

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Sturgeon Bay Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 200 N Seventh Ave Sturgeon Bay, WI 54235	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361</p> <p>Based on staff interview and record review, the facility did not ensure court-ordered protective placement was obtained for 1 resident (R) (R15) of 1 resident with a legal guardian was obtained when the resident's nursing home stay exceeded 90 days.</p> <p>R15 had a legal guardian. The facility did not obtain court-ordered protective placement for R15 to ensure R15 resided in the least restrictive environment at the facility.</p> <p>Findings include:</p> <p>State Statute Chapter 55.03(4) indicates court-ordered protective placement should be obtained for any resident admitted to a nursing home who has a legal guardian and whose nursing home stay exceeds 90 days.</p> <p>On 10/28/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including Down syndrome. R15's Minimum Data Set (MDS) assessment, dated 9/12/24, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R15 had severely impaired cognition. R15 had a guardianship in place at the time of admission.</p> <p>R15's medical record contained a guardianship that was dated 4/6/09. R15's medical record did not contain annual protective placement paperwork.</p> <p>On 10/29/24, the facility provided Surveyor with paperwork for R15's original guardianship in April of 2009.</p> <p>On 10/29/24 at 9:57 AM, Surveyor interviewed Social Worker (SW)-I who indicated R15 was not protectively placed and had resided at the facility for a long time.</p> <p>On 10/29/24 at 10:19 AM, Surveyor again interviewed SW-I who indicated SW-I contacted Adult Protective Services (APS) who indicated R15's guardianship was sought by family in lieu of a Power of Attorney for Healthcare (POAHC) due to R15's developmental disability, not a safety issue. APS indicated the county wasn't involved with R15's guardianship. SW-I indicated SW-I was not aware that no matter how a guardianship was sought, when a resident enters a nursing home for long-term care, the resident needs protective placement in the facility. SW-I indicated APS told SW-I that residents who are admitted to a facility with more than 16 beds and have a guardianship need protective placement. SW-I indicated SW-I would work with APS to get R15's protective placement completed.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563</p> <p>Based on staff interview and record review, the facility did not ensure a comprehensive care plan was developed and implemented for 1 resident (R) (R5) of 13 sampled residents.</p> <p>On 10/18/24, R5 was hospitalized due to not eating or drinking. R5 did not have a care plan that addressed nutrition or hydration.</p> <p>Findings include:</p> <p>The facility's Comprehensive Care Plan policy and procedure, dated 9/23/22, indicates: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>On 10/28/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including cerebrovascular accident (stroke), hemiplegia and hemiparesis, weakness, and diabetes. R5's Minimum Data Set (MDS) assessment, dated 8/19/24, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R5 had severe cognitive impairment. R5's medical record indicated R5 had a guardian.</p> <p>R5's medical record did not contain a care plan to address R5's nutrition/hydration needs.</p> <p>R5's medical record indicated R5 was not eating or drinking and was sent to the hospital on 10/17/24. R5 returned to the facility on [DATE] with diagnoses of thyrotoxicosis, urinary tract infection (UTI), candiduria, hypernatremia, and hypercalcemia. On 10/21/24, hospital staff notified facility staff of R5's lab results and R5 was hospitalized to optimize hydration and stabilize electrolytes. R5 returned to the facility on [DATE]. Surveyor noted R5 had a 12.4 pound (15%) weight loss since admission (including a 3.58% weight loss in the last 30 days).</p> <p>A Nutritional Assessment, dated 10/28/24, indicated R5 was on a regular diet, puree texture, regular thin consistency and contained indications to monitor R5's weight, oral intake, and labs.</p> <p>On 10/28/24 at 11:04 AM, Surveyor interviewed R5's guardian who indicated R5 had not been eating much and staff asked the guardian to bring R5's favorite foods from home to improve R5's nutrition/hydration.</p> <p>On 10/30/24 at 11:19 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated staff tried nutritional shakes with no success and asked R5's guardian to bring R5's favorite foods. LPN-E indicated R5 should have a care plan to address nutrition/hydration.</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 11:21 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R5 did not have a nutrition care plan. DON-B indicated DON-B expected a care plan to be in place to address R5's weight loss and nutritional needs.		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>49563</p> <p>Based on observation, staff interview, and record review, the facility did not ensure nail care was provided for 1 resident (R) (R28) of 14 residents reviewed for activities of daily living (ADL) assistance.</p> <p>Staff did not provide routine nail care for R28.