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 10/02/2023

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 10/02/2023, Surveyor conducted a standard licensing survey and 4 complaint investigations. As a result of the survey, 4 violations of Chapter DHS 83 were issued. One complaint was substantiated. Three complaints were unsubstantiated. Census: 19	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. This Rule is not met as evidenced by: Based on record review and interview, the	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		

provider did not conduct an investigation or report an incident of misappropriation. There was no documented investigation nor did the facility report to the department when a total of 16 tablets of Vicodin were stolen from the facility.

Findings include:

On 09/22/2023, the department received a complaint that alleged resident medications were stolen.

On 10/02/2023 at 11:00 AM, Surveyor asked Wellness Director A if the facility had experienced any issues with missing medications and requested all related investigation documentation. Wellness Director A confirmed there had been a recent incident, but stated, "There isn't one (investigation), not that I can find anyway." Wellness Director A stated that Surveyor could call Regional Director B for more information.

On 10/02/2023 at 11:20 AM, Surveyor interviewed Regional Director B via phone. Regional Director B stated the alleged incident did happen. S/he stated, "I was in contact with the pharmacy and the Police Department. The pharmacy was able to confirm through their documentation that the 16 tablets of Vicodin were delivered to the facility on time and the last known location of the Vicodin was in the facility office after it was signed for by [Former Manager C]. The Vicodin was apparently not secured and went missing. ... [Former Manager C] was supposed to conduct an investigation but [s/he] did not. ... There is no documented investigation and it was not reported to the department. ... [Former Manager C] does not work for the company anymore. Staff searched the facility for the Vicodin but none was found." Regional Manager B stated it was

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N 158	Continued From page 2 concluded a staff person must have stolen the Vicodin and there was a suspected staff member, but it was not able to be substantiated. The suspected staff no longer worked for the facility. On 10/02/2023 at 12:00 PM, Surveyor interviewed Wellness Director A. Wellness Director A confirmed the pharmacy delivered 16 tablets of Vicodin, and that the Vicodin was most likely stolen out of the office. Wellness Director A stated Former Manger C was supposed to document the investigation and report to the department, but s/he did not. Wellness Director A stated, "One of the reasons [s/he] does not work here anymore." Surveyor asked Wellness Director A who the Vicodin was prescribed for. Wellness Director A stated that the Vicodin was prescribed for Resident 1. Wellness Director stated that the Vicodin was not replaced as Resident 1 passed away soon after the incident.	N 158		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify Resident 1's legal representative when there was an allegation of misappropriation of property. After Resident 1's Vicodin was suspected to be stolen, Resident 1's legal representative was not notified.	N 170		

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N 170	Continued From page 3 Findings include: On 09/22/2023, the department received a complaint that alleged stolen resident medications. On 10/02/2023 at 12:00 PM, Surveyor interviewed Wellness Director A. Wellness Director A confirmed that the pharmacy delivered 16 tablets of Vicodin prescribed for Resident 1, and that the Vicodin was most likely stolen out of the office. Surveyor asked Wellness Director A how s/he knew the Vicodin was stolen. Wellness Director A stated, "We searched the building and couldn't find it. The pharmacy confirmed that the Vicodin was delivered here and the last place it was located was in the office, but unsecured." Wellness Director A stated Former Manager C was supposed to conduct and document an investigation and report to the department, but s/he did not. On 10/02/2023 at 12:00 PM, Surveyor asked Wellness Director A if Resident 1's legal representative was contacted. Wellness Director A stated, "I doubt it, [Former Manager C] was supposed to, but there is no documentation of [Resident 1's] legal representative being contacted regarding this incident." Wellness Director A searched the progress notes and Resident 1's closed record and could not find any documentation that Resident 1's legal representative was contacted regarding the above concern. Wellness Director A acknowledged Resident 1's legal representative should have been contacted as this was an allegation of misappropriation. Surveyor gave Wellness Director A until	N 170		

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N 170	Continued From page 4 10/03/2023 at noon to provide any further information. As of noon on 10/03/2023, no further information was provided.	N 170		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider employed Caregiver E despite Caregiver E having been convicted of a serious crime found in s. 50.065, Stats., and ch. DHS 12. Caregiver E was convicted of child neglect and had not been approved under the department's rehabilitation process. Findings include: On 10/02/2023, Surveyor reviewed Caregiver E's employee file. Caregiver E was hired on	N 219		

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N 219	Continued From page 5 09/02/2022. On 10/02/2023, Surveyor reviewed Caregiver E's criminal background check. Caregiver E's Department of Justice (DOJ) background check indicated that on 12/18/2020, Caregiver E was convicted of a felony child neglect (948.21 (2)). There was no documentation in Caregiver E's file that indicated Caregiver E was approved to work at the facility under the department's rehabilitation process. On 10/02/2023 at 12:00 PM, Surveyor discussed the above concern with Wellness Director A. Wellness Director A acknowledged that Caregiver E was convicted of a felony child neglect. Wellness Director A stated s/he was not aware Caregiver E was not to work at the facility. Wellness Director A stated s/he was not aware if Caregiver E had been approved to work at the facility according to the department's rehabilitation process.	N 219		
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	N 239		

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N 239	Continued From page 6 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 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 record review and interview, the provider did not ensure that 1 of 3 employees reviewed completed training in first aid and choking. Caregiver D did not have documented training in first aid and choking. Findings include: On 10/02/2023, Surveyor requested Caregiver D's employee file to review for training compliance. Caregiver D was hired on 06/11/2018. There was no evidence in Caregiver D's file to indicate the completion of training in first aid and choking. There was no evidence in Caregiver D's file to indicate an exemption to this training requirement. On 10/02/2023 at 11:15 AM, Surveyor checked the Wisconsin Community Based Care and Treatment Registry and confirmed Caregiver D was not on the registry for first aid and choking. On 10/02/2023 at 12:00 PM, Surveyor discussed the above concern with Wellness Director A. Wellness Director A acknowledged that all	N 239		

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N 239	Continued From page 7 employees must complete training in first aid and choking within 90 days of hire. Wellness Director A acknowledged Caregiver D had not completed training in first aid and choking.	N 239		