

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525693	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Brown Cty Comm Treatment Ctr-Bayshore Village		STREET ADDRESS, CITY, STATE, ZIP CODE 3150 Gershwin Drive Green Bay, WI 54311	
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a Pre-admission Screening and Resident Review (PASRR) Level I Screen was updated to initiate a PASRR Level II Screen for 1 resident (R) (R6) of 17 sampled residents. Since R6's PASRR Level 1 Screen on 2/14/02, R6 was prescribed antipsychotic medication and had a significant change in status. The facility did not update R6's PASRR Level I Screen and submit for Level II reevaluation. Findings include: From 3/2/26 to 3/4/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including schizophrenia, unspecified dementia, insomnia, and anxiety disorder. R6's Minimum Data Set (MDS) assessment, dated 1/12/26, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R6 had moderate cognitive impairment. R6 had a Guardian who was responsible for R6's healthcare decisions. R6's PASRR Level I Screen, dated 2/14/02, indicated R6 had a major mental illness and was prescribed a major tranquilizer and/or an antipsychotic medication. The Level I Screen also indicated R6 had cognitive deficits due to dementia. Based on the information provided on the Level I Screen, the facility submitted for a PASRR Level II Screen which was completed on 3/5/02. R6's medical record indicated R6 was prescribed the following medications with contributing diagnoses that were not reflected on R6's PASRR Level I or Level II Screens: ~ Haloperidol (an antipsychotic medication) 10 milligrams (mg) twice daily for schizophrenia (starting on 12/18/15) ~ Risperidone (an antipsychotic medication) 0.5 mg three times daily for schizophrenia (starting on 12/18/15) Psychiatry notes from Advanced Practice Nurse Prescriber (APNP)-G, dated 12/30/25, 1/28/26, and 2/25/26, indicated R6 had hallucinations. R6's medical record did not contain an updated PASRR Level I or PASRR Level II Screen that indicated R6 received haloperidol and risperidone and/or had symptoms of mental illness, including hallucinations. On 3/4/26 at 9:49 AM, Surveyor interviewed Certified Social Worker (CSW)-F regarding R6's PASRR Level I and Level II Screens. CSW-F indicated the facility did not complete any PASRR screenings for R6 since 2002 because R6 did not have a change in payor source, a need for specialized services, or a new mental health diagnosis. Surveyor reviewed R6's PASRR Level I with CSW-F and indicated there were no antipsychotic medications listed on the PASRR and the PASRR indicated R6 did not have hallucinations. Surveyor and CSW-F also reviewed R6's progress notes which indicated R6 had hallucinations. CSW-F verified R6's PASRR Level I Screen should be updated and submitted for PASRR Level II reevaluation.		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure 15-minute checks were consistently completed for 1 resident (R) (R54) of 2 sampled residents. R54 was at risk for elopement. R54's care plan contained an intervention for staff to complete 15-minute checks at all times (dated 2/10/26). Between 2/10/26 and 3/3/26, R54's 15-minute checks were not consistently completed. Findings include: The facility's Elopement/Absent Without Leave (AWOL) policy, revised 12/2024, indicates: It is the policy of the facility to provide specific strategies for healthcare personnel in the event a consumer attempts to leave the facility .without notifying appropriate healthcare personnel of his/her intentions to do so. The specific strategies will also apply if a consumer's whereabouts are unknown .Elopement: The act of a consumer leaving the immediate building or facility grounds without permission. The consumer does not have prior-authorization to leave but does .Wandering: A consumer who strays beyond the view or control of staff without the intent of leaving .Observed Departure: An event in which the consumer intends to leave, but remains within the line of sight by healthcare personnel .It is the responsibility of all healthcare personnel to immediately report any consumer whose whereabouts cannot be determined or who is knowingly attempting elopement. Elopement can be a planned or impulsive act. Risk factors for elopement include confusion .history of elopement, problem solving skills .history of wandering .Healthcare personnel are to make all attempts to keep the eloping consumer within a line of sight, if the elopement attempt is observed .From 3/3/26 to 3/4/26, Surveyor reviewed R54's medical record. R54 was admitted to the facility on [DATE] and had diagnoses including dementia with psychotic disturbance, delusional disorder, wandering, and anxiety. R54's Minimum Data Set (MDS) assessment, dated 12/17/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R54 had moderately impaired cognition. R54 had an activated Power of Attorney (POA).A care plan, revised 2/10/25, indicated R54 was at risk for elopement and wandering. R54 had a WanderGuard due to impaired cognition and exit-seeking behavior. The care plan also indicated R54 was at moderate risk for falls due to the use of assistive devices, a decrease in muscle coordination, and a history of multiple falls in the facility. An elopement risk decision tree assessment, dated 9/30/25, indicated R54 was at risk for elopement, (Of note: The last paragraph of the assessment indicated: If Yes to any of the above, consider implementing elopement prevention measures such as 15-minute checks or a WanderGuard). R54's nursing progress notes indicated the following:~ On 3/2/26, R54 wandered to the Blue Ridge unit multiple times on the PM shift (which is separated from R54's unit by double glass doors).