STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 11/27/2023, 11/28/2023, and 12/04/2023, with additional information gathered through 01/09/2024, Surveyors conducted 4 complaint investigations, a verification visit, and a standard survey at Allouez Parkside Village 1 LLC. The previous deficiency was corrected. Four complaints were substantiated. Nine deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 51	{N 000}		
N 156	83.12(1)(b) Death reporting related to accident or injury Resident death related to an accident or injury. When a resident dies as a result of an incident or accident not related to the use of a physical restraint, psychotropic medication, or suicide, the CBRF shall send a report to the department within 3 working days of the resident ' s death. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report a resident's death related to an accident and/ or injury to the department. Resident 1 died as a direct result of sustaining multiple fractures and injuries while residing at the facility and the death was not reported. Findings include: On 08/17/2023, the department received a complaint alleging a resident died 17 days after an unwitnessed injury caused a fractured femur. On 11/27/2023, Surveyor reviewed Resident 1's record. Resident 1 had an accident/ injury that	N 156		

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

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N 156	Continued From page 1 occurred on 08/05/2023 and passed away on 08/19/2023. Surveyor reviewed the death certificate dated 08/19/2023 indicated the cause of death as "Complications of multiple fractures" and "Fall at residence 5/31/23, possible injury at care facility prior to 08/11/23." Surveyor reviewed Resident 1's observation notes dated 08/21/2023, written by Director B, noted the provider received a call from the medical examiner asking for additional information regarding how Resident 1 sustained the injuries and fractures. The call from the medical examiner to the provider regarding the death related to the recent injuries was made 2 days after Resident 1 passed away. This gave the provider time to report the death even if they had not initially recognized the correlation between the injury and the death 17 days later on their own. On 12/04/2023 at 9:02 AM, Surveyors conducted and exit interview with Administrator C, Director A, Director Of Nursing (DON) D, and Licensee E present. At approximately 10:40 AM Administrator C confirmed the provider did not report Resident 1's death to the department. Administrator C stated s/he didn't know it would be a reportable death. Administrator C stated, "How would I know? Hospice doesn't tell us cause of death." At approximately 10:41 AM, Owner E responded to Administrator C and stated, "Cause of death is not always what they're on hospice for." Owner E acknowledged the provider must recognize when injuries occur that may have contributed to the resident's passing, and that is their responsibility to submit a report of the death the department within 3 days.	N 156		

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N 158	Continued From page 2	N 158		
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 provider did not investigate an allegation of caregiver misconduct when it was reported by Resident 1. Resident 1 was documented by the provider as alleging to the provider an injury s/he sustained was caused by a caregiver. The provider did not investigate the allegation. Findings include: On 08/17/2023 the department received a complaint alleging an injury to a resident was not immediately investigated for caregiver misconduct after the resident claimed a caregiver was responsible.	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 158	Continued From page 3 On 11/27/2023 at 10:58 AM, Surveyor interviewed Family Member T. Family Member T stated Resident 1 would frequently make comments about Caregiver G not being kind to him/her and told Family Member T that Caregiver G at times would be rough and/ or aggressive during cares. Family Member T stated s/he brought the concerns to the providers attention but could not recall specifically who or when. Family Member T stated the provider was aware of Caregiver G's behavior but to his/her knowledge had not conducted any formal investigation into the allegations. On 11/27/2023 at approximately 12:00 PM, Surveyor interviewed Director A. Director A stated the provider was aware Caregiver G had not been "nice" to residents and stated his/her attitude and behavior led to him/her being let go from employment. Director A alluded to Caregiver G not being gentle with residents and at times being verbally aggressive towards them. Director A stated to his/her knowledge no investigation of caregiver misconduct occurred as a result of being made aware of the concerns related to Caregiver G's behavior towards residents. On 11/27/2023, Surveyor reviewed Resident 1's record and noted an observation note dated 08/05/2023 at 4:50 PM, by Caregiver F, "resident [sic] was screaming in pain. [S/he] stated that [his/her] knee hurt ... yelled out for help and that caregivers were hurting [him/her] ..." On 08/17/2023, the Department received a self-report from the provider which listed the reason for the report as "acute displaced fracture on left distal femur." The report when on to describe an investigation into an injury of	N 158		

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N 158	Continued From page 4 unknown origin and did not address any allegations of caregiver misconduct. The self-report notes the resident complained of extreme pain on 08/05/2023, an X-ray was not obtained until 08/11/2023, and an investigation was not started until after the X-ray results were noted on 08/13/2023 as a fractured femur. The investigation did not include a line of questioning and was limited to 3 caregiver written statements that did not address any allegation of caregiver misconduct. On 12/04/2023 at 9:02 AM, Surveyors conducted an exit interview with Administrator C, Director A, Director Of Nursing (DON) D, and Licensee E present. At approximately 10:45 AM, Administrator C acknowledged Resident 1's observation notes included a caregiver note indicating Resident 1 alleged caregiver misconduct on 08/05/2023. Administrator C acknowledged all administrators had access to review the observation notes and stated no investigation into the allegation of caregiver misconduct was completed. Administrator C confirmed an investigation into the injury of unknown origin was started after the X-ray results were noted on 08/13/2023, 8 days after the initial complaint of pain. The investigation was a result of the finding of injury and did not include investigation into potential caregiver misconduct. Cross Reference N0161 DHS 83.12(3)(a) Investigate Injuries Of Unknown Source N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	N 158		

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	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 161	Continued From page 5	N 161		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately investigate injuries of unknown source. Resident 1 reported extreme pain in his/her left knee on 08/05/2023 and an investigation not started until 08/13/2023. The investigation comprised of 3 conflicting caregiver interviews which the provider did not look further into and resulted in the provider's investigation conclusion dismissing its own findings. Resident 3 was identified to have a dislocated shoulder. An investigation into the injury or Resident 3's specific allegations was not conducted or documented to determine its source. Findings include: On 08/17/2023 and 11/07/2023, the department received complaint information alleging residents with injuries of unknown source were not investigated. RESIDENT 1 On 11/27/2023, Surveyor reviewed Resident 1's record and noted an observation note dated 08/05/2023 4:50 PM, by Caregiver F, "resident	N 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 161	Continued From page 6	N 161		

[sic] was screaming in pain. [S/he] stated that [his/her] knee hurt ... [S/he] would not let me apply [his/her] PRN pain gel or even look at the knee. [S/he] only yelled out for help and that caregivers were hurting [him/her] ..."

The observation notes dated 08/10/2023 at 11:47 AM, written by Director B noted, "APS [Adult Protective Services] in house inquiring about several complaints ..." APS notes dated 08/10/2023 indicated they were present at the facility to ensure Resident 1's immediate safety after receiving reports of neglect.

On 08/17/2023, the Department received a self-report from the provider dated 08/16/2023 which listed the reason for the report as an incident the occurred on "08/05/2023 ... acute displaced fracture on left distal femur." The report when on to describe an investigation into an injury of unknown origin. The self-report notes the resident complained of extreme pain on 08/05/2023, an X-ray was not obtained until 08/11/2023, and an investigation was not started until after the X-ray results were noted on 08/13/2023 as a fractured femur. The investigation did not include a line of questioning and was limited to 3 conflicting caregiver written statements that did not contain all dates, times, and associate names involved.

Surveyor reviewed the statement from Caregiver F noted Resident 1 was sitting in the dining room in his/her wheelchair with his/her feet under and attempting to self-propel. Caregiver F goes on to note s/he spoke with an unnamed caregiver who informed him/her that the resident had been continually attempting to self-propel. Caregiver F writes, "[sic] Caregiver at the time told me [s/he] had been doing this over and over, even when

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N 161	Continued From page 7	N 161		

telling [him/her] to stop ... [Resident 1] was having spirited expressions ... I tried to push [him/her] to the table. [S/he] would not pick up [his/her] feet and said [his/her] knee was hurting." The statement indicated Caregiver F did not witness the event and did not name who the caregiver was that they spoke with. On 12/04/2023 at 9:02 AM, Surveyors conducted and exit interview with Administrator C, Director A, Director Of Nursing (DON) D, and Licensee E present. At approximately 10:45 AM, Administrator C stated s/he was unaware who the caregiver was that Caregiver F spoke with and did not continue the investigation to find out who the person was.

Surveyor reviewed the statement from Caregiver G noted s/he spoke with a "staff Member who worked when the injury happened" and reported the unnamed staff Member told him/her the resident injured him/herself while self-propelling in his/her wheelchair. The statement indicated Caregiver G did not witness the event and did not name who the caregiver was that they spoke with. On 12/04/2023 at 9:02 AM, Surveyors conducted an exit interview with Administrator C, Director A, DON D, and Licensee E present. At approximately 10:45 AM, Administrator C stated s/he was unaware who the caregiver was that Caregiver G spoke with and did not continue the investigation to find out who the person was who may have witnessed the injury occur.

Surveyor reviewed the statement from Caregiver U noted, "[Resident 1] was walking normal [sic] when [s/he] got into [his/her] wheelchair. Another resident was pushing [him/her] around for a few minutes and [s/he] went around the other side of the wall [sic] and [s/he] put [his/her] feet under the wheelchair to stop [him/her.] I repeatedly told [him/her] not to do that, and [s/he] called me

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N 161	Continued From page 8	N 161		

names because I told [him/her] to stop that before. [sic] Shehe [sic] [s/he] hurt [him/herself] and that's what happened." On 12/04/2023 at 9:02 AM, Surveyors conducted an exit interview with Administrator C, Director A, DON D, and Licensee E present. At approximately 10:45 AM, Administrator C stated s/he was unaware who the resident was that Caregiver U stated was wheeling Resident 1 and did not continue the investigation to find out who the person was. The investigation comprised of 3 incomplete conflicting caregiver statements that were not looked further into and dismissed its own findings. Administrator C's conclusion:

"It has been determined that [sic] obtained the injury from [his/her] leg becoming caught while propelling self in the wheelchair and it becoming [sic] caught under [him/her.] [Resident 1] did not have any falls or other injury that staff have reported. Hospice has been ensuring that [sic] resident is having controlled pain."

During the interview with Administrator C, on 12/04/2023 at approximately 10:45 AM, Administrator C shrugged and was unable to state how the conclusion was made or why Caregiver U's account of events were dismissed. Administrator C stated when s/he received the caregivers written statements s/he did not follow up to find out who the other persons were that were unnamed in the 3 statements. Administrator C stated s/he was unaware of any resident's pushing Resident 1 in his/her wheelchair. Surveyor reviewed Resident 1's observation notes dated 08/04/2023 at 12:30 AM written by Caregiver L, "Resident was wheeled out of [his/her] room by another resident. Before then I was unaware more than one of them were in [his/her] room. From then on the other resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 161	Continued From page 9	N 161		

was pushing [him/her] around the halls and were exit seeking. They stayed up for hours." Administrator C, Director A, DON D, and Licensee E could not state who the resident was that had a history of pushing Resident 1 in his/her wheelchair. Considering the observation notes detailing a history of a resident pushing Resident 1 in his/her wheelchair, Administrator C acknowledged the potential inaccuracy of his/her investigation conclusion that dismissed Caregiver U's statement.

The investigation did not begin until 8 days after the initial onset of symptoms and APS involvement. The information gathered was incomplete with no dates, names, or times, and investigation was not followed through. Of the incomplete statements gathered, a conclusion was made that dismissed its own findings.

RESIDENT 3
On 11/27/2023, Surveyor reviewed Resident 3's record and noted s/he was admitted to the facility on 02/01/2023 with diagnoses of heart disease, diabetes, chronic kidney disease, obesity, pain in left shoulder, and low back pain.
Surveyor reviewed Resident 3's most recent individual service plan (ISP) dated 07/12/2023. Surveyor noted Resident 3 required assistance with activities of daily living including bathing, dressing, toileting, transfers, and mobility. Resident 3 utilized a walker and was identified to have a slow and sometimes unsteady gait. Resident 3 was identified as a fall risk and had a history of unwitnessed and witnessed falls. Resident 3 was his/her own person and able to make his/her needs known.

Surveyor noted on Resident 3's ISP "Short Term Problem - Return From Hospital/ ER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 161	Continued From page 10 ...07/12/2023 Return from the ER. Dislocated Left shoulder. Sling until follow up with orthopedics. Tramadol as needed for pain." Surveyor reviewed Resident 3's ISP "Fall Risk Status" and noted a number of documented falls and interventions. Surveyor noted no falls or incidents listed around or on 07/12/2023. Surveyor reviewed Resident 3's incident and fall reports and did not find any reports related to an incident around or on 07/12/2023. Surveyor reviewed provider's observation notes completed by staff and noted: 07/12/2023 2:39 PM - " ...When staff asked resident how [s/he] injured [him/herself] or what happened [s/he] stated that at about 8:00 this morning a bigger blonde [fe/male] picked [him/her] up and put [him/her] in [his/her] wheelchair ..." 07/13/2023 2:08 PM - "Resident returned from St. Vincent's ED [emergency department] via daughter transport. Resident did have a dislocation of left shoulder. They were able to put shoulder back into place. [S/he] needs to stay in the sling until you are [sic] follow up and cleared by Orthopedic. [S/he] now had an order for PRN Tramadol. Ensure resident is wearing sling and give PRN if needed." 07/14/2023 1:13 PM - "Resident now stating that the person that 'picked [him/her] up and put [him/her] in [his/her] wheelchair' on 7/12 is now a [fe/male] that is heavy, tall, dark haired and younger." Surveyor noted no other observation notes included information about how the injury occurred or further investigation into Resident 3's	N 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 161	Continued From page 11	N 161		

allegations.

Surveyor reviewed the department's provider file and noted a self-report sent in on 07/13/2023 by Director B. Surveyor noted "Incident Description - Left shoulder was 'bulging'. Compared to right shoulder, the left does look and feel abnormal. Shoulder has always been painful to resident, but now just sitting at rest [s/he] is having 5/10 pain. [S/he] stated that earlier in the day [s/he] was put in [his/her] wheelchair too fast and [s/he] put [his/her] arm back to catch [him/herself]." Resident 3 was diagnosed with a shoulder dislocation with the bone puncturing through the muscle.

On 12/06/2023 at approximately 1:20 PM, Surveyor interviewed Family Member GG who stated s/he was the one who noticed Resident 3's shoulder looking abnormal. Family Member GG was very concerned that staff did not notice Resident 3's bulging shoulder and had reported it to Director B. Family Member GG indicated s/he took Resident 3 to the hospital and s/he was found to have a dislocated left shoulder and that the bone had tore through the muscle. S/he emphasized that the bone didn't go around like normal, it went through it. Family Member GG stated Resident 3 was in a significant amount of pain. Family Member GG requested a copy of Resident 3's record and a copy of the investigation completed, but s/he said s/he was not given anything to justify the cause of the injury. Family Member GG shared s/he had reported to management that s/he observed a small blonde [fe/male] caregiver and a young, dark haired [fe/male] caregiver working the morning of the incident. Family Member GG stated s/he still did not receive any follow up how the injury occurred or investigation against staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 161	Continued From page 12	N 161		

pushing Resident 3 into his/her chair.

