

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 08/04/2025
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure 2 residents (R) (R1 and R2) of 4 sampled residents received the appropriate care and services to promote healing and/or prevent pressure injuries from developing. R1 was admitted to the facility with pressure injuries on the coccyx and bilateral heel deep tissue injuries (DTIs). Staff did not change R1's coccyx and heel dressings for 7 days after admission and did not initiate wound care orders until 2/4/25. In addition, R1's coccyx dressing was not changed on 2/7/25, 2/12/25, and 2/13/25. R1's heel dressings were not changed on 2/7/25 and 2/13/25. R2 had wounds on the right great toe, right heel, and coccyx. R2's wound care was not documented as completed on 7/31/25. Findings include: The facility's Pressure Injuries and Non Pressure Injuries policy, revised 7/20/22, indicates: .A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented .If skin is compromised: .iii. Ensure primary care physician is aware of wounds/location of wounds and current treatment orders. .iv. Ensure appropriate treatment orders for each wound area, as needed. .v. Ensure resident/responsible party is aware of wounds and current treatment plan .1. On 8/4/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including multiple rib fractures on the right side, pneumonia, dysphagia, and difficulty with walking. R1's Minimum Data Set (MDS) assessment, dated 2/3/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1 had intact cognition. R1 was responsible for R1's healthcare decisions. An admission skin assessment indicated R1 had two stage 2 coccyx pressure injuries and DTIs on both heels . The assessment did not contain measurements of the wounds. R1 did not have orders to treat the pressure injuries or DTIs at the time of admission. A care plan, dated 2/4/25, indicated R1 had a pressure injury on the left posterior heel related to impaired mobility. The goal indicated R1 would show no signs of infection. The care plan contained the following interventions: Will develop no new areas of skin breakdown; Administer treatment per medical doctor orders; Encourage and assist as needed to turn and reposition; Use assistive devices as needed; and Float heels as able. On 2/4/25, Wound Registered Nurse (WRN)-C assessed R1 and obtained treatment orders for the coccyx and heel wounds to begin on 2/5/25. R1's medical record indicated R1's coccyx dressing changes were not completed on 2/7/25, 2/12/25, and 2/13/25 and R1's heel dressing changes were not completed on 2/7/25 and 2/13/25. On 8/4/25 at 10:54 AM, Surveyor interviewed WRN-C who indicated the facility's procedure is to document wound treatments on the Treatment Administration Record (TAR) following completion of the treatment. WRN-C indicated if a resident with a wound is admitted without a treatment order, the provider should be contacted for an order. On 8/4/25 at 11:15 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R1 did not have wound care orders from admission until 2/4/25 and confirmed staff should have called the provider for orders upon admission. DON-B verified R1's medical record indicated wound care was not consistently completed after the orders were received. DON-B stated DON-B expects staff to provide wound care as ordered. 2. On 8/4/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including dementia, dysphagia, diabetes, and gastrointestinal hemorrhage. R2's MDS assessment, dated 6/2/25, had a BIMS score of 4 out of 15 which indicated R2 had severe cognitive impairment. R2 had an activated Power of Attorney for Healthcare (POAHC). R2's medical record indicated R2 had wounds on the right great toe, right heel, and coccyx and had wound care orders. R2's TAR did not indicate wound care was completed for all of R2's wounds on 7/31/25. On 8/4/25 at 12:35 PM and 1:05 PM, Surveyor interviewed DON-B who verified there were no documented wound treatments on 7/31/25 and stated staff should have completed wound care as ordered. DON-B indicated DON-B spoke with Licensed Practical Nurse (LPN)-D who stated wound care was completed that day but was not documented. DON-B indicated LPN-D would document a late entry for completion of wound care on 7/31/25.</p>		