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	05/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review, the facility failed to protect residents from resident-to-resident abuse for five (Residents (R)1, R6, R19, R12 and R11) of 20 sampled residents. This failure had the potential to create an environment where other residents had the potential to be abused. Findings include: Review of the facility's policy titled Abuse Neglect and Exploitation revised 12/22/24 revealed . The facility will implement policies and procedures to prevent and prohibit all types of abuse . 1. Review of R2's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnosis which included dementia. Review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/25 and located in the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of one out of 15 which indicated the resident was severely cognitively impaired. Review of R1's Face Sheet located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with diagnosis which included fibromyalgia. Review of R1's quarterly MDS with an ARD of 04/22/25 and located in the MDS tab of the EMR revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of Misconduct Incident Report provided by the facility dated 05/06/25 revealed, [R2] touched [R1] breast .[R1] stated to staff that she allowed [R2] to hug her multiple times but the last 2 times he touched her breast. When asked when this occurred, she stated that it was at least 2 weeks ago and around Easter (April 20th) she could not give a specific date. [R1] reported during the interview that she thought it was an accident the first time but the second time she felt it was an intentional rub across the breast. [R1] stated during the interview that she will no longer allow [R2] to hug her anymore and nothing has happened since the incident . 2. Review of R6's Face Sheet located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with diagnosis which included dementia. Review of R6's quarterly MDS with an ARD of 05/02/25 and located in the MDS tab of the EMR revealed a BIMS score of three out of 15 which indicated the resident was severely cognitively impaired. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R7's Face Sheet located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with diagnosis which included paraplegia. Review of R7's quarterly MDS with an ARD of 01/31/25 and located in the MDS tab of the EMR revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of Misconduct Incident Report provided by the facility dated 02/11/25 revealed, Resident to resident altercation in presence of staff members. [R7] made threats of sexually inappropriate behavior to [R6] At approximately 0300 [3:00 AM] 2 CNAs [Certified Nurse Aides] reported to LPN [Licensed Practical Nurse's name] that while they were changing [R6]'s brief [R7] told them he was going to rape [R6] and they he needed to stop running around with his white butt out. CNA told him not to talk like that, and he continued to say he was going to do it around 5am [5:00 AM] and cover his mouth . 3. Review of R12's Face Sheet located under the Profile tab of the EMR revealed he was admitted to the facility on [DATE] with diagnosis which included cerebral infarction. Review of R12's quarterly MDS with an ARD of 04/24/25 and located in the MDS tab of the EMR revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R19's Face Sheet located under the Profile tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses which included absence of right leg and end stage renal disease. Review of R19's admission MDS with an ARD of 03/13/25 and located in the MDS tab of the EMR revealed a BIMS score of 14 out of 15 which indicated the resident was cognitively intact. Review of Misconduct Incident Report provided by the facility dated 05/18/25 revealed, [R12] was in the courtyard and [R19] came out with his music playing. She asked him to turn that (expletive) off he said No. She then called him a [racial expletive], [expletive] and R19 called her a [racial expletive]. R12 went to grab for his phone in his shirt pocket and slapped him. R19 reacted by swinging at her resulting in him hitting her in the face . DON [Director of Nursing] and Administrator contacted Police Department and residents were asked if they wanted to press charges on each other. Both declined. During an interview on 05/28/25 at 5:26 PM, the Administrator and the DON confirmed these incidents occurred and agreed that the incident between R12 and R19 and R6 and R7 were physical and verbal abuse. 4. Review of R11's annual MDS with an ARD of 03/07/25 revealed R11 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included paroxysmal atrial fibrillation, chronic diastolic (congestive) heart failure, type 2 diabetes mellitus, and pulmonary fibrosis. R11 had a BIMS score of 13 out of 15, which indicated R11 was cognitively intact. Review of the facility's investigation into the incident revealed, On 01/04/25, Licensed Practical Nurse (LPN)1 heard agency CNA1 yelling at R11 to roll over by herself .she can do it herself. LPN1 immediately ran into the room and removed CNA1 from the room and escorted the CNA1 out of the facility. Administrator and DON contacted immediately. R11 stated that she was not physically touched and denied any physical harm. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/28/25 at 4:14 PM, the DON stated CNA1 was an agency CNA who was no longer permitted to work in the facility. The DON stated that on 01/04/25, LPN1 heard CNA1 yelling at R11. LPN1 went to the room and attempted to stop CNA1 from yelling at R11. CNA1 threatened LPN1, and LPN1 walked CNA1 out of the building. The DON stated this was verbal abuse. During an interview on 05/29/25 at 1:37 PM, LPN1 stated that she recalled the incident with CNA1 and R11 on 01/04/25. LPN1 stated she was sitting at the nurse's station when she heard a commotion coming from R11's room. CNA1 was yelling loudly at R11. LPN1 stepped in and brought CNA1 out of the room and told her, We do not speak to residents that way. CNA1 stated LPN1 was not her nurse and started to scream at LPN1. LPN1 escorted CNA1 out of the building and called the Administrator.