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	06/18/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not notify 2 of 6 (R1 and R5) resident's representatives of the need to transfer to the hospital. R5's representative was not notified when they were transferred to the hospital.R1's representative was not notified when they were transferred to the hospital. Findings include: The facility policy titled Notification of Changes revised12/22/25 documents, .Circumstances requiring notification include: .2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: .4. A transfer or discharge of the resident from the facility .1. Competent individuals: a. The facility must still contact the resident's physician and notify the resident's representative, if known .c. When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident. 1) R5 was admitted to the facility on [DATE] with an activated POAHC (Power of Attorney for Health Care). On 6/16/26 at 11:00 AM, Surveyor spoke with R5's POAHC. She told surveyor that R5 was in and out of the hospital and the facility never called her whenever R5's health changed. Review of R5's medical record documented R5 was sent to the emergency room and/or hospitalized multiple times: 1/15/26 – sent to the emergency room for evaluation related to amputation site bleeding. There was no evidence that R5's representative/POA was notified of the transfer. 2/3/26 – sent to the emergency room for a change in condition/altered mental status. The Situation, Background, Appearance, Review and Notify (SBAR) form documented: Name of family/health care agent notified – Self. There was no evidence that R5's representative/POA was notified of the transfer. 2/21/26 – sent to the emergency room for a change in condition/altered mental status. The SBAR form documented: Name of family/health care agent notified – Self. There was no evidence that R5's representative/POA was notified of the transfer. 2/24/26 – sent to the emergency room due to hypoglycemia. There was no evidence that R5's (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative/POA was notified of the transfer. On 6/17/26 at 9:30 AM, Surveyor spoke with Director of Nursing (DON)-B related to notification of R5's POAHC. DON-B told Surveyor R5 didn't have a POA, that she was her own person. Surveyor asked if a resident is their own person and they are sent to the hospital for a change in condition, if the facility notifies the resident representative/emergency contact. DON-B stated, No, if they're their own person we don't have to call. Surveyor reviewed the facility's policy and procedure with DON-B which indicates notification should be completed. DON-B stated, Well I can tell you that my nurses do not call if they (residents) are their own person, and I can tell you she (R5) wouldn't have wanted her family notified. Surveyor asked DON-B if R5 was asked if she wanted her family notified and DON-B replied, No, but I just know. On 6/17/26 at 10:30 AM, DON-B provided Surveyor R5's POAHC document. DON-B told Surveyor the facility was not aware R5 had an activated POA until the hospital sent the paperwork after she was discharged . 2) R1 was admitted to the facility on [DATE]. R1's Annual Minimum Data Set (MDS) completed 5/15/26 documented R1's Brief Interview for Mental Status (BIMS) score to be 15, indicating R1 was cognitively intact for daily decision making. R1's ex-spouse was listed on R1's face sheet as R1's representative contact. On 5/13/26, R1 had a fall and R1 had informed staff they hit their head on the floor. R1 was sent to the emergency room. Surveyor reviewed the facility's fall investigation and noted there was no documentation that R1's representative contact had been notified by the facility that R1 had been sent to the emergency room. On 6/16/26, at 12:55 PM, Surveyor interviewed Unit Manager (UM)-J. UM-J informed Surveyor that the nurses should be contacting the representative contact when a resident goes to the emergency room. On 6/16/26, at 3:20 PM, Surveyor spoke with DON-B who explained that when a resident is their own person, the representative is not notified when a resident goes out to the hospital. On 6/17/26, at 9:37 AM, Surveyor asked R1 if R1 would like R1's representative contact notified in the event R1 would need to go to the hospital. R1 informed Surveyor: Yes, he is my ex-husband, but I would want him to know.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview the facility did not provide a safe, clean, comfortable and home-like environment for 1 (R7) of 4 resident's rooms observed.On 6/15/26 and 6/16/26 food crumbs, paper, and other debris were observed under & around R7's bed and under the bedside dresser.Findings include:On 6/16/26, at 10:12 a.m., Surveyor observed R7 in bed. Surveyor observed under R7's bed near the baseboard there is an accumulation of food crumbs, pieces of paper and other debris. On the floor near the head of R7's bed is a roll of tape. On the floor between the bed and the bedside dresser there is a treatment bottle, multiple straw papers and other debris. Under the bedside dresser there is an accumulation of dust, dirt and other debris.On 6/16/26, at 11:17 a.m., 1:12 p.m., and at 3:10 p.m., Surveyor observed R7's room under the bed as previously observed at 10:12 a.m. On 6/17/26, at 7:57 a.m. and at 12:03 p.m., Surveyor observed R7's room. The debris noted on 6/16/26 remained as previously described. On 6/17/26, at 12:06 p.m., while Surveyor was in R7's room, Nursing Home Administrator (NHA)-A approached and asked if everything was alright. Surveyor showed NHA-A food crumbs, paper, & other debris under R7's bed, roll of tape on the floor near the headboard, treatment bottle, multiple straw paper & other debris and under the bedside dresser an accumulation of dust, dirt & other debris. Surveyor informed NHA-A surveyor observed this yesterday during multiple observations. On 6/17/26, at 12:07 p.m., Surveyor asked Housekeeping Manager (HM)-H how she ensures resident's rooms are clean. HM-H explained they have a 5 to 7 step process. HM-H explained they grab the garbage, check supplies, wipe things down vertically & horizontally, dust mop, & damp mop. Surveyor asked HM-H to accompany surveyor to R7's room. When Surveyor & HM-H arrived at R7's room, the housekeeper was in the process of sweeping R7 room. Surveyor informed HM-H the observations of food particles, paper, dust, & other debris observed multiple times on 6/16/26 and 6/17/26. On 6/17/26, at 12:44 p.m., surveyor asked R7 if it was important to him to have a clean room. R7 replied yes, I like a clean room.

