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	01/29/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943 Based on staff interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 2 residents (R) (R4 and R5) of 10 sampled residents. On 11/20/24, staff witnessed R5 kick R4 in the hallway. The facility did not thoroughly investigate the resident-to-resident altercation. Findings include: The Facility's Abuse Prevention Policy, revised 9/28/23, indicates: Abuse is the willful infliction of injury .The term willful .means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means. Physical abuse includes hitting, slapping, pinching, kicking .Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of abuse . Staff will continue to monitor the goals and approaches on a regular basis and update as necessary . Protection of Residents: .Residents who allegedly abuse another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his or her safety, as well as the safety of residents including, but not limited to, the separation of the residents .The appointed investigator will, at a minimum, attempt to interview .anyone likely to have direct knowledge of the incident. On 1/29/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia with psychotic disturbance, anxiety, and chronic pain. R4's Minimum Data Set (MDS) assessment, dated 11/20/24, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R4 had severe cognitive impairment. R4 had an activated Power of Attorney for Healthcare (POAHC) and was discharged to another facility on 1/20/25. On 1/29/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and readmitted on [DATE]. R5 had a fractured left pubis and was non weight bearing on the left lower extremity. R5 also had diagnoses of dementia, a history of falls, and urinary tract infection (UTI). R5's MDS assessment, dated 11/23/24, had a BIMS score of 4 out of 15 which indicated R5 had severe cognitive impairment. R5 had an activated POAHC and was discharged home on 11/23/24. (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's care plan (dated 10/30/24) indicated R5 demonstrated significant mood distress related to sundowning in the evening and made statements that R5 was not taken care of, was treated like garbage, and was being raped when R5 removed R5's own clothing. R5's care plan did not address resident-to-resident altercations. On 1/29/25, Surveyor reviewed a facility-reported incident (FRI) regarding a resident-to-resident altercation between R4 and R5. The FRI indicated on 11/20/24 at approximately 7:51 PM, R5 was standing near Registered Nurse (RN)-D who was passing medication when R5 complained about a B word lady. When R4 passed by in a wheelchair, R5 approached R4 in the hallway and said, There is the B word and kicked R4 twice in the leg. RN-D separated R4 and R5 and asked R4 and R5 not to hit each other. R4 started crying and attempted to push back before R4 and R5 apologized to each other. RN-D indicated R4 and R5 had forgotten about the incident after a few minutes and were back to baseline. R5 had no further resident-to-resident altercations and was discharged home on 11/23/24. Surveyor noted the facility's investigation did not include an interview with R5 (even though R5 was cognitively impaired, R5 was able to express R5's wants and needs), interviews with staff who cared for R4 and R5 (other than RN-D), and documentation that indicated R5's care plan was revised after the incident and included interventions to monitor R5 for behaviors related resident-to resident altercations. On 1/29/25 at 1:47 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed R5 was not interviewed and indicated no other staff interviews were completed to determine if staff had knowledge of R5's aggression toward R4 or other residents. NHA-A indicated NHA-A thought the previous NHA and Social Worker (SW) completed the interviews, however, the interviews were not included in the investigation. In addition, NHA-A indicated R5's care plan did not include interventions to monitor for behaviors related to resident-to-resident altercations. NHA-A indicated staff reviewed R5's care plan after the incident but did not update the care plan because R5 was supposed to discharge on 11/23/24. NHA-A indicated R5 had no previous resident-to-resident altercations but verified R5's action toward R4 on 11/20/24 was willful.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure a written transfer notice was provided for 2 residents (R) (R3 and R8) of 4 sampled residents. R3 was discharged from the facility on 1/16/25 to a community-based residential facility (CBRF). Neither R3 or R3's representative were provided with a written discharge notice. R8 was transferred to the hospital on 1/22/25. Neither R8 or R8's representative were provided with a written transfer notice. Findings include: The facility did not provide a policy related to transfer/discharge notices. 1. On 1/29/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE]. On 12/16/24, the facility notified R3 and R3's legal representative of the facility's impending closure. On 1/16/25, R3 discharged to a CBRF. R3's medical record did not indicate R3 or R3's legal representative were provided with a written discharge notice. 2. On 1/29/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE]. On 12/16/24, the facility notified R8 and R8's legal representative of the facility's impending closure. On 1/22/25, R8 was transferred to the hospital and admitted with sepsis. R8's medical record did not indicate R8 or R8's legal representative were provided with a written transfer notice. On 1/29/25 at 11:22 AM, Surveyor interviewed R8's Guardian ((Family Member) FM-C) who stated FM-C did not receive a written transfer notice when R8 was discharged to the hospital. On 1/29/25 at 3:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed staff did not document that a written discharge or transfer notice was provided to R3 or R8 or their legal representatives.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure a written bed hold notice was provided for 2 residents (R) (R8 and R10) of 3 sampled residents. R8 was transferred to the hospital on 1/22/25. Neither R8 or R8's representative were provided with a bed hold notice. R10 was transferred to the hospital on 1/5/25. Neither R10 or R10's representative were provided with a bed hold notice. Findings include: The facility's undated Bed-Hold Notification policy indicates when a resident is transferred to a hospital or requests therapeutic leave, the center will provide written notice to the resident and/or resident representative regarding the resident's bed hold rights and the center's bed hold policy. 1. On 1/29/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE]. On 12/16/24, the facility notified R8 and R8's legal representative of the facility's impending closure. On 1/22/25, R8 was transferred to the hospital and admitted with sepsis. R8's medical record did not indicate R8 or R8's legal representative were offered the option for a bed hold or provided with a bed hold notice. On 1/29/25 at 11:22 AM, Surveyor interviewed R8's Guardian ((Family Member)-C) who stated FM-C did not receive a bed hold notice when R8 was discharged to the hospital. 2. On 1/29/25, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE]. On 12/16/24, the facility notified R10 and R10's representative of the facility's impending closure. On 1/5/25, R10 was transferred to the hospital due to critical lab results. A progress note, dated 1/6/25, indicated a discharge notice was sent to the hospital, however, R10's medical record did not indicate R10 or R10's legal representative were offered the option for a bed hold or provided with a bed hold notice. A progress note, dated 1/10/25, indicated R10 discharged from the hospital to another skilled nursing facility. On 1/29/25 at 3:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated both R8 and R10 and/or their legal representatives were offered the option to return to the facility following hospitalization . NHA-A confirmed the facility did not have documentation that a bed hold notification was completed and provided to R8, R10 and/or their legal representatives.