

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Green Bay Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1640 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342</p> <p>Based on staff interview and record review, the facility did not ensure appropriate care and treatment was provided for 1 resident (R) (R42) of 21 sampled residents.</p> <p>R42 stated R42 was unusually chilled on 4/1/24. The facility did not complete an appropriate assessment or notify the physician timely of R42's change in condition. In addition, R42's medical record indicated wound care was not consistently provided.</p> <p>Findings include:</p> <p>The facility's Change in Condition of the Resident policy, with a revision date of 9/20/22, indicates: A facility should immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when .a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .When a resident presents with a possible change of condition .1. Assess the resident's need for immediate care/medical attention .2. Assess/evaluate the resident. This assessment/evaluation could include, but is not limited to, the following: a. Vital signs .3. Notify resident's physician .</p> <p>On 5/28/24, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, congestive heart failure (CHF), and diabetes mellitus. R42's Minimum Data Set (MDS) assessment, dated 3/12/24, stated R42's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R42 had no cognitive impairment. R42's medical record indicated R42 was responsible for R42's healthcare decisions.</p> <p>A nursing progress note, dated 4/2/24 at 1:18 AM, indicated R42 had a temperature 101.2 degrees, a pulse of 114, respirations of 30, an oxygen saturation level of 92% and a blood pressure of 242/140. R42 requested a pain pill. Hydrocodone (used to treat moderate to severe pain) was given. R42 was shaking and stated R42 was cold. R42 had white sputum coming out of R42's nose and mouth and wheezes in the lungs. A physician was notified and R42 was sent to the emergency room (ER). R42's family and Director of Nursing (DON)-B were notified.</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
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R42's treatment administration records (TARs) indicated R42 had orders for wound treatments. R42's March 2024 TAR contained no staff initials for wound care on R42's left lower leg and right heel on 3/22/24 and 3/24/24. Wound care for both areas was scheduled to be completed every other day. R42's April 2024 TAR contained no staff initials for wound care on R42's right heel on 4/19/24 and 4/21/24. Wound care was scheduled to be completed every other day. R42's May 2024 TAR contained no staff initials for wound care on R42's right heel on 5/5/24. Wound care was scheduled to be completed every Wednesday, Friday and Sunday. In addition, R42's May 2024 TAR contained no staff initials for wound care on R42's right heel on 5/8/24, 5/18/24, and 5/22/24. Wound care was scheduled to be completed every other day.</p> <p>R42's medical record did not contain documentation that corresponded with the above dates to indicate why R42's wound care was not completed.</p> <p>R42's medical record indicated R42's left lower leg wound was a venous stasis ulcer and was considered healed when R42 returned from a hospital stay on 4/8/24. R42's medical record indicated R42's right heel wound was a pressure injury that showed improvement with the use of a surgical offloading shoe.</p> <p>On 5/28/24 at 11:59 AM, Surveyor interviewed Nurse Practitioner (NP)-H via phone. NP-H reviewed R42's record in the provider group system which indicated the facility contacted the provider group on 4/2/24 just after midnight because the nurse wasn't sure if R42 had a seizure or was shaking from a fever. NP-H stated the on-call provider ordered an ER evaluation.</p> <p>R42's ER record indicated R42 was admitted to the hospital for sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever) source unknown.</p> <p>On 5/28/24 at 2:32 PM, Surveyor interviewed R42 who indicated R42 started feeling cool and chilly on the afternoon of 4/1/24 and continued to feel cold after more blankets were provided. R42 stated Certified Nursing Assistant (CNA) staff assisted R42 to bed at approximately 8:30 PM. R42 told CNA staff that R42 felt chilled and stated, They just gave me more blankets. R42 could not recall the name of the staff. When asked if staff provided wound care every other day as ordered, R42 stated, For the most part. R42 stated R42 didn't remember when R42's wound care was last missed.</p> <p>Surveyor noted R42's medical record did not contain vital signs taken on the 4/1/24 PM shift.</p> <p>On 5/28/24 at 3:17 PM, Surveyor interviewed DON-B. When asked about missing initials on R42's TAR, DON-B stated, If blank then wasn't done. DON-B indicated if staff are unable to complete wound care they should document the reason. Following a discussion of R42's change of condition as indicated above, DON-B stated when a resident complains of feeling chilled, staff should check the resident's temperature and update the provider if the resident is running a fever. DON-B stated CNAs should update a nurse because feeling chilled is a change of condition and stated, CNAs are our eyes and ears.</p> <p>Surveyor reviewed the staffing schedule for the 4/1/24 PM shift and noted CNA-I, CNA-J and Licensed Practical Nurse (LPN)-K were scheduled on R42's unit.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/28/24 at 4:00 PM, Surveyor interviewed CNA-I via phone. CNA-I stated CNA-I worked the PM shift on 4/1/24 but did not assist R42 to bed. CNA-I stated R42 did not complain of feeling chilled to CNA-I. When asked what CNA-I would do if a resident complained of feeling chilled, CNA-I stated CNA-I would let the nurse know.</p> <p>On 5/29/24 at 1:15 PM, Surveyor interviewed LPN-L via phone. LPN-L stated LPN-L worked the PM shift on 4/1/24 but was not on R42's unit. When asked what LPN-L would do if a resident complained of feeling chilled, LPN-L said LPN-L would take a set of vital signs and stated, My first mind would be infection or something. I would ask a series of questions. Feeling chilled is not a natural feeling. LPN-L stated LPN-L would then call the physician as they usually want us to at least get labs based off assessment findings.</p> <p>On 5/30/24 at 2:30 PM, Surveyor interviewed LPN-K via phone. LPN-K stated LPN-K worked the PM shift on R42's unit on 4/1/24. LPN-K stated no one reported to LPN-K that R42 was feeling chilled and LPN-K did not notice anything unusual with R42 that shift.</p>