On 11/27/2023 at approximately 12:53 AM, Surveyors interviewed Director A and Director B. Director B stated Resident 3's family had mentioned to him/her that Resident 3's shoulder was bulging and so s/he was sent to the hospital. Surveyor inquired whether any staff reported Resident 3's shoulder bulging to Director A or Director B and Director B said no, and there was no charting on it.

Director B said when s/he asked Resident 3 at the time of assessing his/her shoulder, Resident 3 reported to him/her a blonde gal picked him/her and put him/her in his/her wheelchair hard at about 8 AM. Director recalled thinking the shoulder looking and feeling abnormal. Director A said they never found a bigger blonde girl that Resident 3 could have been referencing. Surveyor inquired whether there was an investigation done and documented and Director B said s/he did not know.

On 11/27/2023 at approximately 2:03 PM, Surveyor interviewed Director A who stated s/he would reach out to Administrator A for the investigation about Resident 3's injury of unknown source.

On 12/04/2023 at approximately 9:00 AM, Surveyor interviewed Administrator C who stated s/he recalled an investigation being done because it was found that none of the staff Resident 3 made an allegation about matched the profile of the staff working. Surveyor requested a copy of their investigation.

On 12/04/2023, Surveyor reviewed a report completed by Director of Human Resources CC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 161	Continued From page 13 dated 07/13/2023. "In response to complaints that [Resident 3] was having shoulder pain and complained caregivers were rough with [him/her]. I spoke to [Director B] about [Resident 3's] state of mind. Informed resident was unable to articulate specific details and frequently was unable to recollect details. I spoke to [Family Member GG]. [His/her] complaints stated that a caregiver was rough with the resident. [Resident 3] stated it was that [racial identifier] [fe/male]. I asked what had specifically happened leading to the incident and [s/he] stated that the caregiver, name unknown, had gotten into a verbal altercation with [Resident 3]. Following that the caregiver was rough with [him/her]. [S/he] did not know who the caregiver was. [Resident 3] stated [s/he] was upset before the caregiver entered the room. [Resident 3] was unable to articulate specifically what happened. [Resident 3] did not specify an injury. [Family Member GG] stated [s/he] wanted to see the investigation notes. I informed [him/her] that we would not release that information but that [s/he] could view the observation notes from ALIS [electronic member record]. I returned to [Director B's] office. We reviewed the schedule. It was determined there was no [racial identified] caregivers on duty at the time of the incident. [Director B] is going to get statements from three caregivers; [Caregiver HH, Caregiver II, and Caregiver JJ] to see if any further information could be determined. [Director B] would provide observations note to [Family Member GG] if requested. With no defining injury, no caregiver specified, the investigation closed. -End-"	N 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 161	Continued From page 14 Surveyor noted no additional documentation or additional investigation related to Resident 3 dislocating his/her shoulder or allegations towards caregivers once injury was known was conducted. Surveyor noted no documentation of statements from caregivers. On 12/06/2023 at approximately 8:40 AM, Surveyor reviewed written information from Administrator C who stated "[Resident 3] dislocated [his/her] shoulder the one time but came back the very same day. [S/he] did state that it was a staff member that was mean to [him/her] but when we talked to [him/her] the story changed on who it was. [Director of Human Resources CC] looked into it." A former caregiver "actually fit the description. I can dig and look some more but [Resident 3] fell into [his/her] chair a lot when [s/he] was going to sit down." Administrator C acknowledged the documentation did not identify how Resident 3's injury occurred. In conclusion, Resident 3 sustained a significant dislocation of his/her left shoulder. Resident 3 alleged misconduct against 2 different described caregivers who were unable to be identified. The investigation of the allegations was specific to caregivers being rough and did not include specifics to Resident's injury and was not relooked at once the injury was known. Director B and Administrator C speculated that Resident 3 had a fall, but did not document an investigation, document statements from staff as listed in Director of Human Resource CC's investigation, and identify the injury being caused by a fall, or events leading to, until Surveyor requested additional information.	N 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 161	Continued From page 15 Cross Reference N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	N 161		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on record review, interview, and observation, the administrator did not supervise the daily operation of the CBRF related to resident care and services, personnel, and physical plant. The administrator did not provide the supervision necessary to ensure that Resident 1, Resident 2, and Resident 3 received proper care and treatment, that their health and safety were protected and promoted and that their rights were respected. Four of 4 complaints investigated from 11/27/2023 through 01/09/2024 were substantiated and 9 deficiencies were identified.	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 214	Continued From page 16 Findings include: The provider is licensed to provide services for up to 65 residents who may be physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia. On 11/27/2023, 11/28/2023, and 12/04/2023, Surveyors conducted onsite visits for 4 complaints, a verification visit, and a standard survey. On 11/27/2023 at approximately 9:43 AM, Surveyor and Director B toured the facility. At approximately 11:00 AM, Surveyor and Director B toured Deer Wing within the facility. Surveyor requested Director B to test the exit door on the wing in which Director B pushed on the door until the alarm went off. Director B stated s/he did not know the code and did not have a key to turn the alarm off. Surveyor noted the door was a delayed egress door. Director B contacted Maintenance Tech KK. Surveyor and Director B stood by the door as the alarm sounded. Surveyor observed an unidentified caregiver attempt to turn the alarm off with his/her key without success and did not know the code to the key pad. Surveyor observed 3 other caregivers walk near and look over at Director B and Surveyor standing by the door. Director B stated s/he did not know the code. Maintenance Tech KK came to the door and attempted to unlock the door and turn off the alarm without success. S/he stated some of the staff's keys work in this specific door, but some don't. Maintenance Tech KK left to obtain a different key. Surveyor and Director B observed the door alarm for approximately 12 minutes before it was turned off and the door was released. Director B verified s/he did not know how to properly exit through the exit door and did	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 214	Continued From page 17	N 214		

not have the key or code to open it and turn off the alarm.

On 11/28/2023 at approximately 9:20 AM, Surveyors interviewed Director A who stated Director B was delegated to be the primary director for daily operations and staff oversight. Director A noted Director B was not at work on 11/28/2023 following Surveyors' visit on 11/27/2023.

On 12/04/2023 at approximately 9:00 AM, Surveyors interviewed Director of Nursing (DON) D and Administrator C. DON D stated s/he trained Director B and went over the evacuation plan, including the exits with him/her. Administrator C verified concern of Director B not being able to exit, disengage the delayed egress, and silence the alarm.

As a result of Administrator C not upholding his/her responsibility as the administrator and permitting the existence of a condition of risk to the residents, 4 complaints investigated from 11/27/2023 to 01/09/2024 were substantiated and the following 9 deficiencies were identified:

N0156 DHS 83.12(1)(b) Death Reporting Related To Accident Or Injury
Based on record review and interview, the provider did not report a resident's death related to an accident and/ or injury to the department. Resident 1 died as a direct result of sustaining multiple fractures and injuries while residing at the facility and the death was not reported.

N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect
Based on record review and interview, the provider did not investigate and allegation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 214	Continued From page 18	N 214		

caregiver misconduct when it was reported by Resident 1. Resident 1 was documented by the provider as alleging to the provider an injury s/he sustained was caused by a caregiver. The provider did not investigate the allegation.

N0161 DHS 83.12(3)(a) Investigate Injuries Of Unknown Source
Based on record review and interview, the provider did not immediately investigate injuries of unknown source. Resident 1 reported extreme pain in his/her left knee on 08/05/2023 and an investigation not started until 08/13/2023. The investigation comprised of 3 conflicting caregiver interviews which the provider did not look further into and resulted in the provider's investigation conclusion dismissing its own findings.
Resident 3 was identified to have a dislocated shoulder. An investigation into the injury or Resident 3's specific allegations was not conducted or documented to determine its source.

N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment
Based on record review and interview the provider did not ensure Resident 1 was free from neglect.
Resident 1's feeding and medications needs were not met by the provider. Resident 1 sustained an injury that was not promptly evaluated or investigated and was determined to contribute to his/her untimely passing. During the 15 days between sustaining the injury and his/her death, Resident 1 endured extreme pain that was documented by the provider and hospice services and was neglected to be managed. The provider documented pain and regularly provided no effective intervention. The hospice and administration had access to the documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 214	Continued From page 19 and did not intervene to ensure the staff followed through with consistent pain management. N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication Based on record review and interview, the provider did not ensure Resident 2 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 2 did not receive Vitamin C 500 mg tablets, Acidophilus probiotic tablets, Timolol MAR 0.5% eye drops, and Vancomycin eye drops as prescribed. N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary Based on record review and interview, the provider did not ensure Resident 1's Family T or Guardian S received a written summary of their grievances, the findings and the conclusions and any actions taken. Due to the grievances not being handled, future grievances were not reported, resulting in incidents of potential abuse that were uninvestigated. N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable Based on observation and interview, the provider did not provide a living environment that was safe, clean, comfortable, and homelike. Surveyor and Director B had multiple observations of unsecured toxic substances, unsecured resident records, warm refrigerators and freezer, mechanical lifts kept in common areas, unclean areas including the kitchen, fire hazards in relation to duct work, dust, and dryer vents, and a locked exit door. Y3234 DHS 50.09(1)(e) Treatment	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 214	Continued From page 20 Based on record review and interview, the provider did not ensure Resident 2 was treated with courtesy, respect, and full recognition of his/her dignity and individuality by all employees of the facility. On 12/04/2023 at approximately 9:00 AM, Surveyors interviewed Director A, Administrator C, and Licensee E who verified concerns with recent staff and facility daily operation oversight.	N 214		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure Resident 1 was free from neglect. The provider was aware Resident 1 had difficulty feeding him/herself at times and did not ensure Resident 1 was consistently assisted with eating. At times Resident 1 had to rely on other residents to help him/her eat. Concerns related to staff taking away food and medication without assisting or reapproaching the resident were brought to the provider's attention and were not effectively addressed.	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 348	Continued From page 21 Resident 1 sustained an injury on 08/05/2023 that was not promptly evaluated or investigated and was determined to contribute to his/her passing on 08/19/2023. During the 15 days between sustaining the injury and his/her death, Resident 1 endured extreme pain that was documented by the provider and hospice services and was neglected to be managed. The provider documented pain and regularly provided no effective intervention. The hospice and administration had access to the documentation and did not intervene to ensure the staff followed through with consistent pain management. Findings include: The facility is located on a campus with 1 sister facility. Per interview with Director A, on 11/28/2023 at approximately 9:20 AM, Director A stated Director B was an LPN and directly in charge of overseeing the facility, its residents and staff. Director A was the director in charge of the sister facility on campus and assisted with training Director B. Director A stated s/he was asked by Administrator C to assist Director B with further mentoring beginning approximately August 2023 due to concerns related to Director B's performance as a facility director. Director A stated there were caregivers and LPNs in August 2023 that were no longer employed, and Administrator C, who was based at another campus, would come weekly to the campus to check in. Director A stated it was expected that all caregivers would review the resident records but that Director B was supervisor to the facility LPNs, caregivers, medication passers, and outside health providers, including hospice. Director A was to assist by mentoring Director B while Administrator C was the supervisor of Director A, Director B, and Director Of Nursing	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 348	Continued From page 22 (DON) D, and Licensee E supervised Administrator C. Director A stated the resident records were available for the administrators review remotely at any time and was the responsibility of all caregivers to review the records, report changes, and ensure follow-through for pain management and other interventions. History and Death Report: On 10/27/2023, Surveyor reviewed Resident 1's record including the Individual Service Plan (ISP), Medication Administration Record (MAR), Observation notes (ON), Vital Sign Detail Report (VSDR), Initial Admission Assessment (IAA), Hospice record (HR), Adult Protective Services (APS) notes, and provider Self- Reports (SR). Resident 1 had a legal Guardian (Guardian S) beginning on 07/27/2023 and Resident 1's Family Member T was documented as regular visitor for Resident 1. Resident 1 was admitted to the facility and hospice services on 06/07/2023. His/her diagnoses included: Fracture of left pubis, age-related osteoporosis without current pathological fracture, restlessness and agitation, chronic congestive heart failure, pain in right knee, and dysphasia. Administrator C notes on Resident 1's IAA dated 07/17/2023, Resident 1 was on a regular diet with general consistency and no fluid restrictions. Resident was noted to be at risk for falls and could make most of his/her needs known. Resident 1 required full assistance with medication management, including psychotropic medications. The IAA notes Resident 1's pain as, "4-6 Points- Moderate pain ... 06/05/2023 [Resident 1] has [sic] current acute pain due to a fractured pelvis. [sic] Had PRN [as needed] Analgesics [sic] ordered." At the time of the assessment Resident 1 was noted to require, " ...one to two person [sic] pivot transfer with a	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 348	Continued From page 23	N 348		

gait belt for all transfers. [Sic] Broda chair for mobility, staff to escort to all destinations." The corresponding ISP dated 07/27/2023, notes Resident 1 was on a repositioning schedule every 2 hours and, "Staff [sic] to update Nurse [sic] with any issues and they will update the MD ...". Resident 1 had scheduled Tylenol and Tramadol both taken 3 times per day for chronic pain. Resident 1 had PRN medications including lorazepam and Haldol for anxiety and liquid morphine for pain. Interviews with Family Member T, on 11/27/2023 at 10:58 AM, and with Administrator C, Director A, DON D, and Licensee E, on 12/04/2023 at 9:02 AM, both confirmed prior to 08/05/2023 Resident 1 had been beginning to heal from his/her pelvic fracture, as s/he would scoot him/herself in his/her broda chair around the facility and at times would even attempt to self-transfer.

Surveyor reviewed the death certificate, dated 08/19/2023, notes the cause of death as "Complications of multiple fractures" and "Fall at residence 5/31/23 possible injury at care facility prior to 08/11/23."

Surveyor Note: The diagnosis of osteoporosis without current pathological fracture at admission on 06/07/2023 and the death certificate stating the cause of death is related to multiple fractures, shows the injury that resulted in his/her passing was sustained during the time s/he was admitted to the facility.

