STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018885	A. BUILDING: _____ B. WING _____	C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING GREEN BAY	246 BERGER STREET GREEN BAY, WI 54302

(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
U 000	INITIAL COMMENTS On 10/22/2025, with information gathered through 10/28/2025, Surveyor conducted a standard survey and 1 complaint investigation at Dimensions Living Green Bay. One (1) of 1 complaint was substantiated. As a result of the survey, 2 deficiencies were issued. Census: 65	U 000		
U 118	89.23(2)(a)2.c SERVICES SUFFICIENT SERVICES. Minimum required services. A residential care apartment complex shall have the capacity to provide all of the following services to all tenants, either directly or under contract: c. Nursing services: health monitoring, medication administration and medication management. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor the health for 1 of 1 (Tenant 1) tenants reviewed.	U 118		

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

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U 118	Continued From page 1 Tenant 1 had 3 falls within 2 days. Tenant 1's physician was not updated regarding the falls. Findings Include: On 07/03/2025, the department received a complaint regarding care concerns for the tenants. On 10/22/2025, Surveyor conducted an onsite visit to the facility. A sample of tenants were selected, including the closed record of Tenant 1. Tenant 1 was admitted to the facility on 05/27/2025 with diagnoses to include atrial fibrillation, cardiomyopathy, heart failure and anxiety. Tenant 1's service agreement (Service Plan Report) dated 05/28/2025 did not note any falls but did have fall interventions such as reminders to call for assistance, to use mobility devices, to go to activities and to use the bathroom. Tenant 1 was discharged from the facility on 07/02/2025. Surveyor reviewed Tenant 1's progress notes. The following was noted: -06/22/2025 at 1:18 PM, staff noted "During rounds staff found resident sleeping on the floor is [his/her] living room Resident's shirt was soaked and [s/he] had taken off [his/her] brief. Staff didn't see and[sic] bruises or bumps on resident. When staff asked what happened resident said I fell. Staff was able to get resident up changed and in [his/her] recliner." -06/22/2025 at 3:45 PM, staff noted "During rounds staff found resident on the floor by the kitchen. Resident did not say much about how [s/he] fell and was not making any sense. Resident had redness on both knees, upper back and small wounds on one toe of both feet. Staff was able to get resident up and to [his/her] chair.	U 118		

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U 118	Continued From page 2 On call was notified." -06/23/2025 at 3:59 PM, staff noted, "During rounds staff found resident on the floor in [his/her] living room in front of the tv. Resident stated that [s/he] didn't fall but slid out of [his/her] wheelchair. While staff was trying help [sic] and explain how to get resident up, resident got combative. Resident didn't want to get off the floor staff had to explain that [s/he] couldn't stay there. It took a minute, but resident finally let staff get [him/her] up." On 10/22/2025 at 10:45 AM, Surveyor interviewed Caregiver B regarding Tenant 1. Caregiver B verified s/he was familiar with Tenant 1. Caregiver B stated staff did everything for Tenant 1. Tenant 1 used a wheelchair to ambulate throughout the building, but did need staff assistance to transfer out of wheelchair because s/he could not walk. Tenant 1 was incontinent of bowel and wore briefs. Tenant 1 didn't know where bathroom was, so staff needed to assist Tenant 1. Caregiver B stated Tenant 1's memory was poor and would refuse cares at times and was combative but staff would reapproach and eventually were able to provide cares to Tenant 1. Caregiver B indicated Tenant 1 did have falls but no injuries due to falls. On 10/22/2025 at approximately 11:30 AM, Surveyor interviewed Executive Director A regarding the falls. Executive Director A verified Tenant 1 did have falls but there were no injuries from the falls. Executive Director A stated they did not notify Tenant 1's physician of the falls because Tenant 1 was already in the process of moving out of the facility. Executive Director A stated if it happened to a tenant who was remaining at the facility, we would have notified tenant's physician because of the change in	U 118		

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U 118	Continued From page 3 condition.	U 118		
U 188	89.27(4) SERVICE AGREEMENT REVIEW AND UPDATE. The service agreement shall be reviewed when there is a change in the comprehensive assessment or at the request of the facility or at the request or on behalf of the tenant and shall be updated as mutually agreed to by all parties to the agreement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not review and update the service agreement when there was a change in the comprehensive assessment for 1 of 1 (Tenant 1) tenant reviewed. Tenant 1 was noted to have a change in needs and abilities. Tenant 1's service agreement was not reviewed and updated to reflect the changes. Findings Include: On 07/03/2025, the department received a complaint regarding care needs not being met. On 10/22/2025, Surveyor conducted an onsite visit to the facility. A sample of tenants were selected, including the closed record of Tenant 1. Tenant 1 was admitted to the facility on 05/27/2025 with diagnoses to include atrial fibrillation, cardiomyopathy, heart failure and anxiety. Tenant 1's service agreement (Service Plan Report) dated 05/28/2025 indicated Tenant 1 was continent of bowels and required assistance from staff for toileting. Tenant 1 was allowed to make decisions about treatment regimen and	U 188		

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U 188	Continued From page 4	U 188		

establish their personal care routines, the service agreement did not mention Tenant 1 refusing cares or medications. Tenant 1's service agreement did not note any falls but did have fall interventions such as reminders to call for assistance, to use mobility devices, to go to activities and to use the bathroom. The service agreement indicated Tenant 1 had no apparent memory loss and was oriented, able to recall or retain information, make safe judgements and functions appropriately in social situations. Lastly, the service agreement stated Tenant 1 was independent with setup and eating at meals. Tenant 1 was discharged from the facility on 07/02/2025.

