STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525342	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Bay Health Services	1640 Shawano Ave Green Bay, WI 54303

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure PASRR (Pre-Admission Screen and Resident Review) requirements were met for 5 residents (R) (R9, R22, R15, R57, and R43) of 15 sampled residents. R9's medical record indicated R9 had a mental illness (MI) diagnosis upon admission and was prescribed psychotropic medication. R9's PASRR Level I Screen was marked no for major mental disorder, no for signs and symptoms of MI, and yes for intellectual disability (ID). The facility obtained a 30-day county exemption after R9's admission to the facility. The facility did not complete a PASRR Level II Screen when R9 remained in the facility past 30 days. R22's medical record indicated R22 had a history of ID and an MI diagnoses upon admission and was prescribed psychotropic medication. R22's PASRR Level I Screen was marked no for major mental disorder, no for psychotropic medication, and no for history of ID. The facility obtained a 30-day county exemption after R22's admission to the facility. The facility did not complete a PASRR Level II Screen when R22 remained in the facility for long term care. R15's PASRR Level I Screen documented R15 had a serious mental illness and received medication to treat the symptoms of the major mental illness. R15 required a PASRR Level II Screen based on the results of the PASRR Level I Screen. A PASRR Level II Screen was not completed for R15. R57s PASRR Level I Screen did not indicate R57 had a major mental disorder or received medication to treat the symptoms of a major mental disorder; however, R57 had a major mental disorder and received medication to treat the major mental disorder. R57's PASRR Level I Screen was incorrectly completed, therefore a PASRR Level II Screen was not completed for R57. R43's PASRR Level I Screen documented R43 had a serious mental illness and received medication to treat the symptoms of the major mental illness. R43 required a PASRR Level II Screen based on the results of the PASRR Level I Screen. The PASRR Level II Screen was not completed. Findings Include: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the State of Wisconsin Department of Health Services (DHS), PASRR is a federal requirement that all applicants to Medicaid-certified nursing facilities be assessed to determine whether they might have an ID/DD (developmental disability) and/or MI. This is called a Level I Screen. The purpose of a Level I Screen is to identify individuals whose total needs require that they receive additional services for their ID/DD and/or MI. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an ID/DD and/or MI for PASRR purposes. This is a Level II Screen. This assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care. Nursing facilities may seek county exemption (DHS form F-20822), for applicants with ID/DD and/or MI whose stay in the facility is expected to be recuperative care or short-term. 1. Between 5/28/24 and 5/30/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] with diagnoses including epilepsy, unspecified intellectual disabilities, anxiety disorder, and depression. R9 had an order for 20 mg (milligrams) of escitalopram oxalate (an antidepressant medication) with a corresponding diagnosis of depression. A PASRR Level I Screen was completed for R9 upon admission; however, R9's Level I Screen indicated R9 did not have an MI but received psychotropic medication. The Level I Screen also indicated R9 had an ID diagnosis. The facility obtained a 30-day county exemption on 4/16/24. The facility did not obtain a PASRR Level II Screen after R9 remained in the facility past 30 days. On 5/30/24 at 12:04 PM, Surveyor interviewed Social Services Coordinator (SSC)-E who acknowledged a county exemption was obtained on 4/16/24 and confirmed a PASRR Level II Screen was not completed for R9. SSC-E stated SSC-E was working with Behavioral Consulting Services (BCS) to obtain a PASRR Level II Screen but the screen was not yet completed. 2. Between 5/28/24 and 5/30/24, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] with diagnoses including epilepsy and depression. R22 had an order for 20 mg of citalopram hydrobromide (an antidepressant medication) with a corresponding diagnosis of depression. A PASRR Level I Screen was completed for R22 upon admission; however R22's Level I Screen was marked no for a diagnosis and/or signs and symptoms of an MI or ID. The facility obtained a 30-day county exemption on 5/22/24. The facility did not obtain a PASRR Level II Screen after R22 remained in the facility past 30 days and R22's status changed to long-term care. On 5/30/24 at 10:50 AM, Surveyor interviewed SSC-E who confirmed R22's county exemption was obtained on 5/22/24 and the facility did not obtain a Level II Screen for R22 to remain in