STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525318	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Health and Rehabilitation Center	8400 Sheridan Rd Kenosha, WI 53143

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on interview, record review, and facility policy review, the facility failed to inform a family member of care conferences and/or provide sufficient notice in advance of care conferences for one of three residents (Resident (R) 3) reviewed for care planning out of a total sample of 13. This had the potential to affect the family member's right to have input into the development of the resident's care plan. Findings include: Review of the facility's policy titled, Care Planning-Resident Participation (Care Conference), dated 09/18/24, revealed, . The facility will honor the resident's choice in individuals to be included in the care planning process .The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative .If the participation of the resident and/or resident representative is determined not practicable for the development of the resident's care plan, an explanation will be documented in the resident's medical record . Review of R3's Profile tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease stage 3 and mild protein-calorie malnutrition. Review of R3's Social Services Evaluation, dated 06/30/24 and located under the Progress Notes tab of the EMR, revealed, . This writer met with [R3] to complete initial CC [care conference] . There was no documented evidence that R3's family member (Family (F) 3) was in attendance or was invited to participate in the development of the initial care plan. Review of R3's quarterly Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 09/03/24, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R3's Care Conference, located under the Evaluations tab of the EMR and dated 10/15/24, revealed, . Care conference held with residents [family member] on the phone . Review of R3's Progress Notes, Evaluations, and Documents tabs of the EMR revealed no documented evidence that F3 had been invited in advance to attend the resident's care conference. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's Progress Notes tab of the EMR revealed no documented evidence R3 was asked who she wanted to be invited to her care conferences. During an interview on 11/18/24 at 10:07 AM, R3 stated she wanted her family member to be involved in all aspects of her care. During an interview on 11/18/24 at 1:24 PM, F3 stated that on 10/15/24, she had been at work and received a phone call from the Social Services Director (SSD) who informed her they were having a care plan conference at that time, and they were wanting to know if she could participate. F3 stated it was spur of the moment and that was the only invitation she had received regarding care conferences. F3 stated she wanted to be invited to attend care conferences because she was very involved in R3's care. During an interview on 11/19/24 at 10:52 AM, the SSD was asked if invitations to care conferences were issued. She stated, Yes. The SSD stated if a resident was alert and oriented, they would be provided with a letter inviting them to their care conference, and if the resident had requested family or a responsible party be invited, those individuals would be called. She stated the invitations were issued to anyone that the resident wanted to be invited. The SSD stated she did not have a system to track invitations offered to family members and/or responsible parties. The SSD stated R3 wanted to keep F3 involved in her care and that was why the Interdisciplinary Team (IDT) had called F3 on 10/15/24. The SSD was asked if F3 had been informed in advance of the care conference on 10/15/24. She stated, No. She stated she had asked F3 if she could talk at that time, and if she had said no, they would have rescheduled. The SSD was asked if F3 had been invited to R3's other care conferences. She stated she had no documented evidence of the invitations. During an interview on 11/19/24 at 2:34 PM, the Director of Nursing (DON) stated it was her expectation that family members be invited in advance to care plan conferences.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, and review of facility policy, the facility failed to provide nail care to one of three residents (Resident (R) 12) reviewed for assistance with activities of daily living (ADLs). R12 had fingernails that extended approximately one-half inch beyond the tips of his fingers and required staff assistance in trimming them. This failure caused R12 to have unmet personal hygiene needs. Findings include: Review of the facility's undated policy titled, Nail Care revealed, . Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis . Routine nail care, to include trimming and filing, will be provided on a regular schedule . Nail care will be provided between scheduled occasions as the need arises . The resident's plan of care will identify . The frequency of nail care to be provided . The type of nail care to be provided . The person(s) responsible for providing nail care . Review of R12's Profile tab of the electronic medical record (EMR) revealed R12 was admitted to the facility on [DATE] with diagnoses that included paraplegia. Review of R12's Care Plan, dated 09/09/24 and located under the Care Plan tab of the EMR, revealed a focus of a deficit in ADL self-care performance. Interventions included the assistance of one staff member for personal hygiene. The care plan did not specifically address nail care. Review of R12's admission Minimum Data Set (MDS), with an Assessment Reference Date of 09/15/24 and located under the MDS tab of the EMR, recorded R12 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. It was recorded that the resident had bilateral upper and lower extremity functional limitations in range of motion and was dependent on staff for personal hygiene. Review of R12's Physician Order, dated 11/14/24 and located under the Orders tab of the EMR, revealed, . Bed Rest for 1 week . During an observation and interview on 11/18/24 at 9:46 AM, R12's fingernails on all digits were observed to extend past the tip of his fingers approximately one-half inch. The nails appeared thick. R12 stated his nails needed to be cut, but he did not know how to go about getting that done since they were so thick. R12 stated he did not have any nail clippers. R12 stated no staff member had asked him or offered to provide nail care for him. During an interview on 11/19/24 at 11:49 AM, Certified Nurse Aide (CNA) 1 stated nail care was provided to residents on shower days. CNA1 stated she did not know if staff had asked R12 if he would like his nails trimmed. She stated, His nails are long. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 12:00 PM, the Director of Nursing (DON) was asked to observe R12's fingernails. She stated they were long. The DON stated that because R12 was alert and oriented, it was on him to ask for his nails to be clipped. The DON asked R12 if he would like clippers and a file to trim his nails. He stated, Yes. During an observation with Licensed Practical Nurse (LPN) 1 on 11/19/24 at 2:11 PM, R12 was noted to have his fingernails on his left hand trimmed. LPN1 stated staff had to soak R12's nails to soften them enough to clip.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on interview, record review, and review of facility policy, the facility failed to ensure pressure ulcer treatments were ordered and treatments provided for two of four residents (Resident (R) 12 and R2) reviewed for pressure ulcers out of a total sample of 13. This failure put R12 and R2 at risk for deterioration of their pressure ulcers. Findings include: Review of the facility's undated policy titled Pressure Injury Prevention and Management revealed, . This facility is committed to . provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries . 1. Review of a hospital facsimile, dated 09/06/24, located under the Documents tab of the electronic medical record (EMR), and addressed to the Assistant Director of Nursing (ADON), revealed, . Wound care notes for [R12] . Plan: Wound care . Left and right buttocks wounds: Cleansed liberally with wound cleanser and gauze, pat dry. Apply 3M No Sting skin barrier to surrounding skin for protection. Cut strip of Aquacel AG/Hydrofiber AG and tuck into 2 areas of depth/track to left side of sacrum. Then apply Aquacel Ag/Hydrofiber Ag to the rest of the wound bases. 4 pieces of Aquacel AG to right buttock and 1/2 a strip to left buttock folded in half. Cover with the large foam border dressings. On the right buttock you will need to cut one of the edges off of the foam border and toggle the dressings together to make a large dressing. Change daily . Review of R12's Profile tab of the electronic medical record (EMR) revealed R12 was admitted to the facility on [DATE] with diagnoses that included paraplegia and pressure ulcer of unspecified site. Review of R12's Physician Orders, located under the Orders tab of the EMR, revealed no documented evidence of any physician orders for R12's pressure ulcers until 09/11/24. Review of R12's Physician Order, dated 09/11/24 and located under the Orders tab of the EMR, revealed, . Gently cleanse right and left buttock wound with saline or wound cleanser. Apply calcium alginate dressing and cover with border gauze daily, everyday shift for wound care . Review of R12's Treatment Administration Records (TARs) dated September 2024 and located under the Orders tab of the EMR and Progress Notes, located under the Progress Notes tab of the EMR, revealed no documented evidence R12 received any treatment to the pressure ulcers located on his buttocks until 09/11/24. During an interview on 11/19/24 at 2:09 PM, Licensed Practical Nurse (LPN) 1 stated when a resident who had pressure ulcer was admitted to the facility, the nurse should look for treatment orders, and if there were none present on the paperwork, the physician should be contacted immediately for treatment orders. During the survey, the ADON was out of the facility and unavailable for interview. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 2:34 PM, the Director of Nursing (DON) was asked why R12 did not have orders for treatments for his pressure ulcers upon admission and why the resident did not receive treatments for his pressure ulcers until 09/11/24. She reviewed the clinical record and conferred with Unit Manager (UM) 1. The DON stated it appeared the ADON received treatment orders from the Medical Director on the morning of 09/10/24 but received the orders past the time frame for day shift treatments to be completed, so he put the orders in to begin on the following day. The DON stated she had educated the ADON on ensuring that orders were implemented on the day they were received. The DON stated the facility had received orders for the resident's pressure ulcer treatments prior to his arrival at the facility. The DON gave no explanation for why those orders had not been implemented. 2. Review of R2's Profile tab of the EMR revealed R2 was admitted to the facility on [DATE] with diagnoses that included unspecified open wound of the right buttock, chronic osteomyelitis, and unspecified quadriplegia. Review of hospital Case Management notes, with a fax date of 09/09/24 and located under the Documents tab of the EMR, revealed R2 was to have a wound vacuum (wound vac) system for treatment of his pressure ulcer. It was recorded, Wound vac 125 mgHg [millimeters Mercury] continuous suction black foam, change every M/W/F [Monday, Wednesday, Friday] . Review of R2's Progress Notes, dated 09/09/24 at 5:02 PM and located under the Progress Notes tab of the EMR, revealed the resident had arrived at the facility. It was recorded that his dressings were clean, dry, and intact. Review of R2's Progress Notes, dated 09/09/24 at 9:47 PM and located under the Progress Notes tab of the EMR, revealed, . wound dressing changed, wound vac still needed . Review of R2's Progress Notes, dated 09/10/24 at 1:19 AM, revealed, . Resident has wounds to right buttock and left hip. Right buttock has a wound down to bone with 2 cm [centimeter] width and approximately 6 cm depth. Wet to dry dressing applied to right buttock until wound vac arrives . Review of R2's Orders and Progress Notes tabs of the EMR revealed no physician's order for the wet to dry dressing. Review of R2's Physician Orders, dated 09/10/24 at 11:00 AM, revealed, . right gluteal fold: wound vac at 125 mm hg continuous. Cleanse with NS [normal saline]. Apply black foam to wound bed, change T,TH, Sat [Tuesday, Thursday, Saturday]. If vac fails apply wet to dry with NS with bordered gauze . Review of R2's Progress Notes, dated 09/10/24 at 1:14 PM, revealed, . Wound vac ordered and will be applied when arrives . Review of the supply house Proof of Delivery revealed the wound vac system was delivered to the facility on [DATE] at 9:32 AM. Review of R2's Progress Notes tab and Treatment Administration Records (TARs), dated 09/11/24, revealed no documented evidence the wound vac system was applied after it was delivered to the facility. There was no documented evidence that any type of wound treatment was completed on 09/11/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's Progress Notes, dated 09/12/24 at 2:59 PM, revealed the wound vac system had been put into place for R2. During an interview on 11/19/24 at 8:12 AM, UM 1 confirmed the wound vac was not started until 09/12/24 and stated it was because it had to be ordered after the resident arrived at the facility, and delivery took one to two days. She stated the facility's wound doctor saw the resident on 09/12/24 and the wound vac was started then. The UM was asked for the physician's order for the wet to dry dressing that was applied on 09/10/24 at 1:19 AM. She reviewed the clinical record and stated the order for the wound vac system, dated 09/10/24 at 11:00 AM, was the order used for the wet to dry dressing because that order called for a wet to dry dressing if the wound vac system failed. UM1 stated she believed a wet to dry dressing had been applied on 09/11/24. She stated there was no other order for dressing changes other than the order for the wound vac system. During an interview on 11/19/24, the DON confirmed there was no order for wet to dry dressings to be applied to R2's pressure ulcer until the wound vac was started. The DON confirmed the order dated 09/10/24 for a wet to dry dressing if the wound vac system failed was different from having an order for dressing changes until the system was started. The DON confirmed there was no documented evidence that a dressing change was completed on 09/11/24.