Neglect; Meals and Medication:
On 08/17/2023, The department received a complaint alleging a resident was not being fed by staff and staff would not reapproach the resident to offer food or medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 348	Continued From page 24 On 11/27/2023 at 10:58 AM, Surveyor interviewed Family Member T. Family Member T stated Resident 1's dementia would frequently result in Resident refusing, declining, or saying "no" to questions, even when the situation was in his/her best interest or was congruent with the Resident's own wishes. Family Member T stated, "You could offer (Resident 1) a million dollars and (s/he) would say no." Surveyor reviewed Resident 1's HR Plan of Care dated 06/07/2023 notes, in relation to Resident 1's behaviors and agitation, the staff were to " give simple directions and allowing sufficient time to respond, communicate and make decisions ... assess for hunger, thirst, cold, board, tired, pain, Constipation, UTI , etcetera as a cause of behavior ... Consider pain as a possible reason for behaviors ... Monitor tone and body language, as this is often more important than words ..." Resident 1 may automatically respond "no" to questions, which did not necessarily mean s/he was not hungry or was not in pain and did not want food or pain medication. The HR notes on 06/10/2023, "Patient requires assistance with meals. Family &[sic] facility staff supervise and assist patient." Surveyor reviewed Resident 1's ON. Prior to 08/05/2023 it was noted s/he was able to eat and after 08/05/2023 it noted decline and refusals to eat. The ON detail refusals to eat with no reapproach on 08/08/2023 at 7:30 PM and 9:14 PM. On 08/08/2023 at 11:19 AM Unity Hospice LPN Y notes, "[Family Member T] feels that [his/her] [Resident 1] needs assistance with eating, doesn't want the staff to approach [him/her] asking [him/her] if [s/he] is hungry but would rather suggest that they assist [Resident 1] with eating." At 2:14 PM, Unity Hospice LPN Y	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 348	Continued From page 25	N 348		

notes Resident 1 was "very skeletal with boney prominences clearly visible ... call Unity if [s/he] stops completely eating, drinking or trouble taking [his/her] meds [sic] ... SW [sic] also stated that this SW[sic] would call [sic] facility and speak with manager about concerns as well as let the facility know that Unity is aware of the concerns as well." The ON note on 08/09/2023 at 6:32 AM noted Resident 1 was observed eating breakfast when another resident assisted him/her, "... eating breakfast, another resident is assisting [him/her] ... - Unity Hospice RN I." Again on 08/09/2023 at 9:21 PM, Caregiver O noted Resident 1 accepted food when assistance was offered, "Caretaker helped [him/her] drink orange juice and gave [him/her] a cookie to eat. [sic] Resident was very cheerful about the help." On 08/10/2023 at 2:26 PM, Hospice Social Worker EE notes, "[Resident 1] appears much thinner that [sic] previous visit. SW [sic] notes that [his/her] sternum is clearly visible and the [his/her] neck of [his/her] shirt is slipping around [his/her] shoulders." The record showed Resident 1 was observed to be changing in appearance and when s/he was assisted with food, as was care planned in his/her HR, s/he was receptive to eating.

Surveyor reviewed Resident 1's HR including all documented weights. Surveyor noted Resident 1 weight 115 lbs on 06/04/2023 and 108 lbs on 06/29/2023. The HR notes under "Intervention: Assess nutrition and Weights" note the resident was to be weighed weekly and have a left arm circumference measurement completed at the first comprehensive hospice visit of each month, and as needed. On 11/28/2023 at approximately 11:00 AM, Director A gave Surveyor the VSDR with all Resident 1's documented weights. Surveyor reviewed the VSDR received from the provider and noted despite the care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 348	Continued From page 26	N 348		

directives to get a weekly weight, documentation noting the observed changes in the resident's appearance, and the grievances reported regarding not being fed, no additional weights or arm measurements were taken after 07/19/2023. Director A was unable to state why the ordered measurements were not completed after 07/19/2023.

On 12/13/2023 at 12:51 PM, Surveyor interviewed Guardian S. Guardian S stated s/he was concerned the staff were not reapproaching Resident 1 with food after Resident 1 would automatically respond "no" questions. Guardian S stated s/he brought the concern to Director B's attention on 08/07/2023 after witnessing staff not offering Resident 1 mealtime assistance and taking the food away.

Surveyor reviewed an ON dated 08/10/2023 at 11:47 AM written by Director B noted, "APS in house inquiring about several complaints ... if resident refuses to eat, take meds, ect [sic] please document ..." On 08/14/2023 at 10:46 AM Director B writes, ".... Make sure we are also attempting to feed [sic] resident ..." The provider was made aware by Guardian S, Family Member T, the residents own record notes, as well as the Hospice LPN Y and the hospice social worker that there were concerns about Resident 1 not being fed. Director B's own notes show the provider was aware of the issue when APS visited on 08/10/2023 and that the issue persisted on 08/14/2023.

On 11/27/2023 at 10:58 AM, Surveyor interviewed Family Member T. Family Member T stated after 08/05/2023, Resident 1 was in noticeable pain that was unmanaged and observed the pain caused him/her to not eat as much as s/he had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 348	Continued From page 27	N 348		

been. Family Member T stated Resident 1 began to need assistance and encouragement to eat. Family Member T corroborated the concerns were brought to the provider's attention by Guardian S on 08/07/2023 and stated there was no resolution. Family Member T stated Caregiver H would continue to enter the room, ask Resident 1 if they wanted their food and when Resident 1 would give his/her response of "no" Caregiver H would take the tray out of the room. Family Member T stated s/he asked Caregiver H if s/he could try to feed Resident 1 and Caregiver H said no. Family Member T stated s/he tried to explain Resident 1 needed to be reapproached and encouraged to eat when Caregiver H stated to Family Member T that s/he has seen "residents with dementia go for 100 days without eating and still live before they die." Family Member T conveyed feelings of anger and disgust over the staff's response as well and fear and helplessness for Resident 1. In response to Caregiver H's comment Family Member T stated, "It was like 'it doesn't matter to us if [s/he] doesn't eat [s/he's] going to die anyway', it was like since [s/he] was on hospice they didn't care. Just die. These remarks showed me this was just a game to them. Nothing is going to change this. I tried to talk to management and the guardian, and nothing was changing." Family Member T expressed feelings of helplessness and that after trying multiple times to report concerns with nothing addressed, s/he felt reporting the statement was not an option.

On 12/04/2023 at approximately 9:00 AM, Surveyors interviewed Director A, Administrator C, DON D, and Licensee E. Director B acknowledged Resident 1 had a change in condition that at times required reapproach with medication administration and additional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 348	Continued From page 28	N 348		

assistance with meals, including encouraging the resident to eat with feeding assistance. Director A stated it was the providers process to review staff documentation within the resident's records to monitor for any frequent refusals and changes in condition. Director A and Administrator C confirmed it was the providers expectation that the staff would document reapproaching the resident and to document if the resident continued to refuse medication, meals, or cares. Administrator C stated Administrator C reviewed Resident 1's ON record where Director B notes the concerns related to the APS investigations and asks staff to record resident refusals to eat or drink. Administrator C acknowledged, the provider had been made aware of the concerns related to food assistance and reapproach for Resident 1. Administrator C stated there was no further record to indicate staff followed through with documenting refusals to eat or efforts to reapproach for food or medication, and no documentation to indicate the POA's grievance brought to their attention on 08/07/2023 was addressed.

Neglect; Pain and Injury:
On 08/21/2023, the department received a complaint alleging the provider was aware a resident was in extreme pain for 15 days prior to passing and did not provide pain management.

On 08/17/2023, the Department received a self-report from the provider, written by Administrator C dated 08/16/2023, which listed the reason for the report as an incident that occurred on "08/05/2023 ... acute displaced fracture on left distal femur." The report when on to describe an investigation into an injury of unknown origin. The self-report notes the resident complained of extreme pain on 08/05/2023, an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 348	Continued From page 29 X-ray was not obtained until 08/11/2023, and an investigation was not started until after the X-ray results were noted on 08/13/2023 as a fractured femur. The investigation did not include a line of questioning and was limited to 3 conflicting caregiver (Caregivers F, G, and U) written statements that did not contain all dates, times, and associated names involved. Of the incomplete statements gathered, a conclusion was made that dismissed its own findings. On the self-report submitted to the department on 08/17/2023, Administrator C notes "hospice has been ensure that [sic] resident is having controlled pain." After review of the self-report on 12/04/2023 at approximately 11:00 AM, Administrator C stated s/he primarily works at a different campus and at the time, it had been reported to him/her by staff and hospice that Resident 1's pain was being effectively managed. Surveyor note: While on hospice services, residents with suspected injuries can have an x-ray ordered to diagnose possible injury and allow for an appropriate care plan. Residents who are on hospice services are able to use the information provided by an x-ray for a qualified medical professional to determine if a surgical option is available and allow for the resident/guardian and medical professional to decide on a course of treatment. If a surgical option is chosen, the resident can come off of hospice services while at the hospital and resume hospice services once discharged back into the provider's care. If surgical intervention is not an option or is unwanted, the x-ray still gives the assessing medical provider information pertinent to deciding a medical and pharmaceutical plan for pain management.	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 348	Continued From page 30 On 11/27/2023 at 10:58 AM, Surveyor interviewed Family Member T. Family Member T stated s/he frequently visited Resident 1 and noticed Resident 1 had been improving in health after his/her previous injury sustained on 05/31/2023. Family Member T stated Resident 1 was beginning to be able to transfer and ambulate with assistance and had less pain. Family Member T stated after 08/05/2023 s/he noticed a marked difference in Resident 1 stating it was clear that Resident 1 was in "extreme pain." Family Member T stated it appeared to him/her Resident 1 had sustained an injury and s/he could not get answers from any staff s/he asked about what had occurred. Family Member T stated s/he brought his/her concerns to Director B on 08/06/2023 and did not receive an answer or any follow-up to the concerns. Family Member T stated it was evident to him/her that Resident 1 had extreme pain in his/her left leg and s/he asked the provider multiple times for Resident 1 to have an x-ray to determine if an injury occurred. Family Member T stated the Hospice dissuaded the provider and guardian from getting an x-ray stating it wouldn't be of any benefit and Director B, who is not qualified to assess the resident's injury, stated Resident 1 did not qualify for surgical repair if something was found to be broken as s/he was on hospice. Family Member T stated the staff continued to place Resident 1 in a reclined broad chair where his/her legs "dangled off of the edge" causing Resident 1 to "scream" in pain. Family Member T stated, "It was absolute torture. I couldn't watch my (Resident 1) like that and no one would listen to me because I wasn't the POA. I had to watch (Resident 1) scream in pain as they moved (him/her) in that chair with (his/her) legs hanging over the edge. I asked them so many times to get an x-ray and they didn't so they didn't know (his/her) leg was	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 348	Continued From page 31	N 348		

fractured but it was clear (s/he) was in so much pain and they didn't do anything! This went on for days! I couldn't stand it. I can't stop thinking about how much my (Resident 1) suffered in the days before (s/he) died." Family Member T stated s/he reached out to the hospice and Guardian S multiple times for intervention as the provider was aware of Resident1's pain and was not helping.

On 12/13/2023 at 12:51 PM, Surveyor interviewed Guardian S stated s/he was brought in as a 3rd party as guardian for Resident 1 on 07/27/2023. Guardian S stated- Family Member T had been caring for Resident 1, had a good relationship with Resident 1, and that s/he was a positive advocate for Resident 1. Guardian S stated s/he recorded all calls and interactions pertaining to Resident 1's care. Guardian S stated neither the hospice nor the provider updated him/her that Resident 1 had a change in condition with a possible unwitnessed injury on 08/05/2023. Guardian S stated due to Family Member T's reporting to him/her about the change in condition of Resident 1 after 08/05/2023, and concerns related to Resident1's care and treatment since, caused him/her to agree to meet with Family Member T at the facility on 08/07/2023. Guardian S stated upon arrival Resident 1 was found without covers in a state of undress on a bedpan alone in his/her room. Guardian S stated s/he could not tell how long Resident 1 had been left in that position but stated Resident 1 did not appear to be comfortable. Guardian S noted later in the visit caregivers present did not reapproach Resident 1 when s/he stated "no" to food. Guardian S confirmed Resident 1 would say "no" initially to requests as a part of his/her diagnosis and behavior. Guardian S stated it was clear Resident 1 needed staff assistance and encouragement to eat and take medications and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 348	Continued From page 32	N 348		

stated s/he discussed the concerns with Director B prior to leaving.

Guardian S reviewed Resident 1's record from 08/05/2023 through 08/19/2023 and confirmed the dates and times that were noted in the hospice record (8/7, 8/8, 8/11 8/13, and 8/18) were the only dates an update or notification had been received. Guardian S stated the hospice and provider had been reassuring him/her Resident 1's pain was well managed and had given him/her no cause for concern. Guardian S stated the option of an X-ray was presented to him/her by hospice as not needed and Guardian S stated it was Family Member T's communication that led him/her to ultimately request an order for an x-ray on 08/11/2023. Upon review of the record, Guardian S expressed a feeling of shock at the documentation and lack of hospice and provider response to Resident 1's consistent expression of pain. Guardian S stated had s/he been notified of, or accurately reported to, on Resident 1's condition s/he would have sought immediate response for pain management.

On 11/27/2023 at approximately 11:25 AM, Surveyor interviewed Caregiver P. Surveyor inquired what Caregiver P could tell him/her about Resident 1and Caregiver P stated, "[Resident 1] wasn't at the facility for very long." S/he recalled Resident 1 "couldn't put any pressure on [his/her] thigh." Surveyor inquired what happened to Resident 1's thigh and Caregiver P stated s/he did not know. Caregiver P said s/he went from a pivot transfer to a hoyer lift transfer in a very short amount of time. Caregiver P could not recall when the change in transfer assistance changed, but stated Resident 1 had started feeling pain in his/her leg and so hospice ordered an x-ray,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 348	Continued From page 33 which determined his/her leg was broken. On 08/10/2023 APS became involved to ensure the residents immediate safety. APS Notes: On 08/10/2023 APS noted, "... had a lengthy conversation with the director and assistant director. There is no documentation to believe that [Resident 1] had an incident over the weekend of 8/5. Staff stated [Resident 1] had a history of knee replacements, and [s/he] had a topical pain gel they applied, therefore they believed [his/her] pain was related to this." (Resident 1 "screaming in pain" was documented on 08/05/2023 at 4:50 PM giving reasonable cause to believe an incident occurred due to the abrupt change in condition. Additionally, the resident's diagnoses include a history of right knee pain. The provider presumed it was not a new injury and failed to recognize it was his/her left knee that was now in pain, even 5 days after the onset of symptoms.) Surveyor note: Resident 1 had 3 times daily scheduled Tylenol and tramadol pain medication for chronic pain to address the resident's baseline level of pain. Any new or increased pain requires further medication management including increased dosing, and/or additional pain medication for acute pain management. While residents are on hospice services they may receive end of life comfort medications including, but not limited to, morphine (Roxanol) in a liquid form drawn up into syringes that can be administered sublingually (absorbed under the tongue) for verbal or nonverbal signs and symptoms of pain, restlessness, or shortness of breath, and/or liquid sublingual lorazepam for restlessness and agitation. The provider is to	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 348	Continued From page 34	N 348		

provide health monitoring for the resident including medication management to meet their needs while hospice provides oversight and support for the medication management. The provider is to monitor for verbal and nonverbal pain signs to ensure consistent symptom management. Resident 1's PRN dose of Lorazepam was a range between 0.5-1 mg up to every 4 hours. Resident 1's prescribed PRN dose for sublingual morphine(Roxanol) was a range between 5-10 mg up to every 1 hour as the sublingual dose is short-acting and requires consistent administration for effective symptom management.