the facility long-term. On 5/30/24, at 2:59 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated NHA-A expects staff to complete a PASRR Level I Screen, and if necessary obtain a county exemption, prior to a resident's admission to the facility. NHA-A also stated NHA-A expects staff to complete a Level II Screen prior to the lapse of the county exemption or as soon as the facility is aware the resident will remain in the facility long term. 45943 3. On 5/30/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, vascular dementia with behavioral disturbance, and anxiety disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A PASRR Level 1 Screen for R15 was completed on 10/13/23 and indicated R15 was suspected of having a serious mental illness. Within the past six months (of completion of the Level I Screen), R15 received psychotropic medication including divalproex (an anticonvulsant medication), fluoxetine (an antidepressant medication), mirtazapine (an antidepressant medication), and olanzapine (an antipsychotic medication) to treat symptoms of a major mental illness. A 30-day exemption was marked on the Level I Screen but there was no county review of the 30-day exemption. The facility gave Surveyor a PASRR Level II Screen, dated 10/11/22, from a previous facility that indicated yes to nursing home and no to specialized services. The facility did not provide Surveyor with a Level II Screen for R15's 10/9/23 admission. On 5/30/24 at 2:05 PM, Surveyor interviewed SSC-E who indicated as attempt was made to contact the county for county review of the 30-day exemption, but the county individual was out of the office. SSC-E verified the county review was not in R15's medical record and a PASRR Level II Screen was not completed for R15's 10/9/23 admission. SSC-E confirmed a county review of the 30-day exemption should have been done as well as a PASRR Level II Screen. 4. On 5/30/24, Surveyor reviewed R57's medical record. R57 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, anxiety, panic disorder, and depression. A hospital discharge summary, dated 3/8/24, noted diagnoses of generalized anxiety, panic attacks, and suicidal ideation in the setting of Parkinson's disease. R57 was tearful and had anxiety. Initially, R57 had suicidal thoughts and ideation to end things but no plan or intention. Psychiatry was consulted and recommended R57 start sertraline (an antidepressant) for depression. A PASRR Level I Screen was completed on 3/11/24 and indicated R57 did not have a major mental disorder and did not receive medication to treat a major mental disorder; however, R57 was prescribed lorazepam (a sedative medication) for anxiety and quetiapine (an antipsychotic medication) for anxiety related to Parkinson's disease. A 30-day county exemption was not indicated on the PASRR Level I Screen. On 5/30/24 at 12:06 PM, Surveyor interviewed SSC-E who verified R57's PASRR Level I Screen was completed incorrectly. 38793 5. Between 5/28/24 and 5/30/24, Surveyor reviewed R43's medical record. R43 was admitted to the facility on [DATE] with diagnoses including vascular dementia, insomnia, anxiety, and post traumatic stress disorder (PTSD). A PASRR Level I Screen was completed on 11/27/23 and was marked yes for a diagnosis and/or signs and symptoms of MI or ID as well as for psychotropic medications, including Seroquel (an antipsychotic medication), sertraline and lorazepam. The facility did not obtain a PASRR Level II Screen. On 5/30/24 at 10:50 AM, Surveyor interviewed SSC-E who confirmed R43's PASRR Level II Screen was not completed. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/30/24 at 2:59 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated NHA-A expects staff to complete a PASRR Level I Screen, and if necessary obtain a county exemption, prior to a resident's admission. NHA-A stated a PASRR Level II Screen should be completed prior to the lapse of the county exemption or as soon as the facility is aware the resident will remain in the facility long term.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49563 Based on observation, staff interview, and record review, the facility did not ensure assistance with nail care for 1 resident (R) (R19) of 21 residents reviewed for activities of daily living (ADL) assistance. Staff did not provide routine nail care for R19. Findings include: The facility's Nail Care Policy, dated 4/20/23, indicates: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health .2. Identify conditions that increase the risk for foot or nail problems, such as diabetes .4. Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift or shower day). Nail care will be provided between scheduled occasions as the need arises .Principles of nail care: a. Nails should be kept smooth to avoid skin injury. On 5/28/24, Surveyor reviewed R19's medical record. R19 had diagnoses including diabetes, encephalopathy, and stroke. R19's Minimum Data Set (MDS) assessment, dated 5/22/24, indicated R19 had severely impaired cognition. R19 had an activated Power of Attorney for Health Care (POAHC) since 11/25/22. R19's plan of care indicated R19 was dependent on staff for all cares. On 5/28/24 at 2:05 PM, Surveyor observed R19 in a wheelchair in the lounge calling for help. Surveyor noted R19's fingernails were approximately a half inch long with a brown substance underneath. R19's left hand was on R19's right arm and R19's fingernails created indents in R19's right arm. On 5/29/24 at 12:10 PM, Surveyor observed R19 sleeping in bed. R19's fingernails were still approximately a half inch long with a brown substance underneath. On 5/29/24 at 12:18 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-C regarding daily ADL cares. CNA-C stated R19 was showered on Mondays and nail care should be provided at that time. CNA-C stated if a resident is diabetic, nurses perform nail care. On 5/29/25 at 1:53 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who examined R19's fingernails, verified nail care was not completed, and stated, It looks like two or three weeks of growth. LPN-D stated nail care should be performed with weekly showers. LPN-D verified nurses perform nail care for diabetic residents. On 5/29/24 at 1:59 PM, Surveyor interviewed Director of Nursing (DON)-B who examined R19's nails and stated, It looks like it has been a few weeks since nail care was performed. DON-B stated nail care should be performed weekly with showers.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793 Based on staff interview and record review, the facility did not ensure pharmacy recommendation reports were acted on by a physician for 1 resident (R) (R5) of 9 residents reviewed for unnecessary medications. R5 had monthly pharmacy reviews that included pharmacist recommendations on 12/20/23 and 1/22/24. The facility did not ensure the recommendations were reviewed by a physician or nurse practitioner. Findings include: The facility's Medication Regimen Review and Reporting policy, revised 1/2024, indicates that a record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format to nurses, physicians, and the care planning team .The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days. R5 was admitted to the facility on [DATE] and had diagnoses including cerebral palsy, epilepsy, and anxiety. On 5/29/24, Surveyor reviewed R5's medical record and noted the following: ~ A consultant pharmacist medication regimen review, dated 12/20/23, indicated recommendations were made to review the clinical pharmacy report. The clinical pharmacy report indicated R5 was prescribed diazepam (an antiseizure/antianxiety medication) as needed with no stop date. The recommendation indicated the order needed to be discontinued or rationale provided. Surveyor noted the physician/prescriber response was not filled out for the review. ~ A consultant pharmacist medication regimen review, dated 1/22/24, indicated recommendations were made to review the clinical pharmacy report. Surveyor noted there was no clinical pharmacy report or physician/prescriber response in R5's medical record. On 5/30/24 at 1:14 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the consultant pharmacist medication regimen review, dated 12/20/23, was not acted upon by the physician. NHA-A verified the consultant pharmacist medication regimen review, dated 1/22/24, indicated recommendations were made to review the report; however, the report was not in R5's medical record and NHA-A was unsure what recommendations were made.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 45943 Based on staff interview and record review, the facility did not ensure high-risk medications were monitored for 2 residents (R) (R18 and R15) of 5 residents reviewed for unnecessary medications. Staff did not monitor R18 for adverse reactions or potential side effects of divalproex (an anticonvulsant medication). Staff did not monitor R15 for adverse reactions or potential side effects of insulin (a medication used to control blood sugar). Findings include: The facility's Medication Management Policy, dated 1/24, indicates: Each resident's drug regimen is reviewed to ensure it is free from unnecessary drugs. This includes any drug .without adequate monitoring . The facility's medication management supports and promotes .evaluation of a resident's physical, behavioral, mental, and psychosocial signs and symptoms, in order to identify the underlying cause(s), including adverse consequences of the medications. Medlineplus.gov states divalproex is used for the treatment of seizures and possible side effects of divalproex include drowsiness, dizziness, headache, diarrhea, constipation, changes in appetite weight changes, agitation, mood swings, abnormal thinking, uncontrollable shaking of a part of the body, problems with walking or coordination, uncontrollable movements of the eyes, blurred or