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	09/27/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47248 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R1) of 1 sampled resident received a recommended and ordered video swallow study due to swallowing difficulties. On 6/14/24, R1 was assessed by speech therapy for swallowing difficulties and referred for a video swallow study. A physician ordered the swallow study on 7/3/24. The facility did not ensure the swallow study was completed. Findings include: The facility's Physician Orders-Entering and Processing policy, revised 1/11/24, indicates: To provide general guidelines when reading, entering, and confirming physician or prescribers' orders .A licensed nurse will check for any orders that require confirmation .The orders will be confirmed by the nurse and the instructions for the order will be completed. On 9/25/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility for wound care and therapy due to a decrease in cognition following a right leg amputation with sepsis and was currently hospitalized . R1 had diagnoses including chronic venous insufficiency, obesity, chronic diastolic heart failure, history of sepsis and pneumonia (5/2023), and dysphagia (5/2023). R1's Minimum Data Set (MDS) assessment, dated 3/1/24, had a Brief Interview for Mental Status (BIMS) score of 0 out of 10 which indicated R1 had severely impaired cognition. R1 had an activated decision maker. R1 had an order for general texture diet upon admission. R1's care plan, updated 9/6/23, indicated R1 had a chewing problem related to an altered texture diet. The care plan contained interventions to follow R1's diet as prescribed, instruct R1 to eat slowly in an upright position and chew each bite thoroughly, and monitor/document/report signs of dysphagia, pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, and if R1 appears concerned during meals. A speech therapy evaluation and treatment plan, dated 5/6/23, indicated R1 required a mechanical soft diet with thin liquids due to dentition. R1 had a total of 4 teeth and requested the diet. The assessment indicated R1 did not require supervision during meals. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A speech therapy evaluation, dated 6/14/24, indicated R1 had a diagnosis of dysphyagia, oropharygeal phase and was referred for a cognitive and swallowing evaluation due to a decline in function. R1 coughed on thin liquids with copious spillage of liquid on R1's shirt. Prior to the onset, R1 was within functional limits and received a mechanical soft diet with thin liquids. The evaluation indicated R1 had difficulty with oral containment/secretion management 26-49% of the time and required supervision/assistance at meals due to swallow safety 0-25% of the time. A progress note, dated 9/7/24, indicated R1 was discovered in R1's room at approximately 6:15 PM with shortness of breath and cyanosis of the lips and fingertips. R1's oxygen saturation (O2) level was 62% on room air and R1's lungs had crackles. The on-call provider was notified and R1 was sent to the hospital via ambulance at 6:40 PM. R1's hospital record, dated 9/25/24, indicated R1 had diagnoses including acute hypoxic respiratory failure thought to be due to recurrent aspiration pneumonia versus acute lung injury, oropharyngeal dysphagia, critical illness myopathy, and type 2 diabetes mellitus-diet controlled. On 9/27/24 at 8:28 AM, Surveyor interviewed Rehab Director (RD)-C who indicated an assessment was completed on 6/14/24 because there were reports from nursing staff that R1 had difficulty swallowing liquids, held liquids in R1's mouth, and did not swallow properly. It was also noted R1 could not cognitively control R1's swallowing, spilled on R1's self, and had a decline in cognition. RD-C indicated R1 was added to speech therapy for cognition and swallow safety. After the assessment on 6/14/24, speech therapy recommended a video swallow study because therapy staff could not make recommendations for R1 without knowing the state of R1's esophagus. A referral was sent to R1's physician on 6/26/24 and an order was received on 7/3/24. RD-C indicated it was the responsibility of the nursing department to coordinate and schedule the swallow study. On 9/27/24 at 10:16 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding the 7/3/24 order for a video swallow study. NHA-A verified the order was in R1's medical record and was unsure why the swallow study was not completed. On 9/27/24 at 12:09 PM, Surveyor interviewed RD-C who indicated R1's diet would not automatically be downgraded or changed due to R1's diagnosis of esophageal thickening and chronic aspiration pneumonia. RD-C indicated even though there was thickening of the esophagus, it did not mean the thickening caused R1's swallowing difficulties. RD-C indicated the swallow study would have provided the necessary information to make further recommendations because the swallow study would have shown the movement of R1's esophagus and ability to swallow. RD-C indicated the results of the swallow study would have allowed staff to make diet and therapy recommendations. On 9/27/24 at 1:15 PM, NHA-A approached Surveyor and confirmed R1's swallow study was not completed. NHA-A did not have an explanation for why the swallow study was not scheduled or completed.