STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014023	A. BUILDING: _____ B. WING _____	R-C 08/09/2023

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CENTURY RIDGE OF GREEN BAY I	2498 BLUESTONE PL GREEN BAY, WI 54311

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{N 000}	Initial Comments On 07/31/2023, with information gathered through 08/09/2023, Surveyor conducted a verification visit and 4 complaint investigations at Century Ridge of Green Bay I. As a result of the survey, six (6) deficiencies were identified. One (1) of the 6 deficiencies was a repeat violation (see SOD 54L111, dated 03/15/2023). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 17	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1	N 158		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not document and maintain an investigation of an allegation of caregiver misappropriation for 1 of 1 (Resident 3) resident reviewed. In addition, the provider did not report the incident to the department within 7 calendar days from the date the provider knew of the misappropriation of property.

Resident 3's Airpods (headphones) went missing. Caregiver C notified Administrator A about the missing Airpods. Administrator A did not document an investigation into the missing Airpods and did not report the allegation to the department timely.

Findings Include:

On 06/07/2023, the department received a complaint about caregiver misappropriation.

On 07/31/2023, Surveyor conducted an onsite visit to the facility. At 9:45 A.M., Surveyor interviewed Administrator A regarding residents' missing items. Administrator A stated a caregiver reported to Administrator A that Resident 3's Airpods went missing awhile back. Administrator A stated Resident 3 had misplaced them before and Resident 3 was recently in the hospital at the time of the allegation. Administrator A stated Resident 3 had the Airpods connected to his/her phone but the Airpods were not showing as connected to the phone. Administrator A stated s/he would look for documentation of the investigation into the missing Airpods. Administrator A indicated s/he had talked to Resident 3 and staff about the missing Airpods.

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N 158	Continued From page 2 On 07/31/2023 at 12:30 P.M., Surveyor interviewed Resident 3. Resident 3 stated s/he told staff that his/her Airpods were missing. Resident 3 was unsure when this occurred but stated, "It's been awhile since this happened." Resident 3 stated this was the second time the Airpods went missing. After the first time, Resident 3 bought a new pair, and those also went missing. Resident 3 indicated the Airpods never were found and s/he was not sure what happened to them. On 07/31/2023 at 2:05 P.M., Surveyor interviewed Caregiver C. Caregiver C stated about a year ago, the first pair of Airpods went missing. Resident 3 ordered a new pair and Caregiver C assisted Resident 3 with connecting them to Resident 3's phone. Caregiver C verified the second pair of Airpods went missing (unsure of date) as well and when Caregiver C checked Resident 3's phone the Airpods were disconnected from the phone. Caregiver C stated they looked everywhere and could not locate them. Caregiver C stated s/he informed Administrator A and Owner B about the missing Airpods and wanted to inform the police about the missing item because Resident 3 "shouldn't be experiencing things like this." Caregiver C was willing to take Resident 3 to the police station to file a report. Caregiver C did not file a report with police and let Administrator A handle it. On 07/31/2023 at 3:30 P.M., Surveyor interviewed Administrator A regarding the investigation. Administrator A stated s/he would look for the documentation of the investigation. Administrator A was not aware of reporting the allegation of misappropriation to the department. Administrator A thought it was only if after the	N 158		

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N 158	Continued From page 3 investigation the provider felt misappropriation had occurred, s/he needed to file the report. Administrator A was unaware all allegations needed to be filed with the department. Administrator A stated s/he would send the investigation to Surveyor. On 07/31/2023, Surveyor checked the department's records and no self-report was filed for this allegation. As of 08/02/2023, the department had not received documentation of the investigation into the allegation of misappropriation.	N 158		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after an incident or accident resulting in serious injury for 2 of 2 (Residents 2 and 4) residents reviewed. Resident 4 experienced a fall on 06/12/2023 which resulted in a fractured hip and required surgery and hospitalization. The provider did not send the department notification of this incident. Resident 2 experienced a fall on 03/18/2023	N 165		

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N 165	Continued From page 4	N 165		

which resulted in hospitalization. Resident 2 passed away on 03/19/2023. The provider did not send the department notification of this incident.

Findings Include:

On 03/27/2023 and 07/18/2023, the department received complaints regarding resident falls.

On 07/31/2023, Surveyor conducted an onsite visit to the facility. A sample of resident files were selected for review, including Resident 2 and Resident 4.