During an interview with Director A and Director B on 11/26/2023 at approximately 11:00 AM, Director A reviewed the MAR and noted dates when Resident 1's scheduled Tylenol and Tramadol were marked as "refused" or "unavailable." Director A stated there were a "few days" when the medications were not present at the facility and staff had inaccurately documented the medications as refused. Surveyor identified on the MAR 5 doses of tramadol (08/15/2023-08/16/2023) that were not given due to not being present in the medication cart. Director A stated the medications were not ordered on time and as a result were not delivered on time. Director A stated it was Resident 1's initial response to any question to say "no" as a behavior related to his/her diagnosis and, like the need to reapproach for mealtimes, the staff may not have reapproached the resident for his/her medication if it was available but initially refused. Director A stated Resident 1 was more likely to refuse all cares, medications, and treatments if s/he did not have his/her pain managed. Director A stated regardless of the scheduled Tylenol and tramadol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 348	Continued From page 35	N 348		

being refused or not present to be given, a review of the MAR should have alerted staff to Resident 1's baseline pain not being managed with his/her regularly scheduled pain medication not being received. Director A stated the record was available for the administrators review and was the responsibility of all caregivers to review the records, report changes, and ensure follow-through for pain management.

Resident 1's HR Plan of Care dated 06/07/2023 notes the visiting RN was to "... assess pain medication use at each routine visit and PRN" and "... assess progress towards pain goal at each routine visit and PRN." The Tylenol and tramadol were frequently marked in the MAR as refused and no PRN lorazepam was given to help with anxiety to keep Resident 1 calm enough to be receptive to receive consistent pain medication. Resident 1 had orders for both PRN lorazepam and Haldol. No reapproach by the staff was documented. No alternate route for medications was offered. No alternate interventions were documented other than ice and elevation. Regularly scheduled medications Tylenol and tramadol were not effective for pain management of the new acute injury pain. Tramadol was not ordered timely and was not at the facility to be given for 5 doses.

https://hospiceofcincinnati.org/wp-content/uploads/RoxanolLiquid-20180221.pdf (Retrieval date 01/02/2024)

"Roxanol may be used to manage pain or trouble breathing throughout an illness or at the end of life. By managing symptoms, Roxanol plays an important role in maintaining comfort and decreasing fear and anxiety. Roxanol can also ease anxiety and the feeling of air hunger by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 348	Continued From page 36	N 348		

relaxing respirations, making it easier to breathe ... Roxanol is administered with a plastic oral syringe that comes with the medicine bottle. The liquid may be swallowed or placed under the tongue or inside the cheek."

https://www.rxlist.com/roxanol-drug.htm#indications (Retrieval date 01/02/2024)

"[Morphine/ Roxanol] ... Dosage is a patient dependent variable, therefore increased dosage may be required to achieve adequate analgesia. For control of severe, chronic pain in patients with certain terminal diseases, this drug should be administered on a regularly scheduled basis ... at the lowest dosage level that will achieve adequate analgesia ...
During the first two to three days of effective pain relief, the patient may sleep for many hours. This can be misinterpreted as the effect of excessive analgesic dosing rather than the first sign of relief in a pain exhausted patient. The dose, therefore, should be maintained for at least three days before reduction, if respiratory activity and other vitals signs are adequate."

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2546472/ (Retrieval date 01/02/2024)

"Short-acting agents like oral morphine ... are used alone or in combination with acetaminophen, aspirin (ASA), or ibuprofen. Peak analgesic effect occurs within 60 minutes ...
Short-acting oral single agent opioids, can be safely escalated every 2 hours ... recommends around the clock pain control versus "on demand" methods
... Recognition of pain triggers, particularly among cognitively impaired elderly. In cognitively impaired residents, activities or treatments that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 348	Continued From page 37 have caused pain in the past should be anticipated as causing pain in the future. Pain should also be anticipated: cognitively impaired elders should be premedicated (Hutt et al 2007). ... A dual therapy targeted towards the individual pain assessment, with recognition of the following: 1.American Pain Society (Miaskowski et al 2005) and AGS (2002) both emphasize the importance of obtaining the patients' self-report of pain whenever possible. 2.Dementia is prevalent and may impair the perception of pain, ability to report pain, ability to recall pain sensation for evaluating relief, and the ability to communicate about relief. Thus, the potential for unrelieved and unrecognized pain is greater among those who cannot reliably evaluate and/or verbally express their discomfort (AGS 2002)." https://www.aafp.org/pubs/afp/issues/2001/1001/p1227.html (retrieval date 01/02/2024) Challenges in Pain Management at the End of Life "Somatic Pain ...Bone pain typically cannot be completely controlled with narcotics. Therefore, adjuvant agents are added to the narcotic regimen.8 First-line adjuvant therapies for bone pain include NSAIDs and corticosteroids such as prednisone (30 to 60 mg per day taken orally), dexamethasone (Decadron; 16 mg per day taken orally) and methylprednisolone (Medrol; 120 mg per day taken orally) ... ACUTE OR CRESCENDO PAIN	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 348	Continued From page 38 A variant of breakthrough pain occurs in patients who are under good pain control but develop acute onset of new pain or crescendo of established pain. Pain management in these patients should be considered a medical emergency. Acute or crescendo pain can be controlled with the aggressive use of breakthrough pain medication (e.g., immediate-release morphine) every 15 minutes until the patient is comfortable. This medication should be taken in the presence of a health care professional who understands pain management. Once the crisis has resolved, the baseline sustained-release analgesic medication should be adjusted in an attempt to prevent the recurrence of acute or crescendo pain. However, this pain persists in some patients, and arrangements must then be made to provide parenterally administered pain medications. INCIDENT PAIN Incident pain is another type of pain that patients may experience at the end of life. This pain occurs in conjunction with certain activities, such as rolling over in bed, riding in a car or being bathed. Incident pain can be managed by giving patients their breakthrough dose of immediate-release medication 30 minutes before the activity is performed. Premedication can reduce the amount of pain that occurs during the activity. It is also important to assess patients for underlying causes of the pain, and to correct those causes if possible." Timeline: Surveyor reviewed Resident 1's record including the MAR, ON, and HR to compile a timeline of events and provider response: 08/05/2023:	N 348		

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N 348	Continued From page 39 ON: 4:50 PM Caregiver F, "resident [sic] was screaming in pain. [S/he] stated that [his/her] knee hurt ... [s/he] [sic] yelled out for help and that caregivers were hurting [him/her] ..." MAR: No morphine or PRN pain medications were given after the initial report of pain. (Although the resident displayed a change in condition with extreme pain, the provider did not notify hospice or the guardian. No PRN pain medication was given. The caregiver had the resident wait until the evening 8 and 10 PM scheduled doses of Tylenol and tramadol for pain management. The provider relied on the resident's regularly scheduled pain medication to relieve the pain for newly acquired acute pain. The scheduled Tylenol and tramadol were not appropriate to meet the residents new acute pain management needs.) 08/06/2023: MAR: 8:00 AM The scheduled Tylenol was not received. HR: 9:11 AM Hospice RN DD noted, "[Administrator A] is reporting that [sic] patient is crying our [sic] in pain. Patient cannot verbalize what is painful but [s/he] does cry out louder when touched. Tramadol was given this AM and has not been helpful. Crying continues to increase. Writer advises a 5mg dose of Morphine and a call back in 30 minutes if not effective. Caregiver confirms plan." MAR: 9:25 AM Morphine was given. HR: 12:12 PM AM Family Member T called hospice and informed them Resident 1 was in	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 348	Continued From page 40	N 348		

pain. Family Member T stated the last dose of Morphine was not effective and the provider did not call back as they were instructed to do.
ON: 1:50 PM Caregiver G, "Residents [sic] left knee is super sore. Res [sic] was screaming out in pain from even the slightest touch ..."

HR: 2:00 PM Hospice RN I visited and noted, "[Resident 1] has [sic] given scheduled tramodol [sic]/ prn tylenol [sic]& [sic] morphine per unity's instructions and [sic] appling [sic] ice ... left knee is tender to touch and sl [sic]swollen ... [Sic] Elevated left knee on pillow and re-applied ice, enc [sic] staff to continue with same medication regiman [sic] including calling unity if morphine needs to be repeated & [sic] to allow [Resident 1] to rest in bed ..."

(The hospice note is incorrect and misleading. Resident 1 did not receive Tylenol prior to the hospice visit and was given 1 dose of morphine at 9:25 AM with continued pain documented. The staff did not follow through with calling hospice back when the resident experienced more pain control issues as they were directed to do. There was an injury of unknown origin that at this time had not been investigated and neither the provider nor hospice sought an r-xay, a brace for support, or a plan for continual pain management. A single dose of morphine is short acting and peaks in effect within 1 hour. Waiting until the resident was in severe pain before calling for a sporadic dose of morphine was not consistent or effective pain management. No plan for consistent pain management or prevention was put into place. After Family Member T called at 12:12 PM to report pain, the provider documented "screaming out in pain" at 1:50 PM, and the hospice RN evaluated a swollen and tender knee at 2:00 PM, still no medication was

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N 348	Continued From page 41 given by the provider or hospice for pain control.) ON: 5:06 PM Unity Hospice LPN (writer unidentified)," ... did yell out "oww oww" when Unity RN adjusted [his/her] leg on a pillow ..." MAR: 7:54 PM Morphine was given (last given 10.5 hours ago with 4 documented reports of pain during this timeframe.) MAR: 8:00 PM The scheduled Tylenol was not received. ON: 9:26 PM Caregiver O, " ... Resident is experiencing a lot of pain when it comes to movement and just in [sic] general state." (No report to hospice or intervention was provided.) MAR: 10:00 PM The scheduled Tramadol was not received. 08/07/2023: ON: 6:00 AM Caregiver L, "I was told [s/he] did something to [his/her] left leg that was causing [him/her] a lot of pain ... every time I barely touched [him/her], [s/he] yelled out in pain." (Morphine is not given for another hour and 15 minutes.) MAR: 7:15AM Morphine was given (last given 11 hours ago with 1 documented report of pain during this timeframe.) ON: 11:15 AM Director B, " ...Staff also repositioning resident often. Resident continues to c/o [sic] left knee pain ... resident does yell out when left leg is moved ..." (Morphine is not given for another hour.)	N 348		

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N 348	Continued From page 42 MAR: 12:18 PM Morphine was given (last given 5 hours ago with 2 documented reports of pain during this timeframe.) HR: 12:41 PM Family Member T called hospice to report Resident 1 did not have access to food or water and was experiencing "extreme" pain in (his/her) legs. (No PRN pain medication was provided.) HR: 1655 Hospice RN J visited and noted, " ... [Resident 1] is not in pain unless [s/he] tries to move [his/her] left knee or if someone touches or manipulates it ... [Family Member T] reports [Resident 1] 'won't let you touch' the left knee and writer concurs ... ...Pain regimen is working if patient's knee is immobile ..." (Apart from the resident's regularly scheduled doses of Tylenol and tramadol, that were frequently not received as prescribed, and the inconsistent use of PRN morphine, the "pain regimen" included the hospice RN's recommendations of ice, not moving, and a topical analgesic gel not prescribed for a fractured femur.) Hospice RN J goes on to note, " ...call was then placed to [Guardian S] ... Writer discussed the possibility of [sic] portable x-ray, but also discussed that may not show us anything .... and that X-ray may involve manipulating the joint, causing pain ... In the end of our conversation, [Guardian S] agrees that [Resident 1] should not be X-rayed ... Discussed with [Guardian S] [Resident 1's] ... current pain regime was working ...	N 348		

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N 348	Continued From page 43 ... [Family Member T] and [Guardian S] in agreement not to seek further treatment or X-ray ... Please note that [Guardian S] did say [s/he] may be getting a APS involved with what happened at the facility with the left knee." (The hospice RN noted the current "pain regimen," which had no consistent reporting or administration of PRN pain medication and frequently resulted in extreme pain, was "working" as long as the resident didn't move and no one touched his/her leg. The provider knew Resident 1 would need to be repositioned, toileted and dressed, which would require touching and movement. Giving no consistent medication for pain management while waiting for a resident to be in extreme pain before giving a short acting analgesic and then assessing the regimen as working as long as the resident doesn't move and isn't touched, was not appropriate to meet the resident's needs.) The guardian was notified the resident's pain was being consistently managed. A review of the record would have shown the provider and hospice that the pain regime was not effective as the resident was frequently calling out in pain with no report to hospice and had not been receiving consistent doses of PRN Morphine prior to cares or receiving his/her scheduled pain medications. Per the resident's record, hospice and the provider were aware of Resident 1's behaviors including refusals were escalated with increased pain. Despite the record showing the facility was not consistently managing the resident's pain and resulting agitation, there were no orders for the PRN morphine to be scheduled for pain management or directives to use his/her PRN lorazepam or Haldol. The Hospice provider dissuaded the need for an x-ray, but	N 348		

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N 348	Continued From page 44 acknowledged the leg needed to be immobilized for pain management, yet did not provide an order for a leg brace. Conversely to the provider and hospice assuring the guardian the resident's pain was well managed, HR dated 08/31/2023 by Hospice RN FF acknowledged the hospice and provider were aware the "pain regimen" had not been effective, "Pt [sic] had sustained a fracture in [sic] week prior to [his/her] death and had some challenges with pain control following this ...") ON: 7:16 PM Caregiver M, "I received a call from the caregiver that [s/he] was concerned about [Resident 1's] knee pain. [S/he] reported it was hurting whenever they moved it and it was swollen ... instructed to give 1 syringe of morphine ..." (The provider does not give the morphine for another hour.) MAR: 8:19 PM Morphine was given (last given 8 hours ago.) ON: 11:00 PM Caregiver L, "... A soon as It was time to move [him/her], [s/he] yelled out in pain saying [s/he] couldn't do it ..." (No report to hospice or PRN pain medication was provided.) 08/08/2023: ON: 2:00 AM Caregiver L, "Went by resident to encourage [him/her] to allow me to help [him/her] into bed. [S/he] just kept repeating "I can't. I just can't" anytime I would get ready to help [him/her] transfer." (No report to hospice or PRN pain medication was provided prior to attempting cares or after pain symptoms were observed.) ON: 5:00 AM Caregiver L, "I went by [him/her] to try one last time to get [him/her] moved to [his/her] bed. As soon as I thought we were	N 348		

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N 348	Continued From page 45 getting somewhere, [s/he] threw [his/her] hands up and said [sic] "to heck with it." Still [sic] not sure what happened to make [his/her] left leg hurt so much, but I noticed it yesterday morning." (No report to hospice or PRN pain medication was provided prior to attempting cares or after pain symptoms were observed.) ON: 8:30 AM Caregiver G, "[Family Member T] was here and found 3 pills on [his/her] bedroom floor. One was Tylenol, one quetiapine, and one was levothyroxine. [Family member T] was a bit upset as Res [sic] is not prescribed levo. [sic]" (No report to hospice, the resident's medical provider, or the guardian was made regarding the potential for the medication error, and no investigation was completed to see who may be missing medication or was given incorrect medication.) MAR: 9:21 AM Morphine was given (last given 13 hours ago with 2 documented reports of pain during this timeframe.) HR: 10:25 Family Member T notified hospice Resident 1's broda chair is causing him/her "excessive" pain. (Per interview with Family Member T on 11/27/2023 at 10:58 AM, the provider put the resident in a reclined broad chair with his/her legs lifted and hanging causing extreme pain after they were instructed by hospice to let him/her rest in bed and after discouraging an X-ray to find out if anything was broken. The fractured leg was "dangling off of the edge" of the chair placing stress on the fractured bone and causing the resident to scream.) MAR: 10:35 AM Morphine was given. ON: 11:24 AM Director B, " ...Staff also	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 348	Continued From page 46	N 348		

repositioning resident often. Resident continues to c/o [sic] left knee pain ... resident does yell out when left leg is moved ..." (No report to hospice or PRN pain medication was provided.)

