on the record sheet (8:00 AM and 6:00 PM) but were not on R1's MAR. (The doses were not twelve hours apart per the physician's order.)</p> <p>~ On 7/21/24, two doses of lorazepam were documented on the record sheet (11:30 AM and 7:30 PM) but were not on R1's MAR. (The doses were not twelve hours apart per the physician's order.)</p> <p>~ On 7/23/24, one dose of lorazepam was documented on the record sheet (11:30 PM) but was not on R1's MAR.</p> <p>~ On 7/24/24, one dose of lorazepam was documented on the record sheet (11:30 AM) but was not on R1's MAR.</p> <p>~ A physician order, initiated on 7/24/24, indicated to give lorazepam every 6 hours as needed.</p> <p>~ On 7/28/24, one dose of lorazepam was documented on the record sheet (5:00 PM) but was not on R1's MAR.</p> <p>~ On 8/2/24, R1's MAR indicated one dose of lorazepam was administered at 4:30 PM, but the record sheet indicated lorazepam was administered at 1:30 PM and 4:30 PM. (The doses were not 6 hours apart per the physician's order.)</p> <p>~ On 8/3/24, two doses of lorazepam were documented on the record sheet (8:30 AM and 3:08 PM) but were not listed on R1's MAR. (The doses were not 6 hours apart per the physician's order.)</p> <p>~ On 8/4/24, one dose of lorazepam was documented on the record sheet (3:00 PM) but was not on R1's MAR.</p> <p>~ On 8/6/24, four doses of lorazepam were documented on the record sheet (1:30 AM, 1:00 PM, 6:30 PM and</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  CCC of West Green Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11:00 PM) but only two doses were on R1's MAR (12:56 PM and 11:17 PM). R1 received four doses of lorazepam on that date. (The last three doses were not 6 hours apart per the physician's order.)</p> <p>~ On 8/7/24, one dose of lorazepam was documented on the record sheet (6:30 PM) but was not on R1's MAR.</p> <p>On 9/4/24 at 12:34 PM, Surveyor interviewed Registered Nurse (RN)-C who indicated if there were missing signatures on the record sheet, there should be another sheet. RN-C stated if an error occurred, staff should inform DON-B of the error and follow-up with DON-B.</p> <p>On 9/4/24 at 12:50 PM, Surveyor interviewed DON-B who confirmed the Controlled Drug Receipt Record/Disposition Form and MAR should reflect each other and stated, If you give a med, then chart what was given. Surveyor showed DON-B the missing signatures for 7/10/24 through 7/12/24 and noted the first signature was 7/13/24 per the record sheet. No further documentation was given to Surveyor related to the signature sheet from 7/10/24 to 7/12/24.</p>