1. Resident 4 was admitted to the facility on 06/06/2023 with diagnoses to include dysphagia, aphasia following cerebral infarction, atrial fibrillation and cardiovascular disease. An incident report dated 06/12/2023 indicated Resident 4 was found on the floor next to his/her toilet and Resident 4 didn't recall how s/he fell. The incident report indicated Resident 4 was sent out to the hospital with an update from the hospital that Resident 4 fractured his/her hip and had surgery scheduled for 06/13/2023.

Surveyor reviewed the department's facility folder and did not locate a facility self-report to notify the department.

2. Resident 2 was admitted to the facility on 06/09/2017 with diagnoses to include hypertension anemia, dementia and muscle weakness. An incident report dated 03/18/2023 indicated Resident 2 was found on the floor in his/her room and was not responding well to verbal commands. Resident 2 was sent out to the hospital.

A hospital summary indicated Resident 2 was

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N 165	Continued From page 5 transferred to the emergency department after 2 unwitnessed falls (03/17/2023 and 03/18/2023). Resident 2 was diagnosed with sepsis, hypovolemic shock, pneumonia and intraperitoneal hematoma (internal abdominal bleeding) from fall. Resident 2 passed away at the hospital on 03/19/2023. Surveyor reviewed the department's facility folder and did not locate a facility self-report to notify the department. On 07/31/2023 at 3:30 P.M., Surveyor interviewed Administrator A. Administrator A verified s/he did not send self reports to the department for Resident 2 and Resident 4's incidents.	N 165		
{N 239}	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists	{N 239}		

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{N 239}	Continued From page 6 residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Caregiver C obtained all department approved training as required. This is a repeat deficiency. See Statement of Deficiency (SOD) OBJ111 dated 01/27/2021, SOD OBJ112 dated 05/17/2021, SOD OBJ113 dated 09/16/2021, and 54L111 dated 03/15/2023. Findings include: On 07/31/2023, Surveyor conducted a review of employee training records to verify compliance with department approved training requirements. Surveyor requested training records for Caregiver C. Caregiver C was hired on 04/26/2022. Caregiver C did not have training in first aid and choking within 90 days after starting employment. On 07/31/2023, Surveyor verified Caregiver C was not on the Community-Based Care and Treatment training registry for first aid and choking. On 07/31/2023 at 2:05 P.M., Surveyor interviewed Caregiver C. Caregiver C stated s/he had to reschedule the training for first aid and choking twice due to child care issues. Caregiver	{N 239}		

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{N 239}	Continued From page 7 C stated, "I think [Administrator A] set up the training for next week but I don't know the exact date." Caregiver C stated s/he is planning to attend. On 07/31/2023 at approximately 10:00 A.M., Surveyor interviewed Administrator A. Administrator A confirmed Caregiver C had not received first aid and choking but was scheduled for the training the following week. Administrator A stated Caregiver C was signed up for the course twice, but was not able to attend the class.	{N 239}		
N 414	83.37(2)(c) Medication administration not supervised Medication administration not supervised by a registered nurse, practitioner or pharmacist. When medication administration is not supervised by a registered nurse, practitioner or pharmacist, the CBRF shall arrange for a pharmacist to package and label a resident ' s prescription medications in unit dose. Medications available over-the-counter may be excluded from unit dose packaging requirements, unless the physician specifies unit dose. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure prescription medication was packaged in unit dose for 1 of 1 (Resident 1) resident reviewed when a registered nurse (RN) was not supervising medication administration. Resident 1 was prescribed oxycodone 5mg (milligram) every 6 hours as needed for pain. The prescription was filled by an offsite pharmacy and brought to facility in a bottle by family. The facility	N 414		

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N 414	Continued From page 8 does not have an RN on staff administering medications. Findings Include: On 06/30/2023, the department received a complaint related to medication administration. On 07/31/2023, Surveyor conducted an onsite visit to the facility. A sample of resident records were selected, including Resident 1. Resident 1 was admitted to the facility on 05/31/2017 with diagnoses to include unspecified dementia without behavior disturbance, depression, type 2 diabetes mellitus and atrial fibrillation. On 06/26/2023, Resident 1 went to the emergency room due to complaints of pain to his/her side. A hospital discharge summary dated 06/26/2023 indicated Resident 1 was diagnosed with a chest wall contusion and rib contusion. Resident 1 was prescribed oxycodone 5mg every 6 hours as needed for pain. The prescription was sent to a local drug store. On 07/31/2023, Surveyor reviewed Resident 1's June 2023 MAR (Medication Administration Record). Surveyor noted the oxycodone prescription was not listed on the MAR. On 07/31/2023 at 12:30 P.M., Surveyor interviewed Administrator A regarding the June 2023 MAR. Administrator A stated the oxycodone prescription was not filled by the facility pharmacy. It was sent to a local drug store and the family picked up the prescription and brought it to the facility. Administrator A stated when another pharmacy packaged the medication, it	N 414		