ON: 12:39 PM Caregiver G, "Resident has been yelling out in some pain today. Whenever staff tried to change [his/her] brief or touch [him/her] in the slightest, res [sic] was calling out in pain ..." (No report to hospice or PRN pain medication was provided.)

ON: 2:14 PM Unity Hospice LPN Y, "[Director B] reported [Resident 1] is no longer able to bear weight, no longer ambulatory, and no longer able to self-propel [him/herself] in a broda scoot ... [Resident 1] appeared very skeletal with bony prominences clearly visible. Writer did ask that facility call Unity if [s/he] stops completely eating, drinking or trouble taking [his/her] meds ... appeared as if [s/he] could soon transition to active dying ..."

(The visit was performed by Hospice LPN Y. LPNs are not qualified to perform medical assessments. No RN assessment or plan for consistent use of PRN pain medication was provided despite the observations the resident may be transitioning to actively dying.)

MAR: 7:11 PM Morphine was given (last given 9 hours ago with 3 documented reports of pain and an observed change in condition during this timeframe.)

ON: 7:30 PM Caregiver O, "Resident refused medication along with eating or drinking anything. Resident still lays in bed with pain, which[sic] morphine was dispensed to help ease the pm cares and toileting being done."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 348	Continued From page 47 MAR: 8:00 PM The scheduled Tylenol was not received. MAR: 10:00 PM The scheduled Tramadol was not received. 08/09/2023: MAR: No morphine or other PRN pain medication was given all day. ON: 6:32 PM [sic] Unity Hospice LPN, " ... [Resident 1] is sitting in broad scoot eating breakfast, another resident is assisting [him/her] at times ... [Resident 1] just received a tramadol for pain ..." (The tramadol was a scheduled dose for chronic pain management and was not adequate to be expected to manage the pain from the acute injury.) HR: 9:15 AM Hospice RN I notes " Writer met with [Caregiver X] ... inquired if there were any new concerns with [Resident 1,] [s/he] states they have been administering pain medication throughout the day to manage [his/her] left knee pain ... poor appetite ... now transferring with 2 assist ...cannot bear much wt [sic] to left leg ... [Family Member T] inquires if there is any other intervention besides ice/ elevation and pain medication to manage edema to left knee. Writers suggested wrapping with Ace Wrap ... writer will apply with next visit." (Per the record neither the PRN morphine nor the scheduled pains medications were being consistently given. Resident 1 was documented as having pain that was being left unmanaged for hours. Hospice documents Resident 1's decline without further intervention or modification of the	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 348	Continued From page 48 directives to the provider. Family Member T asks for further interventions for pain management and, while still not providing a brace for immobilization, Hospice recommended an ace wrap but was going to make the resident wait until their next visit before applying the intervention. Neither the provider nor the hospice ensured staff were following through with giving pain medication.) ON: 9:21 AM Caregiver O, " ... Resident was in a lot of pain, saying help me ..." (No report to hospice or PRN pain medication was provided.) 08/10/2023: HR: 10:30 AM Hospice RN I visited and placed the ace wrap. S/he advised the provider to, "apply ice, elevate and offer pain medication frequently throughout the day ..." ON: 11:47 AM Director B, "APS [sic] in house inquiring about several complaints received ..." HR: 6:54 PM Call from Hospice RN Z to Family Member T, "... returned call to [Family Member T] who states [s/he] is very concerned about the amount of pain [Resident 1] is having. They are giving [him/her] Tramadol, Tylenol and morphine and [s/he] is still complaining of severe leg pain ... [Family Member T] feels the pain should have improved in five days and feels that maybe an X-ray is warranted. We talked about benefit versus burden and if X-rayed, what we would do with those results. [S/he] understands hospice philosophy but feels since this was an accident and not [his/her] disease progressing, that we should be doing more to control the pain. [Family Member T] states [Resident 1] is not eating now, not sleeping due to pain. They did put an ace	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 348	Continued From page 49 wrap on it today, and the facility will occasionally put ice on it, but not regularly. The leg is swollen, black and blue and hurts to even touch it." HR: 7:30 PM Hospice RN AA visited and noted, "... Upon exam of Lt [sic] knee, Pt [sic]cried out in pain ... facial grimacing ... ace bandage removed having slipped down under knee and constricting ... moderate swelling to Lt [sic] knee with lg [sic] softball size bruise to posterior lower thigh just above knee. Tender to touch ... LLE [sic] slightly rotated internally ... encouraged to ice and elevate LLE [sic] and administer 5mg Morphine SL Q 1 hr PRN [sic] pain/ repositioning ... Primary RN will be following up ... regarding possible Lt [sic] knee xray [sic] ..." MAR: 7:36 PM Morphine was given (last given 48 hours ago with 4 documented reports of pain during this timeframe.) 08/11/2023: ON: 3:00 AM Caregiver L, "... refused my assistance with repositioning due to [his/her] left leg pain." (No report to hospice or PRN pain medication was provided.) MAR: 6:00 AM Scheduled tramadol was not received. ON: 2:35 PM Director B, "[Sic] Received a call from Unity. They will be sending over orders for a [sic] X-ray to LLE ..." ON: 4:09 PM Director B, "Unity RN [sic] in facility. [S/he] stated [s/he] told [Family Member T] 'to appease [him/her]' that [s/he] could go to Walgreens and get a knee brace for [sic] resident. [sic] and that '[Family Member T] would	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 348	Continued From page 50 be in charge of it' ..." HR: 4:15 PM Hospice RN I visit noted, "... assisted [Family Member T] with placing a soft splint to left knee, facility nurse [LPN N] had just recently administered 5 mg of morphine for comfort ... obtained verbal orders for the splint ... request for x-ray ... plan is for [Resident 1] to have x-ray this evening." (Visit note electronically signed by Hospice RN I at 10:17 PM on 08/12/2023.) MAR: 4:31 PM Morphine was given (last given 20 hours ago.) ON: 6:13 PM Director B, "Xray tech is in [sic] house to obtain 1 view xray [sic] on left knee ... await results." (Per the HR on 08/13/2023, the X-ray results were received later in the evening on 08/11/2023 and the provider did not report or follow through with the information.) 08/12/2023: MAR: No morphine or other PRN pain medication was given all day. HR: No Hospice notes were present for the day. ON: 10:50 AM Caregiver P, Resident was in a lot of pain this am during cares. 7/10 resident was given medication for pain. Family Member T ... wanted to know some information in reference to resident x-ray and results. Staff explained we cannot give out resident personal/ health information ... staff informed floor nurse of the situation." (No report to hospice or PRN pain medication was provided.)	N 348		

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	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 348	Continued From page 51 08/13/2023: MAR: No morphine or other PRN pain medication was given all day. ON: 6:21 AM Caregiver F, "resident [sic] was in a lot of pain while changing [him/her] throughout the night. screaming [sic] out." (No report to hospice or PRN pain medication was provided.) ON: 4:33 PM DON D, "Received r-ray results of left knee ... acute displaced fracture of the left distal femur noted ..."(No PRN pain medication was provided.) ON: 4:49 PM DON D, "STAFF: [Resident 1] is on hospice. If [s/he] is screaming out in pain [sic] they must be notified. She also has PRN morphine that can be given." (DON D does not follow through with staff and no PRN pain medication was provided.) HR: 4:49 PM DON D calls Hospice to report the x-ray results, "... xray [sic] on 8/11 for complaints of severe left knee pain. [DON D] reports the results came back Friday but [s/he] didn't see them until today ... [DON D] also reports charting from nurses stating patient has been in severe pain - last PRN morphine dose given was 4:30 PM today and nothing since 8/11. Writer inquired why patients pain has not been treated and Unity not updated on [his/her] condition- [DON D] states [s/he] does not know ..." (No morphine was given at 4:30 PM as reported by DON D to hospice.) ON: 9:52 PM Unity Hospice RN BB, " ... unity Hospice nurse visit made to assess [Resident 1] due to increased pain in [his/her] left leg. X-ray	N 348		

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N 348	Continued From page 52 taken on 8/11/23 shows acute displaced fracture seen on the left distal femur. Writer arrived to [sic] the facility and spoke with LPN and Med Passer. They reported to writer that [Resident 1] has been complaining of pain over the weekend. Writer asked if [s/he] had been administered any morphine. Med Passer stated [s/he] did not receive any PRN morphine in two days ... Writer instructed the staff to administer morphine for pain every hour as needed and to apply ice to the left hip to promote comfort. They stated they understood. Writer placed a call to [Guardian S] to update of same. [S/he] is in agreement with keeping [Resident 1] at the facility and keeping [his/her] comfortable ..." (Hospice does not follow through with staff and no PRN pain medication was provided.) 08/14/2023: MAR: 4:17 AM Morphine was given (last given 60 hours ago with 4 documented reports of pain during this timeframe.) HR: 8:30 AM Hospice RN I notes, "... conferenced with [Caregiver G] ... [Director B] & [sic] [DON D] to continue with administration of morphine prn [sic] & [sic] prior to cares ..." MAR: 8:46 AM Morphine was given (last given 4.5 hours ago.) ON: 10:46 AM Director B, "Please make sure a resident is now on bed rest due to left femur fracture (unless request to get up). Please give morphine 20 minutes before cares, toileting, etc. Make sure we are also attempting to feed [sic] resident. Please document any refusals. Update Unity with any changes."	N 348		

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N 348	Continued From page 53 MAR: 11:16 AM Morphine was given (last given 2.5 hours ago.) 08/15/2023: HR: No hospice notes were present for the day. MAR: 6:00 AM The scheduled tramadol was not received. MAR: 6:30 AM Morphine was given (last given 19 hours ago.) MAR: 8:00 AM The scheduled Tylenol was not received. MAR: 9:10 AM Morphine was given (last given 2.5 hours ago) ON: 10:16 AM Caregiver R, "resident refused daily cares this morning. Resident also refused breakfast .... Administered morphine 20 minutes prior to cares, [sic] did not seem very effective ..." (No report to hospice.) MAR: 11:59 AM Morphine was given (the medication could have been received 45 minutes earlier.) ON: 12:14 PM Director B, "[Sic] Resident continues to be in pain to LLE ...", ON: 1:16 PM Caregiver R, "... 20 minutes after administering 2 syringes of morphine. Residents still moaning in pain ..." (No report to hospice or PRN pain medication was provided.) MAR: 2:00 PM The scheduled Tylenol and tramadol were not received.	N 348		

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N 348	Continued From page 54 MAR: 6:09 PM Morphine was given (last given 5 hours ago and was documented as not effective at that time.) MAR: 8:00 PM The scheduled Tylenol was not received. MAR: 10:00 PM The scheduled tramadol was not received. 08/16/2023: MAR: 6:00 AM The scheduled tramadol was not received. MAR: 8:00 AM The scheduled Tylenol was not received. MAR: 9:29 AM Morphine was given (last given 15 hours ago.) MAR: 2:00 PM The scheduled Tylenol and tramadol was not received. ON: 2:47 PM Director B, "Resident was yelling in pain, however refused to allow staff to give [him/her] morphine. [S/he] was swatting at staff and telling staff to get away. Several staff attempted to give resident meds. Will continue to try." (No report to hospice or PRN anxiety or pain medication was provided.) HR: 8:50 PM Hospice RN I notes, "... met with [Caregiver G] and [Caregiver H] who report they have administered morphine 10 milligrams and this has kept [his/her] pain managed, enc [sic] them to continue with Tramadol and ice. Both express understanding and indicate that [his/her] appetite is decreasing.... concerned about hallucinations at night. Seeing children .... [Family	N 348		

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N 348	Continued From page 55 Member T] present during visit and expressed concerns about the results of the X-ray as [s/he] has obtained a full leg brace for [Resident 1] ..." ON: 9:29 PM Unity Hospice RN I, "... confirmed administration of pain medication ... Staff report decreased appetite and hallucinations at night [sic] these do not appear to be frightening for [Resident 1.] Please continue to monitor." (The caregivers reported the PRN and scheduled pain medications were being consistently given and were managing the residents pain contrary to the ON noting the resident yelling in pain and the MAR showing 1 dose of the morphine had been given and the Tylenol and tramadol had not been given for the last 5 scheduled doses as it was not available at the facility to give. No PRN pain medication was provided and the guardian was not updated regarding the change in condition.) MAR: 10:00 PM The scheduled tramadol was not received. ON: 10:30 PM Caregiver L,"... changed [his/her] brief before bed, It was a fight the whole time because [his/her] pain but s[he/] needed to be changed. Resident was trying to hit staff while being rolled. [S/he] also grabbed one of staff's chests and refused to let go. " (No report to hospice or PRN anxiety or pain medication was provided.) 08/17/2023: ON: 2:40 AM Caregiver L, "[Sic] went by [him/her] to check/change [his/her] brief and repositions [him/her.] [S/he] refused my help. [S/he] fought me the whole time so I wasn't able to change [his/her] brief ..."(No report to hospice or PRN	N 348		

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N 348	Continued From page 56 anxiety or pain medication was provided.) ON: 7:40 AM Caregiver X, "... resident is very out of it ..." (No report to hospice was provided.) MAR: 8:00 AM the scheduled Tylenol was not received. MAR 10:10 AM Morphine was given (last given 23 hours ago with 2 documented reports of pain during this timeframe.) ON: 1:51 PM Director B, "... Staff giving morphine prior to cares/ repositioning ... continues to yell out in pain when moved, however is not speaking to staff or making eye contact." (Only 1 dose of morphine had been given and no PRN pain medication was given prior to the ON overnight when Resident 1 was documented as twice "fighting" during cares. Director B's notes indicated s/he was aware despite the dose of PRN morphine given at 10:10 AM, the residents pain was unmanaged as s/he continued to "yell out in pain" and displayed a change in condition. Hospice and the guardian were not notified, and no PRN pain medication was given.) MAR: 2:00 Pm The scheduled Tylenol was not received. MAR: 4:20 PM Morphine was given (last given 6 hours ago with 2 documented reports of pain during this timeframe.) 08/18/2023: MAR: 8:00 AM The scheduled Tylenol was not received. MAR: 8:48 AM Morphine was given (last given 17	N 348		

