STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525306	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sturgeon Bay Health Services	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide Pre-admission Screening and Resident Review (PASRR) services for 1 resident (R) (R8) of 7 sampled residents.The facility did not contact the state mental health authority to pursue further PASRR screening for R8 when R8's 30-day exemption expired.Findings include:The facility's Resident Assessment: Coordination with Pre-admission Screening and Resident Review Program policy, dated [DATE], indicates: The facility coordinates assessments with the Pre-admission Screening and Resident Review (PASRR) program under Medicaid to ensure individuals with a mental disorder, intellectual disability, or related condition receive care and services in the most integrated setting appropriate to their needs .ii. A positive Level I Screen necessitates a PASRR Level II evaluation prior to admission .2. The facility will only admit individuals with a mental disorder or intellectual disability who the state mental health or intellectual disability authority has determined appropriate for admission .4. Exceptions to the PASRR program include those individuals who are .admitted directly from a hospital, require nursing facility services for the condition for which the individual received care in the hospital, and have been certified by the attending physician before admission as likely to require less than 30 days of nursing facility services .5. If a resident who was not screened due to an exception above (section 4) remains in the facility longer than 30 days: a. The facility must screen the individual using the Level I screening process or refer any resident who has or may have a mental health diagnosis or intellectual disability or related condition to the appropriate state designated authority for Level II PASRR evaluation and determination. B. The Level II resident review must be completed within 40 calendar days of admission .6. Social Services shall be responsible for keeping track of each resident's PASRR screening status and refer to the appropriate authority.On [DATE], Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including bipolar disorder, generalized anxiety disorder, and attention deficit disorder. R8's Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R8 had moderately impaired cognition. R8 was R8's own decision maker.R8's medical record contained a PASRR Level I Screen, dated [DATE], that indicated R8 had a 30-day exemption. Surveyor noted a PASRR Level I Screen was not submitted when R8's 30-day exemption expired on [DATE] and a PASRR Level II Screen was not completed despite the fact R8 had a mental health disorder with medication management. On [DATE] at 8:13 AM, Surveyor interviewed Social Services Director (SSD)-D who indicated a PASRR Level I Screen was not completed because R8 was expected to be at the facility for 30 days for rehabilitation and then discharge to an assisted living facility. SSD-D indicated SSD-D would check R8's medical record to see if the required PASRR Level I and Level II Screens were completed.On [DATE] at 9:50 AM, Nursing Home Administrator (NHA)-A approached Surveyor and indicated PASRR Level I and Level II Screens following the expiration of R8's 30-day exemption were not completed as required.On [DATE] at 1:00 PM, Surveyor interviewed SSD-D who confirmed a PASRR Level I Screen following the expiration of R8's 30-day exemption and subsequent Level II Screen were not completed as required.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525306	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sturgeon Bay Health Services	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview and record review, the facility did not ensure the accurate acquisition and administration of medication for 1 resident (R) (R38) of 6 sampled residents. R38 had orders for 50 milligrams of scheduled and as needed (PRN) tramadol. R38 did not receive eight doses of the medication when the medication ran out and/or was not removed from contingency stock.Findings include:According to the United Stated Drug Enforcement Agency (DEA), controlled medications are medications classified as Schedule I, II, III, IV, or V based on the potential of abuse or dependency. Schedule I has the highest potential and Schedule V has the least potential of abuse or dependency.The facility's Medication Ordering and Receiving From Pharmacy; Provider Ordering and Receiving Controlled Medications policy indicates: Ordering and Receiving Controlled Medications .5. Refill requests for CIII-CV (C = Schedule) and partial fill requests for CII: a. If one or more refills (CIII-Vs) or a partial fill quantity (CIIs) remains: Written on a medication order form or ordered by peeling the top label from the label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose, and requested from the pharmacy a minimum of 3 days in advance of need to assure an adequate supply is on hand. If only one refill remains (CIII-Vs) or only a partial fill quantity remains (CIIs), the pharmacy will simultaneously dispense the remaining fill and, if necessary, proactively seek out a new, complete prescription from the prescriber for future use. The facility may be asked to contact the prescriber for a new prescription upon request for a medication with no remaining