STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016473	A. BUILDING: _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDEMERE BIRCH HOUSE	2999 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 08/16/2024 with additional information gathered through 08/20/2024, Surveyor conducted a complaint investigation at Wyndemere Birch House. As a result, 1 of 2 complaints was substantiated and 1 deficiency was identified. Census: 12	N 000		
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 provider did not ensure 1 of 1 residents received an as needed (PRN) prescribed medication. Findings include: On 06/19/2024, the Department received a complaint alleging concerns residents were not receiving medications as ordered. On 08/16/2024, Surveyor conducted a complaint investigation. Surveyor was informed by Caregiver F Resident 1 was no longer at the facility as s/he passed away on 07/20/2024. Surveyor requested Resident 1's closed record from Resident Coordinator (RC) A. On 08/19/2024, Surveyor reviewed Resident 1's	N 352		

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

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N 352	Continued From page 1	N 352		

closed record and noted s/he admitted to the facility on 03/05/2024 with diagnoses including major depressive order, anxiety disorder, attention-deficient hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), hyperlipidemia, migraine, irritable bowel syndrome, post laminectomy syndrome, brachial plexus disorders, osteoarthritis, history of falls, hypertension, nicotine dependence and personal history of transient ischemic attack and cerebral infarction without residual deficits. Surveyor reviewed Resident 1's individual service plan (ISP) and noted s/he required staff assistance with medication administration and received hospice services. Surveyor observed a section in Resident 1's ISP titled "Pain History & Management" stating "history of chronic back pain, resident has a history of narcotic pain medication dependence, history of attention seeking to get pain medications." The desired goals and outcomes identified "controlled pain" and for service provider responsibilities "monitor and report any pain higher than 8 to leadership, report changes or concerns to admin/wellness."

On 08/19/2024, Surveyor reviewed Resident 1's observation notes from 06/27/2024 at 3:15 PM. RC A stated, "Pt has an appt on July 3rd at 330pm with [Physician J] to remove [his/her] spinal cord transmitter. Prep instructions will be taped to med cart." Surveyor reviewed Resident 1's After Visit Summary dated 07/03/2024 which reflected a new prescription medication for hydrocodone-acetaminophen 5-325 MG tablet: "Take 1 tablet by mouth every 6 hours as needed for pain." Surveyor reviewed Resident 1's July 2024 medication administrator record (MAR) and did not observe hydrocodone-acetaminophen listed as a PRN. Surveyor observed morphine was listed as "as needed" and instructions were

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N 352	Continued From page 2	N 352		

to "Take 0.5ml (10mg) by mouth every hour as needed." Surveyor observed the dates were blank from 07/01/2024 to 07/17/2024.

On 08/19/2024, Surveyor requested the physician orders from Administrator C for hydrocodone-acetaminophen and morphine. Surveyor observed a physician order for morphine concentrate 100mg/5ml oral solution, dated 05/28/2024 and the instructions were to take 0.5 ml every hour as needed. On 08/19/2024 at 4:58 PM, Administrator C stated via email, "You have the AVS [after visit summary] with the order for Hydrocodone, this was sent in electronically to [Pharmacy G] directly from [Hospital H] as this is a narcotic, so it has to be sent electronically."

On 08/19/2024 at 12:44 PM, Surveyor interviewed Registered Nurse (RN) D who stated s/he did not initially have Resident 1 when s/he first admitted to hospice services on 05/31/2024. Upon acquiring Resident 1, RN D stated "[Resident 1] had a pain device protruding out of [his/her] back, so I set up an appointment to have it removed on 07/03/2024." RN D reported s/he wanted to be "proactive" with Resident 1's pain post-surgery so s/he called Resident 1's physician to request pain medication and was told this medication would not be a problem. RN D stated s/he went to visit Resident 1 at the facility on 07/05/2024 and was informed by power of attorney (POA) I, Resident 1 did not receive any pain medication since his/her procedure. RN D reported s/he called the pharmacy and confirmed hydrocodone was delivered to the facility on 07/04/2024. RN D stated s/he received a call from RC B who confirmed Resident 1's "medication was under the door and no one would be coming in." RN D stated, "I was in shock."