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N 348	Continued From page 57 hours ago.) HR: 1:45 PM Hospice RN I notes, "... [s/he] received [his/her] scheduled Tylenol/ tramadol this am ..." (The scheduled Tylenol was not received.) MAR: 2:00 PM The scheduled Tylenol was not received. ON: 4:12 PM Unity Hospice LPN, "... please continue to administer prn morphine prior to cares ..." MAR: 8:44 PM Morphine was given (last given 12 hours ago with 2 documented reports of pain during this timeframe.) 08/19/2023: ON: 5:55 AM Caregiver L, "... I found [him/her] with dark colored vomit on [his/her] top half ... [s/he] appeared as if [s/he] was going to get sick again ..." (No report to hospice, the guardian, or PRN pain medication was provided.) MAR: 9:08 AM Morphine was given (last given 12 hours ago.) HR: 9:34 AM Director A called hospice to report the resident passed away. ON: 9:47 AM (late entry) Director A, "[Sic] Called over to the building for a change in condition. [Resident 1] [sic] struggling to catch [his/her] breath, chest barreled with agonal breathing noted, and [s/he] had been vomiting throughout the early morning ...[Sic] Instructed med [sic] passer to administer PRN morphine to help calm [his/her] breathing. [Sic] Instructed staff to contact	N 348		

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N 348	Continued From page 58 writer once Unity Hospice returned the phone call ... [Sic] Received a phone call from staff that they had gone in to check and reposition [Resident 1] and no vitals were able to be taken ... unity Hospice [sic] called and informed of no vitals present .... Triage stated they will contact Guardian and family..." ON: 11:54 AM Director A, "Unity Hospice RN Here to pronounce death ..." 08/21/2023: ON: 12:57 PM Director B, "Staff received a call from ... the coroner's office. [S/he] asked when the injury occurred and asked what happened. Staff told [him/her] [sic] date of expected injury and that there isn't a documented entry with how exactly [s/he] obtained the fracture, but management has obtained statements. [S/he] stated [s/he] would be faxing a request over for documentation notes related to the injury ..." Exit interview: On 12/04/2023 at 9:02 AM, Surveyors conducted and exit interview with Administrator C, Director A, DON D, and Licensee E present. The administrators confirmed it was their policy and expectation that caregivers document all cares provided and changes in the resident's record. Administrator C stated s/he tells his/her staff, "If you didn't document it, you didn't do it. I tell my caregivers all the time even if its just to CYA, [sic] make sure you document everything you do." All administrators confirmed they have remote access to the computer system and were able to review resident records documented by the staff at any time. Director A stated it was primarily Director B's role to review his/her own facility but	N 348		

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N 348	Continued From page 59	N 348		

that DON D and staff LPN's also were expected to monitor the record for anything that could alert a change for the residents. After review of the MAR showed the regularly scheduled Tylenol and tramadol doses were not consistently given Licensee E stated, "[Resident1's] pain wasn't even managed at baseline. Why were [his/her] scheduled pain medications missed?" Director B stated the medication were either refused without evidence of reapproach or were not ordered in time to be present at the facility to give. Director B and Administrator C confirmed the narcotic log to be accurate to the doses of PRN morphine that were received by the resident versus the medication count and that the medication received was accurately reflected in the resident's MAR documentation.

At approximately 9:45 AM Director A stated s/he recalled Family Member T frequently requesting an x-ray and other interventions for pain management. Director A stated Hospice presented the idea of an X-ray to the family and to the provider as not needed because it would not change their plan of care. Director A acknowledged the value of an x-ray stating knowing if a bone was broken would have provided staff further information as to how much pain the resident may be experiencing and how to better care plan to meet his/her needs. Director A stated s/he was aware Family Member T requested a brace for immobilization of the leg and stated hospice did not initially get an order for the brace. Director A stated it was clear to him/her that the Hospice RN I was annoyed with Family Member T's suggestions and stated Hospice RN I noted s/he would "allow" the brace conditionally if Family Member T bought it and was "in charge" of it to "appease" Family Member T. Director A acknowledged the tone was disrespectful toward

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N 348	Continued From page 60 Family Member T and noted in hindsight, after the x-ray was completed on 08/11/2023, a brace for immobilization was needed. The provider was aware of the family having to suggest interventions for pain management, the hospices' demeanor towards the suggestions, and did not intervene. Upon review of the meeting between hospice with Director B and DON D on 08/13/2023, DON D stated "I don't know. I don't remember it." DON D reviewed the note and saw it was a conference. DON D stated s/he thought it was a phone call but didn't remember. HR dated 08/13/2023 show the results of the x-ray were available on 08/11/2023 but DON D did not check them or notify hospice until after the weekend on 08/13/2023. When asked about the delay, DON D shrugged and offered no explanation. Notes dated 08/13/2023 show DON D read the record, was aware of the resident's pain and status of not receiving any PRN pain medication for over 2 days on the weekend, and resolved to document in the record that the caregivers needed to call hospice in the event the resident was screaming in pain. DON D stated, "where is this information from? Some of the observation notes could be from a caregiver, and then they didn't report it to the med tech." DON D reviewed the observation notes with his/her entries and hospice note on 08/13/2023 when s/he updated hospice and told them the resident had received medication 4:30 PM when s/he did not. DON D stated s/he believed the caregivers had given medication but acknowledged s/he did not follow up to see if it was done before notifying hospice with the inaccurate information. DON D did not offer any explanation as to why s/he did not follow up to ensure Resident 1 received pain medication, to ensure his/her pain was managed, or to address	N 348		

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N 348	Continued From page 61 staff education about pain management. At approximately 11:20 AM, after review of the records, Licensee E, Administrator C and Director A expressed great concern regarding the repeated lack of intervention when extreme pain was documented and no intervention was given. Administrator C stated, "We can't always trust who we hire ... We clearly can't assume that if someone tells us that they gave a med [sic] that they actually did." Licensee E stated, "I cannot believe it. This makes me sick ... clearly, we can't trust the people we put in charge as the directors of the building ... if I would have known, I would have reported and had their licenses pulled. This was absolutely neglect." Administrator C then stated, "it was neglect" followed by Director A stating, "I'm taking full responsibility. It was neglect." Summary The provider was not meeting Resident 1's need for his/her behavior of saying "no" to questions despite knowing the resident's refusals were the result of his/her dementia diagnosis. At times the resident would be asked if they wanted food or pain medication and when the resident responded "no" the food or medication was taken away without efforts to reapproach the resident. The guardian, family, and hospice social worker addressed the concerns with administration on more than one occasion and the provider did not follow through with effective managing of the grievance. Despite the grievances and the hospice plan of care identifying the needs, the provider did not set in place any plan to resolve or monitor the issue, and per their own documentation, allowed it to continue to the detriment of the resident's health and comfort.	N 348		

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N 348	Continued From page 62 The provider did not seek immediate assessment for the residents change in condition on 08/05/2023 and did not provide interventions to adequately manage the pain symptoms during the 2 weeks prior to his/her passing. The provider discouraged further evaluation by a medical professional including an x-ray and provided medical opinions that were not accurate or appropriate to their credentials including stating the resident would not qualify for a surgical intervention and did not need a brace to immobilize the injury. The family had to suggest interventions for pain management and their suggestions were met with resistance causing the family to feel they had no way to help Resident 1. The provider did not seek additional interventions to manage the resident's pain or anxiety and relied on family to do so. The resident initially reported it was a caregiver that hurt him/her and no investigation into caregiver misconduct was completed. The provider did not conduct an investigation into the injury of unknown origin until 08/13/2023, 2 days after an x-ray was completed on 08/11/2023, 3 days after APS became involved on 08/10/2023 and 8 days after the initial change in condition on 08/05/2023. The sum of the investigation was 3 caregiver interviews with conflicting accounts of events. The provider dismissed their own findings with no follow through and did not report to the department until 08/23/2023. The provider did not consistently reach out to the guardian or hospice with unmanaged pain symptoms or changes in condition. When the provider and hospice did speak with the guardian, they reported Resident 1's pain was being effectively managed. Additionally, the self-report submitted on 08/17/2023 also reported Resident	N 348		

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N 348	Continued From page 63 1's pain was being managed. The staff would frequently report to hospice that pain medication was being consistently given, though the record showed it was not, and the provider nor hospice intervened. The provider did not ensure hospice was notified as they had been instructed to do and when hospice was updated, that staff were providing accurate information. The resident initially reported it was a caregiver that hurt him/her and no investigation was started. The provider waited for 2 days after receiving information the resident leg was fractured before informing the hospice. The provider did not ensure hospice was providing adequate pain management. The caregivers regularly documented Resident 1 experiencing intense unmanaged pain symptoms without providing pain medication. The provider had access to the resident records which clearly indicate the resident's pain was unmanaged and they did not review the records or intervene. There were no efforts to schedule pain management and no daily hospice RN oversight. A review of the records would show the extent of pain not being managed, including the need for daily hospice RN assessment to manage pain and anxiety. DON D, multiple staff LPNs, Directors A and B, and the Administrator C had access to the records and did not intervene. The hospice didn't provide oversight and instead of regularly calling and checking in, they relied on the staff to call, even when they had record available that would show the staff were not appropriately calling. Both the provider and hospice would document to give prn pain medication and then not ensure staff followed through. This was not a one-time incident. According to	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 348	Continued From page 64 the record review and interviews, the provider (management and caregivers) as well as the hospice saw what was occurring, had access to the records and means to intervene, and abdicated their responsibility to do so. The record showed continual documented neglect resulting in extreme pain for 15 days prior to death. Cross Reference: N0156 DHS 83.12(1)(b) Death Reporting Related To Accident Or Injury N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect N0161 DHS 83.12(3)(a) Investigate Injuries Of Unknown Source N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary	N 348		
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 Resident 2 received all prescribed medications in the dosage and at intervals prescribed by a practitioner.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 352	Continued From page 65 Resident 2 did not receive Vitamin C 500 mg tablets, Acidophilus probiotic tablets, Timolol MAR 0.5% eye drops, and Vancomycin eye drops as ordered. Findings include: On 10/23/2023, the department received complaint information alleging residents were not given medications as prescribed. On 12/04/2023, Surveyor reviewed Resident 2's record and noted s/he moved into the facility on 11/18/2021 and had diagnoses of multiple sclerosis, anxiety disorder, glaucoma of left eye, dry eye syndrome, macular degeneration, cataracts, and corneal transplant status. Resident 2 had known visual impairment. Resident 2 received full assistance in managing and administering his/her medications. Resident 2 was his/her own person and able to make his/her needs known. On 11/30/2023, Surveyor reviewed Resident 2's September, October, and November 2023 Medication Administration Records (MAR). Surveyor noted the following medications were not administered to Resident 2 as prescribed: OVER-THE-COUNTER MEDICATIONS -Vitamin C 500 mg tablet - "*REPACK MED, REORDER AS NEEDED* TAKE 1 CAPSULE BY MOUTH TWICE DAILY WITH METHENAMINE (UTI PREVENTION) (family supplies, let DRS know when running low)." 8:00 AM & 8:00 PM Surveyor noted Resident 2's documentation identified Resident 2 did not receive Vitamin C 500 mg tablet on: 10/01, 10/03, 10/04, 10/13, 10/14, 10/16, 10/19, 10/20, 10/21, 10/22, 10/25, 10/26, 10/27, 10/28,	N 352		

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N 352	Continued From page 66 10/29, 11/03, 11/05, 11/06 - 8:00 AM 10/15 - 8:00 PM Surveyor noted Resident 2 missed 19 doses of Vitamin C tabs in October - November 2023. -Acidophilus Probiotic - "*REPACK MEDICATION, REORDER AS NEEDED* TAKE 1 TABLEY BY MOUTH TWICE DAILY. (GI [gastrointestinal] HEALTH) (family supplies, let DRS know when running low)." 10:00 AM & 6:00 PM Surveyor noted Resident 2's documentation identified Resident 2 did not received Acidophilus probiotic on: 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, 10/31 - 10:00 AM 10/09, 10/10, 10/11, 10/13, 10/15 - 6:00 PM 10/12, 10/14, 10/16, 10/17 - 10:00 AM, 6:00 PM Surveyor noted Resident 2 missed 27 doses of Acidophil probiotic in October 2023. On 11/28/2023 at approximately 4:15 PM, Surveyor interviewed Resident 2 who stated Family Member FF housed his/her stock of over-the-counter medications such as Vitamin C and Acidophilus probiotic. S/he stated staff were supposed to notify him/her when his/her stock was getting low and s/he would replenish them, but there were multiple times where they would not have them in house or staff didn't know where to find them. Resident 2 stated s/he would get them in the mornings, but not in the evenings at times. Resident 2 stated Family Member FF would bring in the two medications, but then they would need to get sent to Morton's to be bubble-packaged. On 11/28/2023 at approximately 2:00 PM, Surveyor interviewed Family Member FF who stated s/he would replenish Resident 2's Vitamin	N 352		

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N 352	Continued From page 67 C and probiotic as the pharmacy would not provide them. Family Member FF said s/he would have to remind staff numerous times to notify him/her if Resident 2's stock was getting low, but that did not always happen. Family Member FF recalls a few times where staff would wait a day or 2 before letting him/her know that Resident 2 was out of his/her medications. EYE DROPS -Timolol Mal 0.5% eye drops - Insert 1 drop in right eye every morning - Diagnosis: Glaucoma. 8:00 AM Surveyor noted Resident 2's documentation identified Resident 2 did not receive Timolol Mal 0.5% eye drops on: 10/23, 11/4, 11/5 - 8:00 AM Surveyor reviewed a comment left on 11/4 and 11/5 stating "not in med cart." Surveyor noted Resident 2 missed 3 doses of Timolol Mal eye drops in October - November 2023. -Vancomycin eye drops - Instill 1 drop in right eye 4 times daily "**WEAR GLOVES*** WAIT FIVE MINUTES BETWEEN OTHER EYE DROPS *****NOT PROVIDED BY MORTONS - LETS DRS [Director of Resident Services] KNOW WHEN LOW ******" - Diagnosis MRSA Infection (Methicillin-resistant Staphylococcus aureus bacteria) 8:00 AM, 12:00 PM, 4:00 PM, & 8:00 PM Surveyor noted Resident 2's documentation identified Resident 2 did not receive Vancomycin eye drops on: 09/15 - 8:00 AM 09/28 - 12:00 PM 09/10, 09/11 - 4:00 PM 10/09, 10/17, 10/23 - 8:00 AM, 12:00 PM 09/12, 10/13 - 12:00 PM, 4:00 PM, 8:00 PM 09/13, 09/14, 10/10, 10/11, 10/12, 10/14, 10/15, 10/16 - 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 352	Continued From page 68 Surveyor noted Resident 2 missed 52 doses of Vancomycin eye drops in September - October 2023. Surveyor note: According to the National Library of Medicine, "Artificial cornea transplantation, keratoprosthesis, improves vision for patients at high risk of failure with human cadaveric cornea. However, post-operative infection can cause visual loss and implant extrusion in 3.2-17% of eyes. Long-term vancomycin drops are recommended following keratoprosthesis to prevent bacterial keratitis. Evidence, though, in support of this practice is poor. We investigated whether prophylactic vancomycin drops prevented bacterial keratitis in an animal keratoprosthesis model." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4604170/. Retrieved 11/29/2023. Surveyor note: According to Mayo Clinic, "A cornea transplant is an operation to replace part of the cornea with corneal tissue from a donor. This operation is sometimes called keratoplasty. The cornea is the transparent, dome-shaped surface of the eye. Light enters the eye through the cornea. It plays a large role in the eye's ability to see clearly ...Most cornea transplant operations are successful. But cornea transplant carries a small risk of complications, such as rejection of the donor cornea ...Symptoms of cornea rejection: The body's immune system can mistakenly attack the donor cornea. This is called rejection. Rejection might require medical treatment or another cornea transplant." https://www.mayoclinic.org/tests-procedures/cornea-transplant/about/pac-20385285. Retrieved 11/29/2023. On 11/28/2023 at approximately 4:15 PM,	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 352	Continued From page 69 Surveyor interviewed Resident 2 who shared s/he had a cornea transplant surgery in January 2023. S/he indicated s/he was started on Vancomycin eye drops following the surgery for a long-term antibiotic to prevent infection and transplant rejection. Resident 2 stated the eye drops were only made in a pharmacy in Madison and so it was important for staff to call ahead when his/her supply was getting low. Resident 2 said s/he would experience blurry vision and headaches when s/he wouldn't get the eye drops and it gave him/her great anxiety knowing his/her cornea transplant could be rejected. Resident 2 stated there were numerous times where s/he was told by Director B that they had ordered them, but then they wouldn't show up when s/he ran out. Resident 2 shared s/he contacted the Madison pharmacy multiple times him/herself inquiring about refilling the prescription. Resident 2 reported in October, s/he was made aware the eye drops arrived, but when staff administered his/her medications, s/he was notified that the drops had been misplaced in-house. Resident 2 voiced to Surveyor how upsetting this was as s/he had already waited for them to arrive initially. Resident 2 reported his/her other eye drops were not ordered timely at times as well, and s/he would have to contact Morton's pharmacy to inquire about having them refilled. On 12/04/2023 at approximately 9:00 AM, Surveyors interviewed Director A and DON D. Director A and DON D voiced surprise hearing that the vancomycin eye drop was an antibiotic to prevent infection and cornea transplant rejection. Director A and DON D voiced awareness of Resident 2 not always getting his/her eye drops. DON D stated the vancomycin eye drops were only made at a special pharmacy in Madison.	N 352		