fills available. The policy includes a list of medications available through the facility's contingency stock dispensing machine and includes ten tramadol (an opioid medication used to treat moderate to moderately severe pain and classified as a Schedule IV medication) 50 milligram (mg) tablets.From 3/2/26 to 3/4/26, Surveyor reviewed R38's medical record. R38 was admitted to the facility on [DATE] and had a diagnosis of rheumatoid arthritis. R38's most recent Minimum Data Set (MDS) assessment, dated 12/5/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R38 had intact cognition. The MDS assessment indicated R38 had a pain regimen, as needed pain medication that was offered and both taken and declined, a pain level of 6 on a scale of 0 to 10 (0 = no pain; 10 = highest pain), and had pain that occasionally interfered with activities. R38 was R38's own decision maker.A care plan indicated R38 had the potential for pain related to rheumatoid arthritis. The care plan contained a goal that R38 will indicate pain management is within acceptable limits and pain or analgesia will not affect participation in activities of choice or daily care. The care plan contained interventions to administer pain medication per Medical Doctor (MD) orders, implement non-drug therapies to assist with pain and monitor for effectiveness as needed, notify MD if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective, and report non-verbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. R38 had the following physician orders: ~ Tramadol oral tablet 50 mg. Give 1 tablet by mouth every 6 hours as needed (PRN) for pain. ~ Tramadol oral tablet 50 mg. Give 1 tablet by mouth every night shift for pain between 3:00 AM and 4:00 AM.On 3/2/26 at 10:33 AM, Surveyor interviewed R38 who stated R38's pain medication for rheumatoid arthritis (a chronic, systemic autoimmune disease where the immune system attacks the joint lining causing painful inflammation, stiffness, and potential deformity) was not refilled timely and R38 had missed some doses. R38 stated the facility informed R38 that the physician was contacted for a refill. R38 stated R38 was diagnosed with rheumatoid arthritis as a child and had pain and decreased range of motion since childhood. On 3/3/26 at 10:45 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who stated if a resident's medication runs low or runs out, staff reorder from the pharmacy through the resident's electronic medical record. LPN-E stated staff need to reorder a medication when the resident has two to three days of medication remaining. When staff reorder a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525306	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sturgeon Bay Health Services	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication, they write an X or an R on the medication card which means the medication was reordered. LPN-E stated the pharmacy delivers medication every morning between 3:00 AM and 4:00 AM. LPN-E indicated the facility had issues with receiving medication because some staff ordered medication too early and the pharmacy did not fill the medication. LPN-E indicated when a resident's medication is not in the medication cart, staff remove medication from contingency (extra medication provided by the pharmacy in a secure location). If the medication is not in stock or in contingency, the nurse faxes the provider and requests an order for the medication. LPN-E verified R38's tramadol had run out. LPN-E stated tramadol was supposed to be delivered in the early morning of 3/3/26 but did not arrive. LPN-E stated LPN-E will report to the PM shift to pass the information onto the night shift that R38's tramadol will be delivered during the 3:00 AM to 4:00 AM delivery on 3/4/26. LPN-E stated LPN-E would contact the pharmacy to ensure the medication was ordered.LPN-E and Surveyor reviewed R38's Medication Administration Record (MAR) which indicated tramadol was last administered on 2/27/26 at 3:20 AM. LPN-E stated tramadol should be in contingency. LPN-E stated when LPN-E was working and R38's tramadol was due, R38 did not appear to be in pain and was the same as LPN-E and Surveyor observed during medication administration that morning. LPN-E assessed R38's pain during medication administration. R38 stated the pain was the same as usual. LPN-E stated if R38 is sleeping during the 3:00 AM to 4:00 AM tramadol administration time, R38 will wake up, take the medication, and fall back to sleep within five minutes. LPN-E stated R38 had not requested other interventions or pain medication when R38's tramadol was out during shifts that LPN-E worked since 2/27/26 and had not indicated that R38's pain was worse than normal. LPN-E stated the only time R38 appeared to be in pain was during a recent rectal prolapse. On 3/3/26 at 12:28 PM, Surveyor interviewed R38. When asked about R38's pain on a scale of 0 to 10 when tramadol was not administered, R38 stated R38's pain was a 6 out of 10 but worsened when R38 moved around. R38 stated R38's pain was a 4 out of 10 when tramadol was administered. R38 stated staff offered acetaminophen which was ineffective and R38 refused. R38 stated R38 does not know why R38 is not receiving tramadol. On 3/4/26 at 10:43 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated a refill request for R38 was submitted to the provider who had twice sent the refill to the