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, facility policy review, and review of current standards of practice, the facility failed to ensure one of one resident (Resident (R) 3) reviewed for enteral feedings out of a total sample of 13 received appropriate care and services to prevent complications. This failure had the potential to cause increased risk of infection for R3. Findings include: Review of the facility's policy titled, Care and Treatment of Feeding Tubes, dated 08/21/24, revealed, . It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . Review of the Journal of Parenteral and Enteral Nutrition, located at https://www.nutritioncare.org/uploadedFiles/01_Site_Directory/Guidelines_and_Clinical_Resources/EN_Pathway/Boullata_et_al-2016-Journal_of_Parenteral_and_Enteral_Nutrition.pdf, revealed, . Practice Recommendations . standardize the labels for all EN [enteral nutrition] formula containers, bags, or syringes to include who prepared the formula, date/time it was prepared, and date and time it was started . Review of 17.3 Assessments Related to Enteral Tubes, located at https://wtcs.pressbooks.pub/nursingskills/chapter/17-3-assessments-related-to-enteral-tubes/, revealed, . Assess the tube insertion site daily for signs of pressure injury and skin breakdown . Review of R3's Profile tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease stage 3, mild protein-calorie malnutrition, and gastrostomy status. Review of R3's Care Plan, dated 06/28/24 and located under the Care Plan tab of the EMR, revealed a focus, . The resident requires tube feeding r/t [related to] dysphagia . Interventions included to provide care to the feeding tube site as ordered and to monitor for signs and symptoms of infection. Review of R3's quarterly Minimum Data Set, with an Assessment Reference Date (ARD) of 09/03/24 and located under the MDS tab of the EMR, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. It was recorded that the resident had a feeding tube and received 51% or more of her total caloric intake through tube feedings. Review of R3's Physician Orders, dated 09/13/24 and located under the Orders tab of the EMR, revealed R3 was to receive, . Vital 1.5 [an enteral feeding] 60 ml [milliliters] q [every] 4 hours then 1 hour break (0500, 1000, 1500 [5:00 AM, 10:00 AM, 3:00 PM]) & 60 ml q 8 hours (2000-0400 [8:00 PM - 4:00 AM]) . Review of the resident's physician orders revealed no orders for the care and treatment of the resident's feeding tube insertion site. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's Treatment Administration Record (TAR), dated 11/17/24 through 11/19/24 and located under the Orders tab of the EMR, revealed, . Change and date enteral feeding piston one time a day for PEG [percutaneous endoscopic gastrostomy] tube care . It was recorded that this was to be done on the night shift. The TAR documented the care had been done on 11/17/24, 11/18/24, and 11/19/24. During an observation on 11/19/24 at 8:35 AM, R3 was observed lying in bed. An enteral feeding and water flush bag were noted hanging and infusing. There was no label on the enteral feeding container or the water flush bag. A piston syringe and container were noted on the resident's bedside table. The container was dated 11/17/24. R3 was asked when staff had last assessed her feeding tube insertion site. She stated it had been a while. During an observation and interview on 11/19/24 at 8:40 AM, Unit Manager (UM) 1 was asked to observe R3's feeding tube insertion site. UM1 lifted R3's gown, and a split gauze dressing was noted taped around the feeding tube. The date on the tape was 11/17/24. UM1 confirmed the date. UM1 confirmed the dressing had areas of what appeared to be dried blood. UM1 was asked how often the insertion site was to be cleaned. She stated, Every night. UM1 confirmed the current date was 11/19/24. UM1 was asked what the facility's policy was for how long an enteral feeding and water flush could be used before it was changed. She stated, 24 hours. She was asked how she would know how long R3's feeding and water flush had been hanging. UM1 observed the enteral feeding container and water flush bag and stated, I would not. She confirmed that neither the enteral feeding nor water flush bag were labeled with a hanging date or the name of who had hung them. UM1 was asked what the date on the syringe and container was. She stated, 11/17. UM1 confirmed the syringe and container were supposed to be changed daily. UM1 was asked how she monitored to ensure the nurses completed their tasks. She stated she made rounds. On the back of the enteral feeding pump, inside the recessed area near the top of the pump, a build-up of a dark yellow substance was noted. UM1 confirmed the substance appeared to be dried enteral feeding formula. UM1 was asked how often the feeding pumps were supposed to be cleaned. She stated, I'm not sure. UM1 was asked who was responsible for cleaning the pump. She stated, I'm not sure. I guess it would be the floor nurses. During an interview on 11/19/24, the Director of Nursing (DON) confirmed all enteral feedings and water flushes should be labeled with the date and time of when they were hung and the initial of who hung them. She stated that they should be changed every 24 hours. The DON stated the syringe and container should be changed every 24 hours. She stated that dressing changes should be done daily or as ordered by the physician, and the insertion site should be cleaned at that time. The DON stated the tube feeding pump should be cleaned regularly. The DON stated failure to do these things was an infection control concern.