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure reportable allegations of abuse were reported to the State Agency (SA) in a timely manner and failed to notify the police of the abuse allegation for three residents (Resident (R)5, R8 and R11) of five residents reviewed for abuse in the sample of 20. Findings include: 1. Review of R11's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/07/25 in the electronic medical record (EMR) under the MDS tab revealed R11 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included paroxysmal atrial fibrillation, chronic diastolic (congestive) heart failure, type 2 diabetes mellitus, and pulmonary fibrosis. R11 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated R11 was cognitively intact. Review of the facility's investigation into the incident revealed that on 01/04/25, Licensed Practical Nurse (LPN)1 heard agency Certified Nurse Aide (CNA)1 yelling at R11 to roll over by herself and she can do it herself. LPN1 removed CNA1 from the room and escorted the CNA1 out of the facility. Administrator and Director of Nursing (DON) contacted immediately . The investigation indicated the only notification to the SA was dated 01/09/25. During an interview on 5/29/25 at 1:45 PM the Administrator stated she did not call law enforcement and did not send to the SA the mandated 24-hour report until the 5th day after the incident due to system glitches with the State's online reporting portal. 2. Review of R5's annual MDS with an ARD of 04/04/25 located on the MDS tab of the EMR revealed he was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included polyneuropathy, poly-osteoarthritis, type 2 diabetes mellitus hypothyroidism, alcohol abuse, insomnia, schizoaffective disorder, bipolar type, major depressive disorder, and anxiety disorder. R5 had a BIMS score of 14 out of 15, which indicated R5 was cognitively intact. Review of the facility's investigation of the incident of alleged misappropriation of R5's cash revealed the facility reported the incident to the SA. During an interview on 05/28/25 at 4:59 PM, the Administrator stated that staff came to her with money that R5 had given them in cards for Valentine's Day, and wanted to return the money to the resident. The total sum of the cash returned by staff was $58. The Administrator stated she returned the cash to R5. The Administrator thought R4 had a lock box where he kept valuables like cash and felt it was safe to return the money to him. A few days later, R5 reported that he was missing $58. When asked if he kept the money in his lock box, R5 stated he had lost the key to his lock box and had not used it in a while. When asked where the money was kept, R5 stated it was in his wallet on the bedside table. The incident was reported to the SA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/25 at 11:39 AM, R5 stated someone took his money off the bedside table. During an interview on 5/29/25 at 12:41 PM, the Administrator stated she did not know she must call law enforcement when there is suspicion that a crime has been committed against any residents. She stated that R5 declined an offer to notify the police. The Administrator stated she attempted to submit the 5-day follow-up to the initial report but could not log into the Misconduct Reporting System. The Administrator stated she submitted the report via email. 3. Review of R8's Face Sheet located under the Profile tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses which included paroxysmal atrial fibrillation. Review of R8's quarterly MDS with an ARD of 08/09/24 and located in the MDS tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R8's Initial SW/CM (Social Worker/Case Manager) Assessment/Plan of Care Note from the hospital and provided by the facility, dated 01/28/24, revealed R8 stated he feels verbally abused by staff and that they often say things to intimidate residents like, don't forget I put you to bed at night. During an interview on 05/29/25 at 2:15 PM, the Administrator stated they received the information from the hospital soon after R8 went to the hospital. She stated she completed an investigation somewhere between 02/03/25 through 02/17/25. She stated it never occurred to her to report it to the SA but agreed it should have been. The Administrator stated since R8 had not told us about the incident she did not think she needed to report to incident to the SA. Review of the facility's policy titled Abuse Neglect and Exploitation revised 12/22/24 revealed, . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes . Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review, the facility failed to complete a thorough investigation of abuse allegations for three residents (Residents (R)1, R6, and R8) out of 20 sampled residents. The facility demonstrated their lack of knowledge in completing a thorough investigation, which had the potential to increase a resident's risk of abuse throughout the facility. Findings include: Review of the facility's policy titled Abuse Neglect and Exploitation revised 12/22/24 revealed, . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframe's .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports abuse, neglect or exploitation occur . Providing complete and thorough documentation of the investigation. 1. Review of R2's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnosis which included dementia. Review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/25 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of one out of 15 which indicated the resident was severely cognitively impaired. Review of R1's Face Sheet located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with diagnosis which included fibromyalgia. Review of R1's quarterly MDS with an ARD of 04/22/25 and located in the MDS tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of Misconduct Incident Report provided by the facility, dated 05/06/25, revealed (R2) touched [R1] breast .