wrong pharmacy. NHA-A stated a pain assessment was completed, R38 was monitored, and other pain medications were offered and declined. NHA-A stated staff education regarding the availabiity of contigency stock will begin prior to nurses working their next shift. NHA-A stated R38 received tramadol from contingency for the HS dose on 3/3/26 and the 3:00 to 4:00 AM dose on 3/4/26.Surveyor requested the contingency stock dispensing machine report for tramadol 50 mg tablets for February 2026 through 3/4/26. On 3/4/26 at 12:26 PM, Director of Nursing (DON)-B provided a usage report for tramadol 50 mg tablets from the contingency machine. The report indicated R38's tramadol dose was taken from contingency stock on the following dates and times: ~ Removed on 2/26/26 at 11:26 PM by DON-B and administered on 2/27/26 at 3:00 AM - 4:00 AM. (Of note: The dose was not documented as administered according to R38's MAR.)~ Removed on 3/3/26 at 4:56 PM for an as needed (PRN) bedtime dose.~ Removed on 3/4/26 at 4:14 AM for the 3:00 AM - 4:00 AM dose~ On 3/4/26 at 4:19 AM, staff re-counted due to entering the wrong number during the prior transaction. One tramadol 50 mg tablet was removed during two documented transactions on 3/4/26.According to R38's MAR, tramadol 50 mg was not administered at the scheduled time of 3:00 AM - 4:00 AM and the PRN bedtime dose per R38's request to be given every evening before bed on the following dates and times:~ On 2/27/26 at 3:00 AM - 4:00 AM: Documented as code 9 (other/see progress note). (Of note: The dose was taken out of contingency but was not documented as administered.) ~ On 2/27/26 at bedtime: No documentation~ On 2/28/26 at 3:00 AM - 4:00 AM: Documented as code 9~ On 2/28/26 at bedtime: No documentation~ On 3/1/26 at 3:00 AM - 4:00 AM: Documented as code 9~ On 3/1/26 at bedtime: No documentation~ On 3/2/26 at 3:00 AM - 4:00 AM: Documented as code 9~ On 3/2/26 at bedtime: No documentation~ On 3/3/26 at 3:00 AM - 4:00 AM: No documentationSurveyor noted tramadol 50 mg tablets were available in contingency stock during (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525306	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sturgeon Bay Health Services	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the above missed administration times.On 3/4/26 at 1:28 PM, Surveyor interviewed DON-B who worked the night shift on 2/26/26 and was informed by the PM nurse that R38 did not have any tramadol 50 mg tablets. DON-B retrieved one tramadol 50 mg tablet from contingency on the evening of 2/26/26 in anticipation of administering the medication to R38 on 2/27/26 for the 3:00 AM - 4:00 AM dose. DON-B was aware that R38's tramadol was out but did not recall the date. DON-B checked the 24-hour board for documentation but no documentation was found. NHA-A was present during interview and stated NHA-A would check to see if a request for tramadol was made prior to R38's last dose. Evidence of a request to refill was not provided during the survey.On 3/4/26 at 1:40 PM, Surveyor and DON-B reviewed the facility's narcotic log which indicated R38's tramadol ran out on 2/27/26. DON-B stated when there are 5 doses of a medication remaining, staff should reorder the medication through the resident's electronic medical record. The pharmacy fills the request and delivers the medication. DON-B stated the pharmacy contacts the facility if the medication does not have any refills. The nurse then contacts the provider for a refill and writes a progress note. R38's progress notes indicated the following: ~ On 3/1/26 at 12:45 PM, the facility contacted the provider and requested to refill R38's tramadol.~ On 3/2/26 at 2:07 AM, R38's tramadol was on hold until available from the pharmacy.~ On 3/3/26 at 1:30 PM, the pharmacy indicated they did not receive a prescription. The writer stated a tramadol refill was requested from the provider on 3/1/26.~ On 3/3/26 at 6:00 PM, the provider stated previous prescriptions were sent to wrong pharmacy. The provided indicated a presciption would be sent to the correct pharmacy.~ On 3/3/26 at 9:33 PM, the provider indicate a tramadol prescription was sent to the pharmacy.~ On 3/4/26 at 4:38 AM and 5:00 AM, clinical follow-up indicated R38 was resting comfortably in bed. R38's reported pain was chronic and the nurse administered tramadol 50 mg. A one-time pharmacy code was obtained to retrieve the medication from contingency. The pharmacist stated the pharmacy still did not have a tramadol prescription from the provider.~ On 3/4/26 at 11:39 AM and 2:13 PM, there was communication with the provider and pharmacy regarding the tramadol prescription. The prescription was received and the pharmacy indicated they would send it STAT (urgent; without delay).On 3/4/26 at 3:23 PM, Surveyor interviewed DON-B who stated the pharmacy sent DON-B a message that a nurse requested a code to retrieve one tramadol tablet from contingency on 3/4/26, however, the code did not work. A second code was given at 4:19 AM for the 3:00 AM - 4:00 AM dose and one tramadol tablet was removed from contingency. DON-B stated staff are educated on contingency stock and how to obtain medication by requesting a one-time code from pharmacy to access the dispensing machine. DON-B stated nurses are aware tramadol is in contingency but did not use the contingency dispensing machine to obtain tramadol for R38's missed doses.