</p> <p>Findings include:</p> <p>The facility's Nail Care Policy, dated 4/20/23, indicates: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health .2. Identify conditions that increase the risk for foot or nail problems, such as diabetes, peripheral vascular disease, heart failure, renal disease, or stroke. 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis.</p> <p>On 10/28/24, Surveyor reviewed R28's medical record. R28 had diagnoses including renal failure, arthritis, and hypertension. R28's Minimum Data Set (MDS) assessment, dated 8/2/24, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R28 had moderate cognitive impairment. R28's medical record indicated R28 was responsible for R28's healthcare decisions.</p> <p>R28's plan of care indicated R28 required assistance of staff for all cares.</p> <p>On 10/28/24 at 10:40 AM, Surveyor interviewed R28 who indicated R28 had concerns with R28's fingernails and toenails. R28 indicated R28's nails were too long and R28's toenails caused pain/pressure in R28's feet. R28 indicated weekly showers were provided, but nail care was not provided. Surveyor noted R28's fingernails were a 1/2 inch above R28's fingertips. Five of the nails were split/cracked in the middle and many of the nails contained sharp and jagged edges. Surveyor noted R28's toenails were 1/4-1/2 inch above the toe and were thick, yellow, and crusted. In addition, 3 toenails were starting to curl over the toe.</p> <p>On 10/29/24 at 1:51 PM, Surveyor interviewed Certified Nurse Assistant (CNA)-G who indicated residents were provided weekly showers and nail care was provided the CNAs unless the resident was diabetic. CNA-G indicated during the 4 months CNA-G worked at the facility, CNA-G had never provided nail care.</p> <p>On 10/29/24 at 1:53 PM, Surveyor interviewed CNA-H who indicated nail care was provided on shower days once per week.</p> <p>On 10/29/24 at 1:56 PM, Surveyor interviewed Registered Nurse (RN)-D who observed R28's nails with Surveyor and verified there was significant growth and it appeared R28 had not had proper nail care for awhile. RN-D provided nail care for R28.</p> <p>On 10/29/24 at 1:59 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated nail care should be provided on shower days. DON-B indicated CNAs provided nail care unless the resident was diabetic which required a nurse to provide nail care.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563</p> <p>Based on observation, staff interview, and record review, the facility did not provide appropriate care and services for 1 resident (R) (R4) of 2 sampled residents with an indwelling catheter.</p> <p>On 10/28/24 and 10/30/24, R4's catheter drainage bag and tubing were observed in contact with the floor.</p> <p>Findings include:</p> <p>The facility's Catheter Care policy and procedure, dated 3/15/23, does not address the positioning/placement of catheter tubing or drainage bags.</p> <p>On 10/28/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including history of diabetes, chronic kidney disease (CKD), heart failure, and urinary tract infection (UTI). R4's Minimum Data Set (MDS) assessment, dated 9/22/24, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R4 had moderate cognitive impairment. R4 had an activated Power of Attorney (POA) for healthcare decisions.</p> <p>R4's medical record indicated R4 was sent to the Emergency Department (ED) on 10/9/24 for not drinking and lethargic behavior. R4 was treated and returned to the facility. On 10/11/24, ED staff notified the facility that R4 had a UTI and was prescribed antibiotics. R4 had a Foley catheter placed on 10/14/24 for comfort.</p> <p>On 10/28/24 at 12:58 PM and 10/30/24 at 9:01 AM, Surveyor observed R4 and noted R4's catheter bag was covered by a dignity bag and attached to the bottom of R4's wheelchair. Surveyor noted the dignity bag and catheter tubing were dragging on the floor.</p> <p>On 10/30/24 at 9:13 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who indicated Foley care was provided daily in the morning and evening. CNA-F verified catheter bags and tubing should not touch the floor and repositioned R4's catheter bag and tubing to prevent them from touching the floor.</p> <p>On 10/30/24 at 9:16 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who verified catheter bags and tubing should not touch the floor.</p> <p>On 10/30/24 at 9:24 AM, Surveyor interviewed Director of Nursing (DON)-B who verified catheter bags and tubing should not touch/drag on the floor.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361</p> <p>Based on observation, staff interview, and record review, the facility did not ensure necessary treatment and services related to nutrition were provided for 1 resident (R) (R33) of 4 sampled residents.</p> <p>R33 was prescribed large portions for meals. During lunch service on 10/29/24, kitchen staff did not ensure R33 received large portions. In addition, R33 was prescribed a nutritional supplement 3 times per day for weight management. When R33 returned from the hospital on 10/18/24, the nutritional supplement was not provided for 11 days.</p> <p>Findings include:</p> <p>On 10/30/24 at 1:51 PM, [NAME] President of Success (VPS)-C indicated the facility did not have policies for nutrition or re-admission orders.