double vision, ringing in the ears, hair loss, unusual bruising or bleeding, fever, rash, hives, difficulty breathing or swallowing, swollen glands, swelling of face, eyes, lips, tongue, or throat, peeling or blistering skin, tiredness, confusion, vomiting, drop in body temperature, and weakness or swelling in the joints. Medline plus.gov states insulin is used to control blood sugar in people who have type 1 diabetes (a condition in which the body does not make insulin therefore cannot control the amount of sugar in the blood) or in people who have type 2 diabetes (a condition in which the blood sugar is too high because the body does not produce or use insulin normally) that cannot be controlled with oral medication alone. Some side effects of insulin include redness, swelling, and itching at the injection site, weight gain, constipation, rash, and/or itching over the whole body, shortness of breath, wheezing, dizziness, blurred vision, fast heartbeat, sweating, difficulty breathing or swallowing, weakness, muscle cramps, abnormal heartbeat, and swelling of the arms, hands, feet, ankles, or lower legs. 1. On 5/30/24, Surveyor reviewed R18's medical record and noted an order for divalproex sodium oral tablet delayed release 500 mg (milligrams) by mouth two times a day for epilepsy, dated 5/7/24. Although R18's plan of care listed anticonvulsant therapy and indicated R18 was at risk for adverse effects, the plan of care did not include monitoring interventions for adverse reactions or potential side effects of divalproex. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 1:06 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R18's divalproex order and confirmed R18's plan of care did not contain monitoring for adverse reactions or potential side effects of divalproex. DON-B stated staff are expected to monitor residents on anticonvulsant medication. DON-B verified R18's diagnosis of epilepsy with the Advanced Practice Nurse Prescriber (APNP) which prompted an audit of residents on anticonvulsant medication. Monitoring orders were added for residents on anticonvulsant medication. 2. On 5/30/24, Surveyor reviewed R15's medical record and noted an order for insulin glargine subcutaneous solution pen-injector 100 unit/ml (milliliter) inject 16 units subcutaneously at bedtime for (diabetes type 2), dated 4/14/24. R15's plan of care did not contain monitoring for adverse reactions or potential side effects of insulin glargine. On 5/30/24 at 1:14 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R15's insulin order and confirmed R15's plan of care did not contain monitoring interventions for adverse reactions or potential side effects of insulin glargine.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45943 Based on observation, staff interview, and record review, the facility did not establish and maintain an infection control program designed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for 1 resident (R) (R1) of 2 residents observed during the provision of care. During an observation of incontinence care for R1, Certified Nursing Assistant (CNA)-F did not perform hand hygiene following glove removal on multiple occasions. Findings include: The facility's Hand Hygiene policy, revised 11/02/22, indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Hand hygiene is indicated and will be performed under the conditions listed in the hand hygiene table which include: ~ Before applying and after removing personal protective equipment (PPE) including gloves ~ Before and after handling clean or soiled dressings, linens, etc. ~ After handling items potentially contaminated with blood, body fluids, secretions, or excretions ~ During resident care when moving from a contaminated body site to a clean body site ~ After assistance with personal body functions (e.g., elimination, hair grooming, and smoking) On 5/28/24 at 10:04 AM, Surveyor observed CNA-F provide care for R1. After performing hand hygiene and donning gloves and a gown, CNA-F and Assistant Director of Nursing (ADON)-G positioned R1 on R1's side. CNA-F provided pericare, used wipes to remove stool, and removed soiled gloves. Without performing hand hygiene, CNA-F donned clean gloves and touched R1, R1's blanket, R1's bedside cabinet, and a package of wipes. CNA-F then placed a bag with R1's soiled incontinence brief and wipes on the floor and removed gloves. Without performing hand hygiene, CNA-F donned clean gloves. On 5/28/24 at 10:11 AM, CNA-F removed a stool-soiled Duoderm dressing from R1's right buttock. CNA-F did not perform hand hygiene following removal of the dressing. On 5/28/24 at 10:15 AM, Surveyor interviewed CNA-F who verified CNA-F should have performed hand hygiene after glove removal and when moving from dirty to clean tasks. Surveyor also interviewed ADON-G who confirmed CNA-F should have completed hand hygiene after removing soiled gloves and prior to donning cleaning gloves.