STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016472	A. BUILDING: _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDEMERE ASPEN HOUSE	**3001 RIVERSIDE DR GREEN BAY, WI 54301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/07/2025 with additional information gathered through 05/12/2025, Surveyors conducted a standard survey and complaint investigation at Wyndemere Aspen House. As a result two deficiencies were identified. The complaint was substantiated. Census: 20	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure immediate notification to a resident's legal representative when there was an incident or injury to the resident. On 11/16/2024, Resident 1 experienced a physical change in condition including pain, lethargy and decrease in alertness. Resident 1 was sent to the ED (Emergency Room), treated and sent back to the facility with a diagnosis of acute UTI (Urinary Tract Infection). There was no evidence Resident 1's legal representative was immediately notified of the change of condition or the need for hospital transfer.	N 169		

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

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N 169	Continued From page 1 Findings include: On 05/07/2025, Surveyor reviewed the medical record for Resident 1. The record indicated Resident 1 was admitted to the facility on 11/07/2022 with diagnosis to include dementia, hypertension, and depression. Additionally, the record indicated Resident 1 had a APOA (activated power of attorney). On 05/07/2025, Surveyor reviewed Resident 1's observation notes from 11/01/2024 through 11/30/2024 and the following was noted: *11/18/2024 at 5:15 AM- "Late entry [Resident 1] was extremely lethargic, not responding, complaining of pain in abdomen, contacted hospice who gave direction to continue to monitor and someone would be sent out in morning, [Resident 1] continued to decline, contacted hospice to advise and due to resident being unresponsive to usual commands [Resident 1] was sent out to ED. Called for report to ED prior to leaving shift and they were still evaluating resident and would call with report when able, advised on-call of incident." *11/18/2024 at 11:30 AM- "...[Resident 1] was sent to the ED over weekend and diagnosed with UTI. Will be treated with antibiotic..." An ED after visit summary for Resident 1, dated 11/16/2024 indicated, "Reason for Visit: Lethargic, Diagnosis: Acute UTI.." On 05/07/2025 at 11:45 AM, Surveyor requested an incident/event report for Resident 1's change of condition and hospital transfer on 11/16/2024. Wellness Coordinator A verified there was no	N 169		

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N 169	Continued From page 2 incident/event report for Resident 1 on 11/16/2024. ***No documentation was located within Resident 1's medical record or observation notes indicating Resident 1's legal representative was notified immediately of Resident 1's change of condition and need for hospital transfer on 11/16/2024. On 05/07/2025 at 12:00 PM, Surveyor interviewed Wellness Coordinator A regarding the above information and notification to Resident 1's legal representative. Wellness Coordinator A verified Resident 1's legal representative was not immediately notified of Resident 1's change of condition and need for hospital transfer on 11/16/2024. Wellness Coordinator A stated, "There's no documentation staff notified [Resident 1's] legal representative. An incident report would've directed staff to call the legal representative, but because staff did not fill out an incident report there's no documentation... I would've expected staff to notify [Resident 1's] legal representative immediately, even if the resident was receiving hospice services."	N 169		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the	N 352		

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N 352	Continued From page 3	N 352		

provider did not ensure 1 of 1 resident reviewed (Resident 1) received all prescribed medications in the dosages and at intervals prescribed by a practitioner.

Resident 1 had a physician's order dated 11/16/2024 for cephalexin (Keflex) twice daily for an acute UTI (urinary tract infection). Resident 1 did not start receiving the medication until 8 PM on 11/19/2024, two and a half days later.