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N 414	Continued From page 9 did not show up on the MAR. Administrator A stated they kept track of the administration of the oxycodone on a separate sheet. On 07/31/2023 at 2:05 P.M., Surveyor interviewed Caregiver C. Caregiver C verified Resident 1 went out to the hospital for rib pain on 06/26/2023 and came back with an order for oxycodone. Caregiver C stated s/he was working the evening Resident 1 returned from the hospital. Caregiver C stated the oxycodone medication came from a local drug store in a pill bottle, not unit dose. Caregiver C stated there were only a few pills in the bottle and the facility kept the pills in the bottle until all the pills were gone. On 07/31/2023 at 3:15 P.M., Surveyor interviewed Administrator A. Administrator A confirmed the oxycodone prescription was brought to the facility in a pill bottle. Administrator A stated s/he was unaware the prescription came to the facility in a pill bottle until there were only 2 pills left. Administrator A confirmed the facility does not have an RN onsite to administer medications on a daily basis and they did not have the medication repackaged on a unit dose form.	N 414		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication	N 415		

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administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on record review and interview, at the time of administering medications, staff members did not document in the resident record the name, dosage, date and time of the medication taken for 2 of 2 (Residents 1 and 2) residents reviewed.

Resident 1 reported complaints of pain. Staff members indicated Tylenol was administered, however, Resident 1's Medication Administration Record (MAR) does not indicate Resident 1 received Tylenol, nor does the documentation include the dosage, date and time the medication was administered. Additionally, Resident 1's June 2023 MAR contained 2 days where staff did not document if Resident 1 refused/received medications.

Resident 2's February 2023 MAR contained 7 days where staff did not document if Resident 2 refused/received medications. Additionally, Resident 2's March 2023 contained 4 days where staff did not document if Resident 2 refused/received medications.

Findings Include:

On 03/27/2023 and 06/30/2023, the department received complaints related to medication administration.

On 07/31/2023, Surveyor conducted an onsite

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visit to the facility. A sample of resident records were requested, including the resident records of Resident 1 and Resident 2. Surveyor reviewed Resident 1's MAR for February and March 2023 and Resident 2's MAR for June 2023. Review of the MARs showed days where medication administration was not documented as indicated by no medication passer's initials on specific dates.

Additionally, progress notes for Resident 1 on 06/20/2023 and 06/25/2023 indicated Resident 1 was given Tylenol due to complaints of pain. Also, an incident report dated 06/25/2023 indicated Resident 1 reported to staff that his/her right side, under the armpit, down to waist hurt; it felt sore like Resident 1 pulled a muscle. The incident report stated staff administered Tylenol.

RESIDENT 1: Missing Documentation on MARs:

Levothyroxine 200mcg (micrograms) 1 tab daily
-6AM dose on 06/28/2023 and 06/29/2023

Losartan 50mg (milligrams) 1 tablet daily
-8AM dose on 06/28/2023 and 06/29/2023

Potassium Chloride ER (extended release) 10 MEQ (milliequivalent) 2 tablets daily
-8AM dose on 06/28/2023 and 06/29/2023

Eliquis 5mg 1 tablet twice daily
-8AM dose on 06/28/2023 and 06/29/2023

Amlodipine 5mg 1 tab daily
-8AM dose on 06/28/2023 and 06/29/2023

Atenolol 100mg 1 tablet daily
-8AM dose on 06/28/2023 and 06/29/2023

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Bumetanide 2mg 1 tablet twice a day
-8AM dose on 06/28/2023 and 06/29/2023

Paroxetine HCL 30mg 1 tablet every morning
-8AM dose on 06/28/2023 and 06/29/2023

In addition, Resident 1 had an order for Acetaminophen (tylenol) 325mg take 1 or 2 tablets every 4 hours as needed. The MAR did not show Resident 1 received any doses for the month of June 2023, including on 06/20/2023 and 06/25/2023.