[R1] stated to staff that she allowed [R2] to hug her multiple times but the last 2 times he touched her breast. When asked when this occurred, she stated that it was at least 2 weeks ago and around Easter [April 20th] she could not give a specific date. [R1] reported during the interview that she thought it was an accident the first time but the second time she felt it was an intentional rub across the breast. 2. Review of R6's Face Sheet located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with diagnosis which included dementia. Review of R6's quarterly MDS with an ARD of 05/02/25 and located in the MDS tab of the EMR, revealed a BIMS score of three out of 15 which indicated the resident was severely cognitively impaired. Review of R7's Face Sheet located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with diagnosis which included paraplegia. Review of R7's quarterly MDS with an ARD of 01/31/25 and located in the MDS tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Misconduct Incident Report provided by the facility, dated 02/11/25, revealed Resident to resident altercation in presence of staff members. [R7] made threats of sexually inappropriate behavior to [R6]. At approximately 0300 [3:00AM] 2 CNAs [Certified Nurse Aides] reported to LPN [Licensed Practical Nurse's name], that while they were changing [R6]'s brief [R7] told them he was going to rape [R6], and they he needed to stop running around with his white butt out. CNA told him not to talk like that, and he continued to say he was going to do it around 5am [5:00 AM] and cover his mouth . 3. Review of R8's Face Sheet located under the Profile tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses which included Paroxysmal Atrial Fibrillation. Review of R8's quarterly MDS with an ARD of 08/09/24 and located in the MDS tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R8's Initial SW/CM (Social Worker/Case Manager) Assessment/Plan of Care Note, from the hospital and provided by the facility, dated 01/28/24, revealed R8 stated he feels verbally abused by staff and that they often say things to intimidate residents like, don't forget I put you to bed at night During an interview on 05/28/25 at 5:26 PM, the Administrator and the Director of Nursing (DON) stated they did not conduct a thorough investigation and contact the police for R1 and R6 because the residents didn't want to press charges. They both stated that they thought if the resident did not want the police contacted then they did not need to contact the police. During an interview on 05/29/25 at 2:15 PM, the Administrator stated they received the information from the hospital soon after R8 went to the hospital. She stated she completed an investigation somewhere between 02/03/25 through 02/17/25. She stated the investigation was not completed timely after learning of the allegation from the hospital.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to revise the care plan for one resident [(R)4] of 20 after a change in the resident's medication self-administration status. This failure had the potential for the resident's need to be not known by nursing staff. Findings include: Review of facility's policy titled Comprehensive Care Plans revised 05/01/25 revealed: It is the guideline of this facility to develop and implement a comprehensive person-centered care plan for each resident .5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment . Review of the policy titled Resident Self-Administration of Medication revised 04/17/25 revealed: It is the guideline of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely .The care plan must reflect resident self-administration and storage arrangements for such medications . Review of R4's Minimum Data Set (MDS) with an Assessment Reference Date of 02/28/25 record located on the MDS tab of the electronic medical record (EMR) revealed R4 was readmitted to the facility on [DATE]. with diagnoses that included end stage renal disease, asthma, type 2 diabetes mellitus without complications, thoracolumbar region spondylopathies, paroxysmal atrial fibrillation, depression, intestinal obstruction, personal history of sudden cardiac arrest, and left knee arthritis. Review of R4's care plan located on the Care Plan tab of the EMR revealed, Medication Self-Administration: R4 has requested to execute right to self-administer medications revised 02/06/23; R4's prescribed medications will be safely stored and secure at bedside. Lock box secured on bedside table. Revision on: 04/08/2023 .R4 is able to self-administer scheduled medication per evaluation but is not able to administer any medications that have hold parameters. Revision on 04/08/23. During an interview on 05/27/25 at 3:24PM, R4 stated she is no longer permitted to self-administer her medications because she failed the test of not leaving a medication on the bedside table. R4 stated she used to be able to keep her medications in her room, but since she failed the test, she is no longer allowed to keep mediations to self-administer. During an interview 05/28/25 at 4:57 PM, the Director of Nursing (DON) stated R4 hoards her medications, leaves them at the bedside, and does not take them in a timely manner. When medications are scheduled to be taken twice daily, R4 would keep the morning dose and take both the morning and evening dose at once. The DON stated she determined this was not safe for R4 and after several violations, terminated R4's self-administration of medication. The DON stated she had two years of documentation of R4 being non-compliant with the terms of self-administration of medications. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Self-Administration of Medications Evaluation dated 01/02/25 located under the Assessment tab of the electronic medical record (EMR) revealed R4 was not safe to self-administer medications. When informed that R4's care plan has not been updated, the DON stated it should have been updated and that she was responsible for revising the care plan. The DON stated she just did R4's quarterly on 05/21/25 and must have missed updating that aspect of the care plan. During an interview on 05/29/25 at 11:00 AM, the Administrator provided the same care plan that indicated R4 could self-administer her medications. The Administrator stated she did not find any updated care plan.