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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** 25225 Based on interview and record review, the facility failed to ensure medications were available for administration for two of three residents (Resident (R) 5 and R2) reviewed for medication availability out of a total sample of 13. R5 did not have pain medication available to treat pain and R2 did not receive cefepime, an antibiotic, for 22 hours after admission to the facility. This had the potential to cause uncontrolled pain for R5 and increased risk of infection complications for R2. Findings include: 1. Review of R5's Profile tab of the electronic medical record (EMR) revealed R5 was admitted to the facility on [DATE] with diagnoses that included spondylosis without myelopathy and polyosteoarthritis. Review of R5's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/22/24 and located under the MDS tab of the EMR, revealed R5 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. Review of R5's Progress Notes and Documents tabs revealed R5 underwent outpatient surgery on 11/08/24 related to a left ankle bone infection. Review of R5's Physician Orders, dated 11/08/24 and located under the Orders tab of the EMR, revealed R5 was to receive hydrocodone-acetaminophen 5/325 milligram (mg) tablet, two tabs by mouth every four hours as needed for post operative pain for 14 days. Review of R5's Medication Administration Records (MARs), located under the Orders tab of the EMR, revealed R5 received the following doses of hydrocodone-acetaminophen: 11/16/24 - one dose at 12:02 PM for a pain level of 5 (on a zero to 10 scale, with zero being no pain and 10 being the worst pain imaginable), one dose at 4:16 PM for a pain level of 7, and one dose at 8:17 PM for a pain level of 4. 11/17/24 - one dose at 5:30 AM for a pain level of 8, and one dose at 7:40 PM for a pain level of 5. Review of R5's Progress Notes tab of the EMR revealed no documented evidence that any of the doses administered on 11/16/24 and 11/17/24 were less than the physician prescribed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24 at 9:21 AM, R5 stated his pain level was at a 10. He stated he was out of pain medication. R5 stated on 11/16/24, a nurse had given one pill instead of two as ordered, and then on 11/17/24 on the evening shift when he had asked for pain medication, the evening shift nurse had told him he only had one pain pill left but she could give him that if he wanted. R5 stated he had been told the medication had been reordered, but he was in pain. He stated he could have the pain medication every four hours, but he had not asked because he knew he was out. R5 stated his pain was usually at 3 or 4, and that was tolerable to him. He stated the pain on the evening of 11/17/24 kept him from enjoying the football games on television. He stated, Sure took the joy out of it. Review of R5's Controlled Drug Record, dated 11/17/24 at 7:40 PM and provided by the facility, revealed R5 received one tablet of hydrocodone-acetaminophen 5/325. It was recorded that this was the last tablet of hydrocodone-acetaminophen the resident had. During an interview on 11/18/24 at 7:42 AM, Licensed Practical Nurse (LPN) 1 stated when a narcotic pain medication needed to be reordered, the nurse was to call the pharmacy, the pharmacy would let the nurse know if a new prescription was required, and if so, the nurse was to contact the physician to have a new prescription sent to the pharmacy. Review of R5's Progress Note, dated 11/18/24 at 9:48 AM, revealed, . writer spoke with Pharmacy re: delivery of hydrocodone 5/325 mg stated medication would be delivered on first run around 230 PM per Pharmacist . requested a code to get medication from contingency due to increased pain to left ankle rated 10 per resident authorization code . medication obtained and given to resident . During an interview on 11/19/24 at 1:52 PM, LPN2, who was assigned to R5 on the evening shift on 11/17/24, stated R5 had requested pain medication during her shift, but he only had one tablet left. She stated she had let R5 know and had administered the one tablet. LPN2 stated the day shift on 11/17/24 had not informed her that R5 was almost out of pain medication. LPN2 stated she had called the nurse practitioner for a prescription to be sent to the pharmacy. LPN2 stated medications were supposed to be reordered when only the last row of medication on the medication card was