</p> <p>Between 10/28/24 and 10/30/24, Surveyor reviewed R33's medical record. R33 was admitted to the facility on [DATE] and had diagnoses including T11-T12 vertebra subsequent encounter for fracture with routine healing and displaced intertrochanteric fracture of the right femur. R33's Minimum Data Set (MDS) assessment, dated 10/24/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R33 did not have cognitive impairment. R33 was R33's own decision maker.</p> <p>A nutrition care plan, initiated on 9/23/24, indicated R33 was at risk for nutritional status change related to low body weight upon admission and weight decline. A goal, dated 9/23/24, indicated R33 would maintain R33's weight with no significant weight changes and weight gain was desirable. An intervention, dated 9/30/24, indicated to provide diet as ordered .large portions.</p> <p>On 10/30/24 at 11:51 AM, Surveyor interviewed R33 who confirmed R33 had lost a significant amount of weight in the last year. R33 was not sure why R33 lost weight and indicated R33 wanted to gain weight.</p> <p>R33's medical record indicated the following:</p> <ul style="list-style-type: none"> ~ On 9/24/24, R33 weighed 130.6 pounds (lbs). ~ On 9/27/24, R33 weighed 123.7 lbs. ~ An admission nutrition progress note, dated 9/30/24, indicated R33 should receive large portions. R33 had a low body weight upon admission and weighed 165 lbs approximately 1 year ago. At home, R33 consumed 2-3 meals per day. R33's appetite was pretty good but there could be more. R33 was offered and accepted large portions. ~ On 10/11/24, R33 weighed 122.2 lbs (which was a 6.4% weight loss in less than 30 days). ~ On 10/14/24, staff notified the physician of R33's significant weight loss and initiated Sysco shakes three times daily (TID) with meals. R33 was admitted to the hospital. <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>~ On 10/18/24, R33 returned to the facility. Sysco shakes were not re-initiated.</p> <p>~ A nutrition assessment, dated 10/28/24, indicated R33 weighed 122.0 lbs on 10/25/24. A gradual weight change was present (a 6.58 % decline over 30 days). Nursing staff updated R33's physician when R33 weighed 122.2 lbs on 10/14/24. R33's weight had stabilized since that time. R33 had a low body weight upon admission and weighed 165 lbs approximately 1 year ago. At home, R33 consumed 2-3 meals daily. R33 was offered large portions upon admission which R33 wanted to continue. R33 also wanted to resume Sysco shakes. A request was sent to R33's physician. The assessment indicated staff should continue to monitor R33's weight and oral intake. R33's care plan was reviewed and revised.</p> <p>~ On 10/28/24, an intervention was added to R33's care plan to provide supplements as ordered.</p> <p>~ A progress note, dated 10/29/24, indicated R33's physician ordered Sysco shakes TID due to weight loss and low body weight.</p> <p>During lunch service on 10/29/24 at 12:01 PM, Surveyor noted R33's meal ticket indicated R33 should receive regular large portions, 1 cup of carrots, 1 cup of scooped noodles, and 4.5 ounces of meat. Surveyor observed [NAME] (CK)-J plate a 1/2 cup of carrots (1 scoop), a 1/2 cup of noodles (1 scoop), and 1 scoop of meat for R33 and then cover R33's plate. Dietary Aid (DA)-K placed R33's tray on a meal cart. Surveyor stopped DA-K and asked if R33 received large portions. DA-K sent the tray back to CK-J who put another scoop of each item on R33's plate.</p> <p>On 10/30/24 at 8:55 AM, Surveyor interviewed Certified Nursing Assistant (CNA-G) and CNA-M who were familiar with R33. CNA-G and CNA-M indicated they did not notice if R33 received double portions for meals or more food than others, however, CNA-M indicated R33 received 2 servings of oatmeal for breakfast that day but ate only 1 serving. CNA-G indicated R33 was a decent eater and staff documented R33's intake.</p> <p>Surveyor reviewed R33's meal intakes and noted they were mostly 75-100%.</p> <p>On 10/30/24 at 9:17 AM, Surveyor interviewed Registered Dietician (RD)-L who indicated R33 lost weight R33's first week in the facility which wasn't unusual and R33's weight had been stable since then. When asked about the supplement that was initiated on 10/14/24 prior to R33's hospital stay, RD-L confirmed the supplement did not get re-initiated when R33 returned from the hospital. RD-L confirmed when a resident returned from a hospital stay, RD-L hoped what the facility did dietary-wise prior to the hospital stay was re-initiated or that staff asked if they were unsure. RD-L indicated R33's weight remained stable without the supplement. When Surveyor indicated R33 wanted to gain weight and informed RD-L that CK-J did not initially provide R33 with large portions during the lunch meal on 10/29/24, RD-L indicated CNAs should double check residents' meal tickets when meals were served to help ensure nothing was missing.</p> <p>On 10/30/24 at 12:47 PM, Surveyor interviewed VPS-C who indicated if a resident was out of the facility for more than 3 days, the facility treated the resident as a new admission when they returned. VPS-C indicated the Nurse Manager, Director of Nursing (DON), or Assistant Director of Nursing (ADON) should review and compare orders to what the resident had previously. VPS-C confirmed R33's supplement should have been initiated upon R33's return from the hospital.</p>		