Findings Include:

On 05/06/2025, the department received a complaint alleging concerns with medication administration.

https://www.webmd.com/a-to-z-guides/what-are-antibiotics-for-uti, reviewed on 12/11/2023 indicated, "A urinary tract infection (UTI), also called a bladder infection, starts when bacteria get into your bladder, kidneys, or another part of your urinary tract. The best way to treat a UTI and to relieve symptoms like pain, burning, and an urgent need to pee is with antibiotics. These medications kill bacteria that cause the infection. It's important to take them just as your doctor prescribes. A minor UTI can turn into a serious kidney or blood infection if you don't...It's important for older people to be treated quickly with antibiotics. Research shows that not getting antibiotics or waiting to take them can increase the risk of blood infections and death..."

https://www.drugs.com/cephalexin.html, updated 05/2025 indicated, "Cephalexin is a cephalosporin antibiotic. It works by fighting bacteria in your body. Cephalexin is used to treat infections caused by bacteria, including urinary tract infections...Take cephalexin exactly as

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prescribed by your doctor...Take the medicine as soon as you can..."

On 05/07/2025, Surveyor reviewed the medical record for Resident 1. The record indicated Resident 1 was admitted to the facility on 11/07/2022 with diagnosis to include dementia, hypertension, and depression. Additionally, the facility managed and administered all of Resident 1's medication.

On 05/07/2025, Surveyor reviewed Resident 1's observation notes from 11/01/2024 through 11/30/2024 and the following was noted:

*11/18/2024 at 5:15 AM- "Late entry [Resident 1] was extremely lethargic, not responding, complaining of pain in abdomen, contacted hospice who gave direction to continue to monitor and someone would be sent out in morning, [Resident 1] continued to decline, contacted hospice to advise and due to resident being unresponsive to usual commands [Resident 1] was sent out to ED (Emergency Department). Called for report to ED prior to leaving shift and they were still evaluating resident and would call with report when able, advised on-call of incident."

*11/18/2024 at 11:30 AM- " ...[Resident 1] was sent to the ED over weekend and diagnosed with UTI. Will be treated with antibiotic ..."

An ED after visit summary for Resident 1, dated 11/16/2024 indicated, "Reason for Visit: Lethargic, Diagnosis: Acute UTI...Your medications have changed start taking: cephalexin (Keflex) 500 mg capsule. Take one capsule (500 mg) total) by mouth twice daily for 5 days. Take until gone."

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N 352	Continued From page 5 On 05/07/2025, Surveyor reviewed Resident 1's November 2024 eMAR (electronic Medication Administration Record), and discovered the following: *Cephalexin medication was not given on 11/17/2024, 11/18/2024 or during the morning/afternoon of 11/19/2024 because the medication was not transcribed onto the eMAR until 8 PM on 11/19/2024. The first dose of the cephalexin medication was administered on 11/19/2025 at 8 PM, two and a half days later. On 05/07/2025 at 11:30 AM, Surveyor spoke with Wellness Coordinator A regarding the above medication error and the delay in Resident 1's cephalexin medication. Wellness Coordinator A verified Resident 1 was sent to the ED on 11/16/2024 due to being lethargic and returned sometime after 11:42 PM on 11/16/2024, with a diagnosis of an acute UTI and a prescription for cephalexin 500 mg capsules twice daily. Wellness Coordinator A indicated the cephalexin medication was not transcribed onto the November 2024 eMAR until 11/19/2024 at 8 PM, and the first dose of the cephalexin medication was not administered until 8 PM on 11/19/2024. Wellness Coordinator A stated, "The cephalexin prescription was sent to the wrong pharmacy. The on-call staff did not do a follow-up after [Resident 1's] ED visit. If staff would've followed up right away after [Resident 1's] ED visit, [Resident 1] would've started receiving the medication sooner. Wellness Coordinator A went on to say, "I was told staff called the ED on 11/18/2024 to have the cephalexin prescription sent over to our pharmacy. The cephalexin medication was delivered and signed for by staff on 11/18/2024 at 8 PM, but the medication was	N 352		

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N 352	Continued From page 6 not administered until 8 PM on 11/19/2024. Resident 1 should've received the first dose on 11/18/2024 at 8 PM because the medication was available." In conclusion, Resident 1 had a physician's order dated 11/16/2024 for cephalexin twice daily for an acute UTI. Resident 1 did not start receiving the medication until 8 PM on 11/19/2024, two and a half days later.	N 352		