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	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 352	Continued From page 70 S/he stated s/he had contacted Madison pharmacy him/herself about Resident 2's eye drops not being at the facility at one point, but otherwise Director B did. S/he stated "what did you want me to do, drive down there and pick it up?" On 12/04/2023 at approximately 9:00 AM, Surveyors interviewed Director A, Administrator C, Director of Nursing (DON) D, and Licensee E. Director A stated they were in the midst of changing pharmacies from Morton's due to medications not being brought to the facility timely, medications not being filled, and concerns with follow up with physicians. Director A and DON D acknowledged the eye drops and over-the-counter medications were not always in the facility at the time they needed to be administered. Director A and Administrator C verified Resident 2 did not receive his/her eye drops and over-the-counter medications as prescribed. Cross Reference: Y3234 Ch 50.09(1)(e) Treatment	N 352		
N 362	83.33(1)(d) Grievance procedure: written summary The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation. This Rule is not met as evidenced by:	N 362		

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	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 362	Continued From page 71 Based on record review and interview, the provider did not ensure Resident 1's Family T or Guardian S received a written summary of their grievances, the findings and the conclusions and any actions taken. Due to the grievances not being handled, future grievances were not reported, resulting in incidents of potential abuse that were uninvestigated. Findings include: On 08/17/2023, the department received a complaint alleging the provider was notified of grievances and did not provide any follow-through or resolution. Surveyor reviewed records and noted the provider's admission agreement notes as part of their written grievance procedure: "4. The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident's legal representative and the resident's case manager. The CBRF shall maintain a copy of the investigation." On 10/27/2023, Surveyor reviewed Resident 1's record including the Individual Service Plan (ISP) Medication Administration Record (MAR) Observation notes (ON), Initial Admission Assessment (IAA), and Hospice record (HR) . Resident 1 had a legal Guardian (Guardian S) beginning on 07/27/2023 and Resident 1's Family Member T was documented as regular visitor for Resident 1. Resident 1 was admitted to the facility and hospice services on 06/07/2023. His/her diagnoses included: Fracture of left pubis, age-related osteoporosis without current	N 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 362	Continued From page 72	N 362		

pathological fracture, restlessness and agitation, chronic congestive heart failure, pain in right knee, and dysphasia. Administrator C notes on Resident 1's IAA dated 07/17/2023, Resident 1 was on a regular diet with general consistency and no fluid restrictions. Resident 1 is noted to be at risk for falls and can make most of his/her needs known. Resident 1 required full assistance with medication management, including psychotropic medications. The IAA notes Resident 1's pain as, "4-6 Points- Moderate pain ... 06/05/2023 [Resident 1] has [sic] current acute pain due to a fractured pelvis ..." The corresponding ISP dated 07/27/2023, notes Resident 1 was on a repositioning schedule every 2 hours and, "Staff [sic] to update Nurse [sic] with any issues and they will update the MD ...". Resident 1 had scheduled Tylenol and Tramadol both taken 3 times per day for chronic pain. Resident 1 had PRN medications including morphine for pain.

Bathroom Assistance:

On 11/27/2023, Surveyor interviewed Resident 1's family, Family T, at 10:58 AM. Family T stated on 08/06/2023 they came into the facility to find Resident 1 was in his/her room on the commode and was left on the commode for approximately 45 minutes. Family Member T stated s/he had to go find Caregiver G to assist. Family Member T stated Caregiver G stood in the doorway, asked Resident 1 is s/he was "done" and when Resident 1 stated his/her standard "no" response Caregiver G left the room. Family T stated on 08/07/2023, s/he and Guardian S found Resident 1 in his/her room left "half naked" in bed trying to cover him/herself. (Picture 1.) Family Member T stated s/he went to Director B, showed the pictures, and asked that something be done

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 362	Continued From page 73 about the lack of care and the treatment Resident 1 was receiving. Family Member T stated Director B stated s/he would look into the issue an get back to him/her about it. Family Member T stated, "I never heard back from anyone. I didn't get anything." Family Member T stated no written summary or resolution was received. On 12/13/2023 Surveyor interviewed Guardian S at 12:51 PM. Guardian S stated due to Family Member T's reporting to him/her about concerns related to Resident1's care and treatment on 08/05/2023 and 08/06/2023, s/he agreed to meet with Family Member T at the facility on 08/07/2023. Guardian S stated upon arrival, Resident 1 was found without covers in a state of undress on a bedpan alone in his/her room. Guardian S stated s/he could not tell how long Resident 1 had been left in that position but stated Resident 1 did not appear to be comfortable. Guardian S stated it was clear Resident 1 needed staff assistance and stated s/he discussed the concerns with Director B prior to leaving. Guardian S stated s/he did not hear back from the provider or receive any form of written statement regarding his/her grievance. On 12/04/2023 at 9:02 AM, Surveyors conducted and exit interview with Administrator C, Director A, DON D, and Licensee E present. At approximately 11:00AM, Director A and DON D stated they did not have record of Director B conducting an investigation into the grievance and stated to their knowledge the grievance was not followed through with. Administrator C stated not fulfilling the responsibilities of the role, including not responding to grievances, was a reason Director B "doesn't work here anymore." Meals and Medication:	N 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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N 362	Continued From page 74 On 11/27/2023 at 10:58 AM, Surveyor interviewed Family Member T. Family Member T stated Resident 1's dementia would frequently result in Resident refusing, declining, or saying "no" to questions, even when the situation was in his/her best interest or was congruent with the Resident's own wishes. Family Member T stated, "You could offer (Resident 1) a million dollars and (s/he) would say no." Surveyor reviewed Resident 1's HR Plan of Care dated 06/07/2023 notes, in relation to Resident 1's behaviors and agitation, the staff are to " give simple directions and allowing sufficient time to respond, communicate and make decisions ... assess for hunger, thirst, cold, board, tired, pain, Constipation, UTI noise, etcetera as a cause of behavior ... Consider pain as a possible reason for behaviors ... Monitor tone and body language, as this is often more important than words ..." Resident 1 may automatically respond "no" to questions, which did not necessarily mean s/he was not hungry or was not in pain and did not want food or pain medication. The HR notes on 06/10/2023, "Patient requires assistance with meals. Family &[sic] facility staff supervise and assist patient." Surveyor reviewed Resident 1's ON. On 08/08/2023 at 11:19 AM Unity Hospice LPN Y notes, "[Family Member T] feels that [his/her] [Resident 1] needs assistance with eating, doesn't want the staff to approach [him/her] asking [him/her] if [s/he] is hungry but would rather suggest that they assist [Resident 1] with eating." At 2:14 PM, Unity Hospice LPN Y notes," ... call Unity if [s/he] stops completely eating, drinking or trouble taking [his/her] meds [sic] ... SW [sic] also stated that this SW[sic] would call [sic] facility and speak with manager about concerns as well as let the facility know that Unity	N 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 362	Continued From page 75 is aware of the concerns as well." Surveyor reviewed ON dated 08/10/2023 at 11:47 AM, written by Director B noted, "APS in house inquiring about several complaints ... if resident refuses to eat, take meds, ect [sic] please document ..." On 08/14/2023 at 10:46 AM Director B writes, " .... Make sure we are also attempting to feed [sic] resident ..." On 12/13/2023 at 12:51 PM, Surveyor interviewed Guardian S. Guardian S stated s/he was concerned the staff were not reapproaching Resident 1 with food after Resident 1 would automatically respond "no" questions. Guardian S stated s/he brought the concern to Director B's attention on 08/07/2023 after witnessing staff not offering Resident 1 mealtime assistance and taking the food away. Guardian S stated s/he did not hear back from the provider or receive any form of written statement regarding his/her grievance. On 11/27/2023 at 10:58 AM, Surveyor interviewed Family Member T. Family Member T stated after 08/05/2023, Resident 1 was in noticeable pain that was unmanaged and observed the pain caused him/her to not eat as much as s/he had been. Family Member T stated Resident 1 began to need assistance and encouragement to eat. Family Member T corroborated the concerns were brought to the provider's attention by Guardian S on 08/07/2023 and stated there was no resolution. Family Member T stated Caregiver H would continue to enter the room, ask Resident 1 if they wanted their food and when Resident 1 would give his/her response of "no" Caregiver H would take the tray out of the room. Family Member T stated s/he asked Caregiver H if s/he could try to feed Resident 1 and Caregiver H said	N 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 362	Continued From page 76	N 362		

no. Family Member T stated s/he tried to explain Resident 1 needed to be reapproached and encouraged to eat when Caregiver H stated to Family Member T that s/he has seen "residents with dementia go for 100 days without eating and still live before they die." Family Member T conveyed feelings of anger and disgust over the staff's response as well and fear and helplessness for Resident 1. In response to Caregiver H's comment Family Member T stated, "It was like 'it doesn't matter to us if {s/he} doesn't eat {s/he's} going to die anyway', it was like since [s/he] was on hospice they didn't care. Just die. These remarks showed me this was just a game to them. Nothing is going to change this. I tried to talk to management and the guardian, and nothing was changing." Family Member T expressed feelings of helplessness and that after trying multiple times to report concerns with nothing addressed, s/he felt reporting the statement was not an option.

On 12/04/2023 at approximately 9:00 AM Surveyors interviewed Director A, Administrator C, DON D, and Licensee E. Director B acknowledged Resident 1 had a change in condition that at times required reapproach with medication administration and additional assistance with meals, including encouraging the resident to eat with feeding assistance. Administrator C reviewed Resident 1's ON record where Director B notes the concerns related to the ASP investigations and asks staff to record resident refusals to eat or drink. Administrator C acknowledged, the provider had been made aware of the concerns related to food assistance and reapproach for Resident 1. Administrator C stated there was no further record to indicate staff followed through with documenting refusals to eat or efforts to reapproach for food or medication,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 362	Continued From page 77 and no documentation to indicate the POA's grievance brought their attention on 08/07/2023 was addressed. Director A acknowledged Director B not following through with the reported grievance caused a situation where Family Member T felt reporting to the administration served no purpose. Because the family no longer felt comfortable or confident in reporting, the concerning behavior and statements made by Caregiver H to Family Member T were not reported and therefore unaddressed. Director A stated Caregiver H no longer worked at the facility and stated Caregiver H telling Family Member T that s/he couldn't not assist the resident with his/her meal was not congruent with Resident 1's plan of care and had not been appropriate. Director A, Administrator C and Licensee E expressed shock at the alleged statement made to Family Member T regarding residents with dementia being able to go without food for over 100 days. Director A, Administrator C and Licensee E expressed concern that without Director B following through for the reported grievances, Family Member T did not feel comfortable reporting the incidents, therefore they were not investigated, and Caregiver H may still be working with vulnerable populations elsewhere. Cross Reference: N0214 DHS 83.15(3)(a)Administrator Shall Supervise Daily Operation N0348 DHS 83.32(3)(d)Rights Of Residents: Free From Mistreatment	N 362		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 481	Continued From page 78	N 481		

environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not provide a living environment that was safe, clean, comfortable, and homelike. Surveyor and Director B had multiple observations of unsecured toxic substances, unsecured resident records, warm refrigerators and freezer, mechanical lifts kept in common areas, unclean areas including the kitchen, fire hazards in relation to duct work, dust, and dryer vents, and a locked exit door.

Findings include:

On 11/16/2023, the department received complaint information alleging toxic substances were unsecured.

On 11/27/2023 at approximately 9:43 AM, Surveyor and Director B toured the facility. Director B reported the facility was laid out into 4 wings: north (front left from main entrance), south (front right from main entrance), deer (back left from main entrance), and magic (back right from main entrance).

NORTH WING:
At approximately 9:45 AM, Surveyor and Director B observed a common area located between two resident room hallways on the north wing.

Surveyor observed a sink, cupboard space, and a fridge. Surveyor looked in the fridge and noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 481	Continued From page 79	N 481		

the fridge felt warmer and tested the temperature. Surveyor observed the fridge temperature to be 42 degrees Fahrenheit. Surveyor inquired with Director B if the fridge was tested regularly and if there was a temperature gauge. Director B stated "there should be a gauge in there." Surveyor opened the 2 cupboard doors below the sink. Surveyor and Director B observed bleach, unsealed Clorox bleach disinfectant wipes, and a spray bottle of Clorox disinfectant cleaner. Surveyor noted the cupboards contained a cupboard lock, but they were not locked.

Surveyor and Director B observed a closet labeled as "JANITOR" closet propped open with a large, empty television box. The closet was located between two resident rooms. Surveyor observed multiple shelves of boxes and multiple boxes stacked 5-6 boxes high from the floor. From the hallway, Surveyor could read a sign on one of the boxes to say "discharged residents." Surveyor stepped into the closet and noted stacks of resident files stacked on the shelves and a sample of a box with a printer paper sign that listed "November 2020 thru December 2020 Discharged residents ..." with discharged resident names listed. Inside the box were resident records which included date of birth, date of admission, assessment information, and care records. Surveyor observed at least 24 boxes of resident records throughout the janitor closet. Surveyor inquired with Director B whether the door was always propped open, and Director B stated "yes." Surveyor inquired whether it was known that there were resident records, and this was a confidentiality, HIPPA issue and Director B stated yes, and rescinded his/her statement that the door was left open regularly. Surveyor observed Director B to close the janitor closet behind him/her. Surveyor observed the door to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 481	Continued From page 80	N 481		

be unlocked even when closed.