Surveyor reviewed Tenant 1's progress notes. The following was noted:
-06/11/2025 an order for Rivastigmine Transdermal Patch 24 hour 4.6 mg(milligrams)/24 hr (hour) to apply 1 patch transdermally one time a day for dementia was entered into the MAR (Medication Adminstration Record)
-06/15/2025 staff noted Tenant 1 has open sore on his/her "rear end"
-06/22/2025 at 1:18 PM, staff noted "During rounds staff found resident sleeping on the floor is [his/her] living room Resident's shirt was soaked and [s/he] had taken off [his/her] brief. Staff didn't see and[sic] bruises or bumps on resident. When staff asked what happened resident said I fell. Staff was able to get resident up changed and in [his/her] recliner."
-06/22/2025 at 3:45 PM, staff noted "During rounds staff found resident on the floor by the kitchen. Resident did not say much about how [s/he] fell and was not making any sense. Resident had redness on both knees, upper back and small wounds on one toe of both feet. Staff was able to get resident up and to [his/her] chair.

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U 188	Continued From page 5	U 188		

On call was notified."
-06/23/2025 at 3:59 PM, staff noted, "During rounds staff found resident on the floor in [his/her] living room in front of the tv. Resident stated that [s/he] didn't fall but slid out of [his/her] wheelchair. While staff was trying help [sic] and explain how to get resident up, resident got combative. Resident didn't want to get off the floor staff had to explain that [s/he] couldn't stay there. It took a minute, but resident finally let staff get [him/her] up."

On 10/22/2025 at 10:45 AM, Surveyor interviewed Caregiver B regarding Tenant 1. Caregiver B verified s/he was familiar with Tenant 1. Caregiver B stated staff did everything for Tenant 1. Tenant 1 used a wheelchair to ambulate throughtout the building, but didn't staff assistance to transfer out of wheelchair because s/he could not walk. Tenant 1 was incontinent of bowel and wore briefs. Tenant 1 didn't know where bathroom was, so staff needed to assist Tenant 1. Caregiver B stated Tenant 1's memory was poor and would refuse cares at times and was combative but staff would reapproach and eventually were able to provide cares to Tenant 1. Caregiver B indicated Tenant 1 did have falls but no injuries due to falls. Caregiver B stated s/he remembered that Tenant 1's buttocks area was reddened but they had barrier creams and s/he applied the creams. Caregiver B stated Tenant 1 was not appropriate for this building but "we tried our best" in care for Tenant 1.

On 10/22/2025 at 10:55 AM, Surveyor interviewed Caregiver C regarding Tenant 1. Caregiver C verified s/he was familiar with Tenant 1. Caregiver C stated staff assisted Tenant 1 "with everything." Caregiver C stated this included toileting, bathing, transferring and ambulation at

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U 188	Continued From page 6	U 188		

times. Caregiver C stated Tenant 1 would refuse cares all the time and never wanted staff in his/her room. Caregiver C stated Tenant 1 would "elope" alot of times wanting to go to the "casino." Caregiver C stated, "We had to keep an eye on [him/her]." Caregiver C stated Tenant 1 was "not a good fit for the facility."

On 10/22/2025 at 11:30 AM, Surveyor interviewed Executive Director A. Executive Director A indicated s/he was not involved at the time Tenant 1 was admitted, however, was aware of Tenant 1's stay. Executive Director A stated Tenant 1 was only at the facility a brief amount of time due to the facility not being a good fit for Tenant 1. Executive Director A stated the preadmission assessment was completed however it did not reflect the accurate needs/abilities of Tenant 1. Executive Director A stated that within 3 days of admission, facility staff were reporting higher care needs, memory issues, supervision, refusals of care and behaviors than what was initially assessed. At that time, the facility and Tenant 1's family agreed to start looking for alternative placement. Executive Director A stated the previous Wellness Director was aware of the additional needs and was instructing staff to document the behaviors, falls, refusals, etc. in a communcation section of the computer system which deletes it after 1 week. Additionally, the previous Wellness Director was writing the concerns on a whiteboard not in the computer system so therefore those notes were not saved either. Executive Director A confirmed the facility did not have record of Tenant 1's change in condition and did not conduct a service agreement review to reflect Tenant 1's higher care needs.