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N 352	Continued From page 3 On 08/19/2024 at 1:49 PM, Surveyor interviewed Operational Manager E who verified the pharmacy received an order for hydrocodone-acetaminophen on 07/03/2024 at 5:40 PM and the pharmacy delivered the medication to the facility at 8:09 PM and was signed by facility staff. Operational Manager E confirmed the order was for 20 tablets of hydrocodone-acetaminophen and 1 tablet was to be taken by mouth as needed every 6 hours for pain. Operational Manager E stated it should be listed on the MAR as they "profiled it to the e-Mar." On 08/19/2024, Surveyor reviewed Resident 1's observation notes dated 07/04/2024 at 9:15 AM by Caregiver F who stated, "This morning resident continuously rang call light requesting pain medication. Staff informed resident that all [s/he] has available is Tylenol. Staff offered, resident did accept. Approximately 5 minutes later resident rang and said that the Tylenol was not helping and [s/he] wanted [his/her] pain medication. Staff once again told resident that [s/he] does not have anything else. Resident called POA. Told POA 'PLEASE HURRY WRITEER [sic] IS GIVING ME A HARD TIME ABOUT MY PAIN MEDS [S/HE] IS SAYIGN [sic] I DONT HAVE ANY [S/HE'S] ONLY GIVING ME TYLENOL. PLEASE HURRY IM IN SO MUCH PAIN.'" In an observation note dated 07/05/2024 at 12:30 PM, Caregiver F stated, " ...POA has been complaining to staff about the narcotics. Staff did inform POA that management is not in for the weekend as there was a holiday/that [s/he] would be able to speak to someone Monday regarding this. [S/he] said that this is unprofessional as	N 352		

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N 352	Continued From page 4 [s/he] was supposed to have the pain meds right after the operation ..." On 08/19/2024, Surveyor observed a pain scale assessment dated 07/04/2024 at 9:57 AM which stated, "Resident said that [his/her] pain level was at a 9, when staff asked where [s/he] said [his/her] hip because [s/he] had hip surgery. Staff informed resident that [s/he] did not have hip surgery. [S/he] is requesting stronger pain meds. Tylenol was offered and accepted." Surveyor observed the "pain level" was left blank. At 4:54 PM, a pain level of 6 was identified. Surveyor observed a numeric pain scale identifying "total points: 0 = no pain; 1-3 = mild pain (offer non-narcotic pain reliever); 4-7 = moderate pain (offer non-narcotic or narcotic pain reliever); 8-10 = severe pain - offer non-narcotic or narcotic pain reliever." Surveyor observed a total of 7 points was identified and a non-narcotic pain reliever was offered and Resident 1 accepted. At 7:44 PM, it is noted, "Resident is saying the pain is in [his/her] hips. [S/he] is requesting oxy." Surveyor observed the "pain level" was left blank. On 07/05/2024 at 10:02 PM, the pain level was not identified, but Resident 1 reported pain in his/her hips. A total of 7 points was identified and a non-narcotic pain reliever was offered and Resident 1 accepted. On 08/19/2024 at 3:06 PM, Surveyor sent an email to Administrator C inquiring why Resident 1 never received his/her hydrocodone and why it was not listed on the July MAR. Surveyor received a return email from Administrator C stating, "The procedure was carried out on 07.03.24, and due to the holiday, the pharmacy was closed. Additionally, our office was closed on the 4th and 5th for the holiday. On our return on Monday, July 8th, we discovered that a board had	N 352		

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N 352	Continued From page 5 been delivered and was slipped under the door, but the prescription had already been filled as they had only provided a 5-day supply, which was completed as of the 7th ..." On 08/20/2024 at 12:17 PM, Surveyor interviewed RC B and Administrator C. RC B stated the pharmacy procedure for night drop is to put medication under Administrator C's door, but this drop off was after hours and it was the holiday weekend. RC B reported, "We were off 3 to 4 days and we were never notified of any of this." Administrator C stated s/he spoke with the hospital upon Resident 1's discharge and they were not made aware of any new medication orders. Administrator C acknowledged "morphine was available" if Resident 1 needed any pain medication. The provider did not ensure 1 of 1 resident reviewed received their medications as prescribed.	N 352		