STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018078	A. BUILDING: _____ B. WING _____	C 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIL COOPERS RUN	2460 FORESTVILLE DRIVE GREEN BAY, WI 54304

(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
M 000	INITIAL COMMENTS On 03/25/2026, Surveyor conducted 1 complaint investigation at HIL Coopers Run. The complaint was substantiated and resulted in 1 deficient practice. Census: 4	M 000		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure monitoring and documentation of Resident 1's chronic health condition was completed. Resident 1 was diagnosed with a condition which requires daily monitoring and documentation of his/her protein intake to monitor the resident's health and report to his/her chronic illness specialist physicians. The documentation was incomplete. Findings include: On 01/26/2026, the Department received a complaint alleging residents' dietary needs were not met or documented after previously notifying management. On 03/25/at 1:15PM, Surveyor reviewed Resident 1's record and noted Resident 1 was admitted to the facility on 08/11/2022 with diagnoses including autistic disorder, profound intellectual disability, and Phenylketonuria (PKU.) Resident 1's	M 448		

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

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M 448	Continued From page 1 Individual Service Plan (ISP) (dated 03/25/2026) noted, "[Resident 1] is diagnosed with PKU; [s/he] is unable to process protein"..." [Resident 1] is prescribed a PKU diet. [S/he] needs to limit [his/her] protein intake to 18-20 grams/ day. Staff record the number of grams of protein[s/he] intakes [sic] daily in [his/her] diet logbook." Surveyor reviewed Resident 1 had a binder of information on PKU that included printed off information sheets for the staff's reference. One reference form from www.newbornscreening.info titled Genetic Fact Sheets for Parents: Amino Acid Disorders (dated 05/16/2013) noted, "Some of the effects of untreated PKU include: mental retardation, behavior problems, hyperactivity, restlessness or irritability, seizures..." On 03/25/2026 at 1:20 PM, Surveyor interviewed Director A and Manager B while reviewing Resident 1's records. Director A stated Resident 1's PKU was a chronic illness that the provider managed by documenting daily intakes of protein that have to be reported to Resident 1's specialized PKU medical team monthly. Director A stated s/he was aware of the importance of keeping track of Resident 1's protein intake and stated if Resident 1 had too much protein it would "cause behaviors and do something to [his/her] brain." Manager B stated s/he was aware of the importance of monitoring his/her protein intake and stated s/he has observed Resident 1 have increased agitation and behaviors when his/her protein intake has been too high. Director A stated the resident had daily dietary charting and that it has been brought to his/her attention "a few times" during staff meetings that the staff have not been filling out the dietary logs. Director A stated s/he has had to address the issue multiple times with his/her staff. Manager B stated s/he was present at the facility a few times a week and	M 448		

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M 448	Continued From page 2 reviewed the charting to ensure the logs were being completed, but would still find caregivers left charting blank at times. Manager B stated s/he would call the caregiver who left it blank to have them come in to fill out the charting. Surveyor reviewed Resident 1's daily dietary logs from 03/01/2026- 03/24/2026. Each day had 5 spaces to be filled out by the staff including breakfast, snack, lunch, snack, and supper. Of the 24 days reviewed, 31 out of 120 entries were left blank. Manager B had no explanation for why the documentation was left blank if s/he had been routinely checking it a few times per week for completion and stated if the resident skipped a meal it was expected that a notation would be made to indicate no food was consumed for that entry. Director B acknowledged the documentation was not completed but stated it was still an improvement from previous months documentation. Director A stated s/he was aware of the importance of the documentation of the resident's health monitoring of his/her chronic illness, that medical decisions would be made based on the information gathered and reported to the doctors, and that not monitoring the resident's protein intake could result in harm to the resident. Director B stated s/he would immediately take further steps to correct the monitoring and documentation process to ensure it was accurately completed on a daily basis.	M 448		