left. LPN2 stated she did not know if a previous shift had attempted to reorder the medications because no one told her. During an interview on 11/19/24 at 3:08 PM, the Director of Nursing (DON) stated the facility had pain medications available in the contingency box, and there was no reason for R5 to have been without pain medication. The DON stated when the resident had complained of pain to the evening shift nurse on 11/17/24, the nurse should have taken the necessary steps to procure pain medication for R5 from the contingency box. The DON stated a medication error had occurred on 11/16/24 when the resident was only administered one pain medication and again on 11/17/24 when the nurse only administered one pain medication. The DON was asked to provide the facility's policy on reordering narcotic pain medications. A policy was not provided prior to the end of the survey. 2. Review of R2's Profile tab of the EMR revealed R4 was admitted to the facility on [DATE] with diagnoses that included unspecified open wound of the right buttock, chronic osteomyelitis, and unspecified quadriplegia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525318	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Health and Rehabilitation Center	8400 Sheridan Rd Kenosha, WI 53143

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's hospital Physician Discharge Summary, dated 09/09/24 at 1:00 PM and located under the Documents tab of the EMR, revealed the resident was to receive the following antibiotics due to a diagnosis of acute and chronic multifocal osteomyelitis (bone infection): cefepime 2 grams (gm) every 12 hours intravenously (IV) twice daily until 10/02/24, ciprofloxacin (Cipro) 750 milligrams (mg), take one tablet by mouth twice daily until 10/02/24, and metronidazole (Flagyl) 500 mg one tablet every eight hours until 10/02/24. The discharge summary recorded the resident last received cefepime at 7:49 AM on 09/09/24 and Flagyl at 7:53 AM. Review of R2's Progress Notes, dated 09/09/24 at 5:02 PM and located under the Progress Notes tab of the EMR, revealed the resident had arrived at the facility, and the nursing admission assessment had been started. Review of R2's MAR dated 09/10/24 and located under the Orders tab of the EMR, revealed R2 received Cipro and Flagyl on the morning shift of 09/10/24. The MAR indicated the resident did not receive cefepime until 3:00 PM on 09/10/24. This was 22 hours after the resident arrived at the facility and 31 hours after the last dose. Review of R2's Progress Note, dated 09/10/24 at 1:14 PM and located under the Progress Notes tab of the EMR revealed, . IV ABT [antibiotic] has not arrived, will be delivered today, [physician's name withheld] aware of missed doses of unavailable medications . During an interview on 11/19/24 at 7:42 AM, LPN1 was asked what the facility's policy was for ordering IV antibiotics for a newly admitted resident. LPN1 stated the facility had some antibiotics in the facility's contingency boxes, and if the antibiotic needed was not there, staff should order the antibiotic stat (for immediate delivery). LPN1 stated stat orders were delivered within one to one and one-half hours. LPN1 stated the unit managers usually put orders in for new admissions. LPN1 was asked if the facility had a local pharmacy to use for emergency situations. She stated she was not sure. During an interview on 11/19/24 at 8:12 AM, Unit Manager (UM) 1 confirmed R2 did not receive the first dose of cefepime until 3:00 PM on 09/10/24. She stated the medication may not have been available in the facility's contingency kit, and the pharmacy might not have delivered it based on the cut off time for orders. UM1 confirmed the IV antibiotic met the criteria for ordering stat. UM1 stated stat orders were delivered typically within three to five hours. During an interview on 11/19/24 at 9:41 AM, the DON stated that new admissions do not normally receive their medications until the following day. She was asked if the facility had the ability to order medications, such as IV antibiotics, for a stat delivery. She said yes. She stated if an order was placed before 3:00 PM, it would be delivered after 10:00 PM. She stated if an order was called in at 8:00 or 9:00 PM, then stat would be on the next pharmacy run. She was asked why R2 was admitted at approximately 5:00 PM on 09/09/24 but did not receive the first dose of cefepime until 3:00 PM on 09/10/24. She stated, That's when it was available.