Surveyor and Director B observed an open and unlocked room identified as the hair salon located directly across the hall from resident rooms and in the hallway leading to the dining room. In the hair salon, Surveyor observed 2 cupboard doors located below the salon sink. Surveyor opened the cupboard doors and observed a jug of bleach, a spray bottle of Windex, and a spray bottle of all-purpose cleaner with bleach. Surveyor noted a wheelchair scale in the hair salon. Director B stated the door was left open so staff could get resident weights.

Surveyor and Director B observed a fridge located in the medication room. Surveyor observed open and unlabeled: container of cream cheese, container of cottage cheese, single yogurt pack, and a snack bag of granola. Surveyor inquired with Director B what the food items were for and whether it was known when they were opened. Director B stated s/he was unsure.

Surveyor and Director B entered a room identified as the mechanical room located along a resident hallway. Surveyor observed a duct vent from the ceiling from the furnace which was located in the attic. Multiple boxes of incontinent products were stacked from the floor to just below the vent. One of the boxes was blocking part of the vent.

Surveyor observed an external door located at the end of the north wing located to the left of the main entrance. Surveyor observed the door had a light up "Exit" sign above it. Surveyor observed a printer paper sign taped to the door that said "Please Keep door locked at all times and use this exit for Emergencies Only." Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 481	Continued From page 81	N 481		

attempted to open the door and observed it was locked. Surveyor inquired with Director B whether the door was used in emergencies and s/he said yes. Surveyor inquired how it could be used in an emergency if it was locked and Director B did not have a response.

Surveyor viewed a "FIRE ESCAPE ROUTE" posted on the resident hallway wall in the north wing. Surveyor noted this exit was the only external door on this wing and was highlighted as an exit.

KITCHEN & COMMON AREA:
On 11/27/2023 at approximately 10:15 AM, Surveyor and Director B toured the kitchen. Surveyor observed at least 12 reddish-brown splatter marks spanning from mid-wall to about 4 feet of the ceiling. Surveyor inquired with Director B what the splatter marks were from and Director B stated s/he was not sure. Surveyor observed 2 ceiling fans, at least 4 fluorescent light fixtures, and 2 different styles of air vents to have thick gray debris and dust on them. Surveyor inquired with Director B how often the kitchen was cleaned and s/he said there was a schedule, but was unsure when then ceiling was last cleaned. Surveyor observed the floor to be sticky and have stains and debris on it. Surveyor inquired with Director B how often the kitchen floor was mopped and s/he stated it was supposed to be done at least daily, but verified it did not look like it had been done recently.

Surveyor and Director B toured the common area located outside the kitchen and separating the 4 wings. Surveyor noted 4 Hoyer lifts located next to an exit door and next to a piano. Surveyor inquired with Director B whether the piano was utilized, and s/he stated yes. Surveyor inquired if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 481	Continued From page 82	N 481		

residents sat near or around the piano and Director B stated yes. Surveyor inquired whether the Hoyer lifts were utilized and Director B was unsure. Surveyor inquired whether there was a storage space where the Hoyer lifts could be kept instead of in the common area where activities were held, and Director B stated "probably."

SOUTH WING:
At approximately 9:45 AM, Surveyor and Director B observed a common area located between two resident room hallways on the south wing.

Surveyor observed a sink, cupboard space, and a fridge. Surveyor looked in the fridge and noted the fridge felt warmer and tested the temperature. Surveyor tested and observed the fridge temperature to be 44 degrees Fahrenheit. The fridge did not contain a temperature gauge.

Surveyor opened the 2 cupboard doors below the sink. Surveyor and Director B observed a jug of bleach and a spray bottle of Clorox bleach disinfecting spray. Surveyor noted the cupboard contained a lock on it, but the cupboard doors were not locked.

Surveyor and Director B toured the laundry room located on along the resident hallway. Surveyor noted the tubing and floor behind the 2 washing machines to have thick, standing dust on them. Surveyor observed behind the dryer and noted the right dryer of the 2 had 4 spots with repair tape. Surveyor and Director B observed a 1 inch gap between the dryer and the vent. Surveyor observed at least 4 piles of lint and dust on the floor behind the dryers. Surveyor observed 4 wires, 2 with caps, 1 taped, and 1 exposed, dangling from conduit (tubing over wires) behind the dryer with standing dust and a dryer sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 481	Continued From page 83 hanging from one of the wires. MAGIC WING: At approximately 10:50 AM, Surveyor and Director B observed a common area located between two resident room hallways on magic wing. Surveyor observed a sink, cupboard space, and a fridge. Surveyor opened the 2 cupboard doors below the sink. Surveyor and Director B observed a jug of bleach, a can of Comet odorizing cleanser powder with bleach, spray can of disinfectant spray, 3 bottle of odor remover with bleach, 2 spray cans of furniture polish, a spray bottle of PP-Gone urine stain and odor remover, and 1 bottle of Comet liquid odorizing cleanser with bleach. Surveyor noted the cupboard contained a cupboard lock, but the cupboards were not locked. Surveyor and Director B toured the laundry room located along the resident hallway. Surveyor observed thick standing dust and lint located behind the dryer and under the dryer vent. DEER WING: At approximately 11:15 AM, Surveyor and Director B observed a common area located between two resident room hallways on deer wing. Surveyor observed a sink, cupboard space, oven, microwave, and a fridge. Surveyor looked in the fridge and freezer. Surveyor tested and observed the fridge to be 42 degrees Fahrenheit and the freezer to be at 10 degree Fahrenheit. Surveyor noted there was food in both the fridge and freezer. Surveyor inquired how often the fridge and freezer were tested and Director B stated they were supposed to be tested regularly.	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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N 481	Continued From page 84 Surveyor and Director B observed the stove to have dried debris and crumbs under the burners and the oven to have burnt debris on the bottom of it. Surveyor inquired when the stove and oven were last cleaned and Director B stated s/he did not know. Surveyor opened the cupboard doors under the sink and noted a spray can of Clorox disinfecting spray, 2 spray bottles of Clorox disinfectant cleaner with bleach, and a bottle of dish soap. Surveyor noted the cupboard contained a cupboard lock, but they were not locked. Surveyor and Director B observed the laundry room located along a resident hallway. Surveyor observed a large shelf containing bedsheets and blankets on the wall located next to the dryer. Surveyor noted the shelves to be overflowing and some of the bedsheets and blankets to be falling out of the shelving. Surveyor looked behind the dryer at the dryer vent and observed a bed sheet on top of the dryer vent, covering the vent. Surveyor observed lint and thick gray dust on the wall, on the floor, along the back of the dryer, and all over the bedsheet behind the dryer. Surveyor also observed extra tubing, debris, and garbage between the dryer and the wall. In conclusion, the facility did not maintain a clean, safe, and homelike environment. Four of 4 resident room hallways contained unsecured toxic substances, a dryer vent was not well-maintained, laundry rooms and the kitchen were unclean, not all common areas were clean and homelike, common area refrigerators were not at appropriate temperatures or monitored, a furnace return vent was partially blocked by stacked boxes, discharged resident records were unsecured, and an exit door was kept locked.	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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 481	Continued From page 85 On 12/04/2023 at approximately 9:15 AM, Surveyors interviewed Director A, Administrator C, and Licensee E who verified and acknowledged concerns with maintaining a safe, clean, and homelike environment.	N 481		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 was treated with courtesy, respect, and full recognition of his/her dignity and individuality by all employees of the facility. Findings include: The provider is licensed to provide services for up to 65 residents who may be physically disabled,	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST 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
Y3234	Continued From page 86	Y3234		

of advanced age, terminally ill, and/or have Alzheimer's/dementia.

On 10/23/2023, the department received complaint information alleging residents were not treated with dignity and respect.

On 11/27/2023, Surveyor reviewed Resident 2's record and noted s/he moved into the facility on 11/18/2021 with diagnoses of multiple sclerosis (MS), chronic kidney disease, spinal stenosis, obesity, hypertension, major depressive disorder, anxiety disorder, vertigo, neuromuscular dysfunction of bladder, general weakness, history of falling, insomnia, sleep apnea, glaucoma of left eye, dry eye syndrome, macular degeneration, cataracts, and corneal transplant status.

Surveyor reviewed Resident 2's most recent individual service plan (ISP) dated 10/09/2023 and noted s/he required full assistance from 1-2 with bathing, dressing, toileting, and transferring. Resident 2 required a mechanical hoyer lift for transfers and utilized a power wheelchair for mobility. Resident 2 had a suprapubic catheter and received health services from 2 home health agencies for catheter and wound care. Resident 2 was his/her own person and able to make his/her needs known. Surveyor noted Resident 2's most recent ISP was not reviewed/signed by Resident 2.

On 11/28/2023 at approximately 4:15 PM, Surveyor interviewed Resident 2 who resided at a different residence following hospitalization and placement of a wound vac.
Resident 2 shared s/he found out provider staff were charting and timing everything s/he did and what the staff did for him/her. S/he said it affected his/her entire experience. S/he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Y3234	Continued From page 87	Y3234		

presented emotional when s/he stated "to know that you're tested and timed for everything you do" was an awful feeling. S/he said it made him/her feel unhappy and caused staff to present unhappy that they had to time everything, but also to provide him/her care in general. Resident 2 stated s/he was involuntarily discharged 3 times in the past year. Resident 2 stated the last 2 years were really hard. S/he indicated s/he had become more dependent because of his/her condition on staff which was really hard to depend on people that didn't want to take care of him/her. S/he stated "I have MS, they moved me in knowing I had MS." Resident 2 stated "they were gunning for me and you could really tell. Especially towards the end [of him/her living at the facility] it really sucked." Resident 2 began crying and stated "I hated it there and how they treated me, especially in the end." S/he could tell they were avoiding his/her call light. "They made me feel like [profanity] and as if I was the worst resident to care for they ever had. I sure felt like it." Resident 2 noted s/he felt like staff didn't order his/her eye drops and other medications timely.

Resident 2 shared examples of caregivers voicing displeasure with caring for him/her or impacting his/her care routines. Resident 2 stated s/he was told by various caregivers multiple times that "there are other residents to care for other than you [Resident 2]." Resident 2 reported 2 (unnamed) caregivers were rough with turning and refused to do things that Resident 2 requested such as adjusting his/her brief. Resident 2 described Caregiver G as being very short tempered and saying things like "your brief is on good enough."

Resident 2 shared s/he felt bad about being showered because s/he knew the staff's focus was timing him/her. The caregivers didn't "make

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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(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
Y3234	Continued From page 88	Y3234		

sure I was totally clean so I would have to give more prompting and make more requests which would make the shower go longer." S/he indicated they would stop in the middle of showers to take notes on the time. Resident 2 stated given the turnover in staff and staff not wanting to assist him/her, s/he would have caregivers that never showered him/her before, which took an even longer time. S/he indicated it was challenging to have new staff or unfamiliar staff all the time and have to explain all of his/her needs all the time. Resident 2 indicated his/her showers went from twice to once a week because staff didn't want to do it or didn't prioritize it. Resident 2 indicated at times, only 1 staff would try to assist him/her, but s/he didn't feel comfortable with only 1 staff transferring him/her or repositioning him/her given his/her history of falls and general weakness.
Surveyor inquired whether s/he had met with provider management to discuss his/her concerns before or since s/he was discharged. Resident 2 couldn't recall the last time s/he had met with anyone in management, but questioned maybe January 2023.
On 11/28/2023 at approximately 2:00 PM, Surveyor interviewed Family Member FF who stated s/he witnessed a staff member tell Resident 2 s/he was high maintenance. Family Member FF stated "that's why they kicked [him/her] out." Family FF indicated Resident 2 costs too much money. S/he shared feeling that staff were not efficient enough and wondered if it was because they were new or because they had to time everything.

On 11/27/2023 at approximately 11:25 AM, Surveyor interviewed Caregiver P who described Resident 2 as being "sort of picky and particular." Caregiver P stated Resident 2 required 2-staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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ALLOUEZ PARKSIDE VILLAGE 1 LLC	1901 LIBAL ST GREEN BAY, WI 54301

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Y3234	Continued From page 89	Y3234		

assistance, full assistance for transfers with a Hoyer lift. S/he reported feeling like s/he had to walk on eggshells because of having to time his/her cares for management and having to meet Resident 2's needs.

On 11/30/2023 at approximately 3:21 PM, Surveyor interviewed Caregiver V who referenced Resident 2 as being "super particular with [his/her] cares." Caregiver V stated Resident 2 was a 2-person transfer, but didn't really understand why. S/he stated Resident 2 wouldn't allow (caregivers) to transfer him/her unless there were 2 people in the room. Caregiver V stated "to be able to be running efficiently we need to be able to do things [assist residents] with 1-assist," which made it difficult to assist Resident 2. Caregiver V stated "[Resident 2's] cares are easy, it was just having to have the second person aspect of it that made it challenging." Surveyor inquired whether s/he witnessed anyone timing Resident 2 and Caregiver V stated yes, we all had to. Caregiver V stated some staff would flat out refuse to help Resident 2 when s/he needed it or when Caregiver V would ask for assistance with Resident 2 on numerous occasions. Surveyor noted Resident 2 had a wound on his/her coccyx. When Caregiver V would attempt to reposition Resident 2, Resident 2 would refuse because there wasn't a second person to assist Caregiver V in repositioning him/her. Caregiver V indicated Resident 2 didn't feel comfortable being transferred or repositioned by 1 staff person, so in turn s/he stated his/her "wound definitely worsened." Caregiver V stated s/he directed any concerns s/he had to management.

On 01/29/2023, Surveyor reviewed the department's provider file and noted Resident 2 was involuntarily discharged on 10/25/2022,

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	0017630	A. BUILDING: _____ B. WING _____	R-C 01/09/2024

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Y3234	Continued From page 90 05/22/2023, and 10/09/2023. All 3 discharges were appealed and upheld by the department. Surveyor noted Resident 2 was enrolled with a Managed Care Organization and a specific rate was provided for Resident 2's care. Upon document request from the provider for the 10/09/2023 involuntary discharge, Surveyor noted time studies completed by provider during Resident 2's cares, observation notes discussing his/her needs, Resident 2's list of diagnoses as a means to discharge, and a cost analysis. On 12/04/2023 at approximately 9:00 AM, Surveyors interviewed Director A, Administrator C, and Licensee E. Director A acknowledged belief that Resident 2 was told by staff that s/he was being timed during his/her cares. Administrator C acknowledged belief that Resident 2 felt rushed during cares and staff's approach was not always best. Licensee E voiced concern of how staff approached timing Resident 2's care and how it could have been handled differently. Director A acknowledged Resident 2 likely did not receive care as timely as result of staff not wanting to assist him/her or not having time at the time requested. Director A, Administrator C, and Licensee E acknowledged Resident 2 was not always treated with dignity, respect and individuality. Cross Reference: DHS 83.32(3)(h) Rights Of Residents: Receive Medication	Y3234		