~ On 3/1/26, R54 was awake all shift, paced the hall, and attempted to exit the unit. R54 exited to the Meadowview unit and was redirected by staff.~ On 2/18/26, R54 wandered off the unit and was redirected by staff. R54 continued to attempt to leave and was redirected several times.~ On 2/6/26, R54 had increased exit-seeking behaviors. R54 exited the unit, sat in the town hall, and was redirected by staff. ~ A psych note, dated 1/7/26, indicated nursing staff reported exit seeking behavior for R54. Surveyor reviewed R54's 15-minute check sheets and noted the following:~ On 2/16/26 from 3:00 PM to 8:45 PM, twenty-three 15-minute checks were not documented.~ On 2/19/26 from 3:00 PM to 5:45 PM, eleven 15-minute checks were not documented. From 11:00 PM to 11:45 PM, three 15-minute checks were not documented. ~ On 2/27/26 from 7:00 PM to 10:45 PM, fifteen 15-minute checks were not documented.~ On 3/2/26 from 7:15 PM to 10:45 PM, fourteen 15-minute checks were not documented. On 3/3/26 at 10:42 AM, Surveyor interviewed Certified Nursing (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant (CNA)-H who confirmed that R54 wandered and exit sought. CNA-H stated R54 did not have a WanderGuard. On 3/3/26 at 1:25 PM and 1:32 PM and on 3/4/26 at 11:19 AM, Surveyor interviewed Registered Nurse (RN)-C who indicated R54 used to reside on another unit and thinks R54 still lives there. RN-C verified R54 is on 15-minute checks and staff complete 15-minute check sheets every shift. RN-C and Surveyor reviewed a 15-minute check sheet, dated 3/2/26, that indicated 15-minute checks were not completed from 7:15 PM to 10:45 PM. RN-C verified CNAs are responsible for completing and documenting 15-minute checks. RN-C stated agency staff get busy, forget, and don't document. RN-C indicated R54 was on 15-minute checks after 8:00 PM prior to 2/12/26; however, the checks were upgraded due to R54's increased wandering. RN-C stated RN-C reports missing safety checks to RN-C's supervisor. On 3/4/26 from 9:00 AM to 12:00 PM, Surveyor observed R54 and noted a 15-minute check was completed at 9:14 AM. At 9:32 AM, staff had not checked on R54 who was in another resident's room. The resident asked Surveyor to get a nurse to remove R54 from the room. Surveyor informed Life Enrichment Supervisor (LES)-I who assisted R54 to R54's room. On 3/4/26 at 1:00 PM and 3:06 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility audits 15-minute check sheets to ensure they are completed each shift. DON-B verified several sheets were not completed. DON-B indicated R54 previously had a WanderGuard; however, R54 could remove the WanderGuard and did not leave the premises. DON-B indicated a WanderGuard was unnecessary for R54 and was for residents who had a pattern of leaving the unit. DON-B confirmed CNAs are responsible for completing and documenting 15-minute checks. DON-B was not aware that R54's safety checks were not consistently documented. Surveyor referred to a progress note, dated 3/2/26 at approximately 9:50 PM, that indicated R54 wandered to another unit that was separated by glass doors. When Surveyor indicated 15-minute checks were not documented on 3/2/26 from 7:15 PM to 10:45 PM, DON-B stated R54 can go to the neighborhood next door because it is the same unit and staff work both units together. DON-B indicated the nurse who charted on R54 on 3/2/26 was watching R54 which is why it was documented in a progress note. DON-B verified the 15-minute check sheets didn't indicate the same. On 3/4/26 at 3:10 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated R54's unit and the Blue Ridge unit are considered different units. LPN-D stated CNAs are designated to each unit and a float CNA goes between the units. On 3/4/26 at 3:10 PM, Surveyor interviewed CNA-J who was assigned to the Blue Ridge unit. CNA-J indicated R54's unit and the Blue Ridge unit are considered a household and staff work as a team; however, CNA-J's duties are on the side on which CNA-J is assigned. CNA-J stated each unit has one CNA and there is a float (who goes between the units) for the AM and PM shifts. CNA-J works on CNA-J's assigned unit unless alerted via walkie talkie that help is needed on the other unit. CNA-J stated residents usually stay on their units but occasionally wander and are redirected. CNA-J indicated 15-minute check documentation includes codes for the resident's activity and location and should be completed as soon as possible. CNA-J verified residents occasionally wander through the automatic push doors and are redirected back to their unit. On 3/4/26 at 3:14 PM, Surveyor interviewed CNA-E who ensures 15-minute checks are completed by taking the clipboard and documenting after CNA-E makes contact with R54. CNA-E indicated if there are missing entries on the 15-minute check sheets, it could mean the checks were not done. CNA-E verified R54 can exit through the unit's automatic push doors independently and go to the town square which is on the way to the main exit. On 3/5/26, Surveyor requested the facility's wandering, supervision, and/or monitoring policy via email. Surveyor received an email from Nursing Home Administrator (NHA)-A that indicated the facility does not have a policy related to wandering, supervision, or monitoring,		