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	525318	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Health and Rehabilitation Center	8400 Sheridan Rd Kenosha, WI 53143

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, and review of facility policy, the facility failed to serve food that was served at an appetizing temperature for one of three residents (Resident (R) 5) reviewed for food palatability out of a total sample of 13. This failure had the potential for R5 to have unmet nutritional needs. Findings include: Review of the facility's policy titled, Food Preparation Guidelines, dated 10/24/22, revealed, . It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status . Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature . Strategies to ensure resident satisfaction include . Serving hot foods/drinks hot . Review of R5's Profile tab of the electronic medical record (EMR) revealed R5 was admitted to the facility on [DATE] with diagnoses that included spondylosis without myelopathy and polyosteoarthritis. Review of R5's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/22/24 and located under the MDS tab of the EMR, revealed R5 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. During an interview on 11/18/24 at 9:21 AM, R5 stated he ate his meals in his room, and all meals, and especially breakfast meals, were lukewarm when served. R5 stated the food had good flavor, but it bordered on being cold. R5 stated he had made multiple complaints related to food temperatures. On 11/19/24 at 8:56 AM, a sample test tray consisting of biscuits and gravy was obtained. It was the last tray served for the morning meal. It was noted the meal trays were delivered on a cart with a zippered insulated cover. As trays were being delivered, the cover was left unzipped. The test tray was served approximately 15 minutes after the food cart had been delivered to the North hall. The Dietary Manager (DM) measured the serving temperature of the biscuits and gravy, and it registered 110 degrees Fahrenheit (F). Upon tasting the food, a thin film was noted to have developed on top of the food. The food did not taste over seasoned or sweet. The DM confirmed the serving temperature was too low for palatability. During an interview on 11/19/24 at 8:56 AM, the DM confirmed residents had complained about the serving temperatures of food. She stated they tried to make sure all plates were heated. The DM stated an enclosed metal cart had been ordered as she did not think the insulated cover was sufficient. The DM stated that sometimes, staff on the floor did not get meal trays delivered quickly enough, and that was a problem as well. On 11/19/24 at 9:02 AM, the DM provided the holding temperatures for the breakfast meal. It was recorded that the holding temperature for the biscuits and gravy had been measured to be 180 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, and review of facility policy, the facility failed to perform pressure ulcer treatments in a manner to prevent potential cross contamination for one of four residents (Resident (R) 12) reviewed for pressure ulcers out of a total sample of 13. Licensed Practical Nurse (LPN) 1 took the treatment cart into the resident's room while performing the treatment and placed unused supplies back into the cart after the treatment was performed. This placed any residents requiring treatments at risk for cross-contamination. Findings include: Review of the facility's policy titled, Infection Prevention and Control Program, dated 05/16/23, revealed, . This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services . Review of R12's Profile tab of the electronic medical record (EMR) revealed R12 was admitted to the facility on [DATE] with diagnoses that included paraplegia and pressure ulcer of unspecified site. During an observation and interview on 11/19/24 at 2:11 PM, LPN 1 was observed providing a pressure ulcer treatment to R12. When the surveyor entered the resident's room, the treatment cart was noted to be in the resident's room. Pressure ulcer treatment supplies, including a bottle of Dakin's solution, gauze pads, a tube of Santyl (a medication used in the treatment of pressure ulcers), and foam bordered dressings, were noted on the top of the cart. While performing the treatment, LPN1 poured Dakin's solution from the bottle onto gauze. After completing the treatment, LPN1 placed the opened bottle of Dakin's solution, three unopened packages of dressing supplies, and the tube of Santyl back into the treatment cart. She then pushed the treatment cart out of the room and back to the nurses' station. Once LPN1 arrived at the nurses' station, she stepped away from the treatment cart and asked LPN2 if she was ready to take report for the next shift. The surveyor asked LPN1 to stop giving report. LPN1 was asked if she always took the treatment cart into a resident's room when completing wound care. She stated not always, but if the treatment was involved, she liked to take the cart into the room to keep the supplies tidy. At this time, LPN1 stated she was going to wipe the treatment cart down with a sanitizing wipe and began wiping down the top of the cart. LPN1 was asked if she placed supplies back into the treatment cart after they had been out in the resident's room. She stated yes. She stated the supplies had not been opened. During an interview on 11/19/24 at 2:34 PM, the Director of Nursing (DON) confirmed it was an infection control concern to take the treatment cart into a resident's room and then to put supplies that had been out in the resident's room back into the treatment cart. The DON confirmed the supplies should have been left in R12's room. The DON stated she had not observed LPN1 do this before.