RESIDENT 2 - Missing Documentation on MARs:

Atenolol 25mg 1 tablet daily
-8AM dose on 02/17/2023, 02/22/2023, 03/10/2023, 03/12/2023, 03/14/2023 and 03/15/2023

Multi-Vitamin 1 tablet every day
-8AM dose on 02/17/2023, 02/22/2023, 03/10/2023, 03/12/2023, 03/14/2023 and 03/15/2023

Hydrochlorothiazide 12.5mg 1 tablet daily
-8AM dose on 02/17/2023, 02/22/2023, 03/10/2023, 03/12/2023, 03/14/2023 and 03/15/2023

Latanoprost 0.005%(percent) 1 drop into right eye nightly
-8PM dose on 02/11/2023, 02/18/2023, 02/19/2023, 02/24/2023 and 02/28/2023

Acetaminophen 325mg 2 tablets 3 times daily scheduled - 1 time per day at bedtime, may refuse, no longer scheduled for 3x a day
-8AM dose on 02/17/2023, 02/22/2023, 03/10/2023, 03/12/2023, 03/14/2023 and

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N 415	Continued From page 13 03/15/2023 -2PM dose on 03/09/2023, 03/10/2023, 03/15/2023 -8PM dose on 02/11/2023, 02/18/2023, 02/19/2023, 02/24/2023 and 02/28/2023 On 07/31/2023 at 2:05 P.M., Surveyor interviewed Caregiver C. Caregiver C stated the first s/he heard of Resident 1 having pain to side area was on 06/25/2023. Caregiver C stated s/he administered tylenol to Resident 1. Caregiver C stated s/he wrote in the daily progress note that s/he administered tylenol. On 07/31/2023 at 3:30 P.M., Surveyor interivewed Administrator A. Administrator A verified there were no staff initials on Resident 1 and Resident 2's MARs to indicate staff administered the medications. Administrator A stated, "Staff must have not clicked the box" when they finished administering the medications. Additionally, Administrator A verified Resident 1's MAR did not document that Resident 1 received tylenol on 06/20/2023 and 06/25/2023.	N 415		
N 496	83.45(1)(e) Electrical, mechanical, water supply Systems. The CBRF shall maintain all electrical, mechanical, water supply, plumbing, fire protection and sewage disposal systems in a safe and functioning condition. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain the call light system for 1 of 17 (Resident 5) resident rooms. Resident 5's call light did not activate when pulled. Administrator A acknowledged the system	N 496		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014023	A. BUILDING: _____ B. WING _____	R-C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 496	Continued From page 14	N 496		

was not working properly in Resident 5's room. The provider did not have another system in place for Resident 5 to alert staff if Resident 5 needed assistance.

Findings Include:

On 07/18/2023, the department received a complaint indicating the call light system was not working properly in the facility.

On 07/31/2023, Surveyor conducted an onsite visit and observed the call light system. Each resident room had a call light located on the wall in the bedroom area and a call light located in the bathroom. The call light had a cord attached to it and when the cord was pulled, the call light was activated and an alarm was heard throughout the building to notify staff. Additionally, the resident's room number lights up on the switchboard located in the hallway to notify staff which resident's call light was on.

On 07/31/2023 at 10:30 A.M., Surveyor interviewed Resident 5. Resident 5 indicated his/her call light was not working. Resident 5 stated s/he was mostly independent in his/her room and if s/he fell s/he would attempt to get up by him/herself or wait until someone came around. Resident 5 stated s/he did not have a cell phone as guardian took it away in February and had not returned it.

On 07/31/2023 at approximately 11:00 A.M., Surveyor asked Administrator A to come to Resident 5's room to test the call light. Administrator A stated the call light did not work, and pulled the cord to show Surveyor. No alarm went off and no light on the switchboard lit up to indicate Resident 5's call light was on. Surveyor

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N 496	Continued From page 15 and Administrator A also tested Resident 5's call light in the bathroom, and experienced the same results. Administrator A stated s/he was aware the call light in Resident 5's room was not working, thus they had a new pager system installed but that was not up and running yet either. Administrator A stated they made the call light company aware of the issue last week and they needed to come out and fix it. During the testing, Administrator A asked Resident 5 if s/he had a cell phone to use to call the facility if Resident 5 needed something. Resident 5 explained his/her guardian had taken the cell phone in February and had not returned it. Administrator A stated s/he was unaware Resident 5 did not have a cell phone. Administrator A indicated they would get Resident 5 some type of bell to ring if s/he would need assistance.	N 496		