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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 and staff interviews, the facility did not ensure all allegations involving potential abuse, neglect, and misappropriation of resident property were thoroughly investigated for 2 of 2 Residents (R1 and R2) of 11 sampled residents.A facility reported incident (FRI) submitted to the State Agency on 5/8/26 stated that R1 had communicated that R2 had been harassing R1 which included R2 watching R1 when R1 slept. The FRI did not contain staff interviews or statements of who may have witnessed inappropriate behaviors from R2 directed at R1 or other residents.Based on record review and staff interviews, the facility did not ensure all allegations involving potential abuse, neglect, and misappropriation of resident property were thoroughly investigated for 2 of 2 Residents (R1 and R2) of 11 sampled residents.A facility reported incident (FRI) submitted to the State Agency on 5/8/26 stated that R1 had communicated that R2 had been harassing R1which included R2 watching R1 when R1 slept. The FRI did not contain staff interviews or statements of who may have witnessed inappropriate behaviors from R2 directed at R1 or other residents.Findings include:The facility's Abuse, Neglect and Exploitation policy and procedure reviewed/revised 5/13/26 documented:Explanation and Compliance Guidelines:.1.The facility will develop and implement written policies and procedures that:b.Establish policies and procedures to investigate any such allegationsV.Investigation of Alleged Abuse, Neglect and ExploitationA. An immediate investigation is warranted when suspicion abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.B. Written procedures for investigations include:1.Identifying staff responsible for the investigation;2.Exercising caution in handling evidence that could be used in a criminal investigation;3.Investigating different types of alleged violations;4.Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;5.Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause;6.Providing complete and thorough documentation of the investigation;7.Investigations involving alleged financial exploitation or misappropriation should include review of available financial records, copies/images of checks or transaction records, witness interviews, assessment of resident cognition and vulnerability, review of prior staff boundary concerns, and evaluation of whether additional residents may have been affected.R1 was admitted to the facility on [DATE] with diagnoses of Acquired Absence of Right Leg Below Knee, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Lymphedema, Anxiety Disorder, and Depression.R1's Annual Minimum Data Set (MDS) completed 5/15/26 documented R1's Brief Interview for Mental Status (BIMS) score to be 15, indicating R1 was cognitively intact for daily decision making.R2 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease, Peripheral Vascular Disease, Type 2 Diabetes Mellitus, Psychoactive substance abuse, Anxiety Disorder, and Depression.R2's Annual Minimum Data Set (MDS) completed 5/25/26 documented R2's Brief Interview for Mental Status (BIMS) score to be 15, indicating R2 was cognitively intact for daily decision making.A facility reported incident (FRI) submitted to the State Agency on 5/8/26 stated that R1 had communicated that R2 had been harassing R1which included R2 watching R1 when R1 slept. The FRI documented the facility could substantiate that R2 made unwelcome sexual comments to R1.The facility obtained one staff statement from Registered Nurse (RN)-K. RN-K documented that RN-K observed R1 crying and asked R1 what was wrong. R1 had stated that R2 had been harassing R1 and had told R1 R2 had watched R1 while R1 had slept and wanted to record R1.Surveyor noted the facility's investigation did not include any other staff statements. On 6/16/26, at 1:12 PM, Surveyor interviewed Social Worker (SW)-J in regard to the process of investigating FRIs. SW-J stated that SW-J obtains resident statements, and the Director of Nursing (DON)-B obtains the staff interviews.On 6/16/26, at 3:20 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON-B) in regard to the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process of investigating FRIs. Surveyor was informed that NHA-A or DON-B completes staff interviews and sometimes the unit manager. Surveyor was also informed that statements should be obtained from all staff members on shift. Surveyor shared that the FRI that involved R1 and R2 contained only one staff statement. Surveyor shared the concern that had the facility obtained other staff statements, the facility may have determined a pattern of R2's inappropriate behavior. Surveyor shared other staff members may have observed R2 demonstrating inappropriate behavior prior to the incident between R1 and R2 or R2 displaying inappropriate behavior toward other residents. Surveyor expressed that other staff statements may have indicated that R2 may have displayed inappropriate behavior toward vulnerable residents who had not been able to be interviewed.On 6/17/26, at 12:41 PM, Surveyor shared the concern with NHA-A and DON-B that the facility did not complete a thorough investigation of the FRI involving R1 and R2 as evidenced by the facility obtaining only one staff statement.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not provide a comprehensive care plan for 3 (R1, R2, and R10) of 11 residents reviewed for care plans*R1 had a history of trauma and did not have a comprehensive care plan with person centered interventions for trauma.*R2 had a history of trauma and did not have a comprehensive care plan with person centered interventions for trauma. R2 had been in an intimate relationship with R10 and did not have a comprehensive care plan with person centered interventions for an intimate relationship.*R10 had been in an intimate relationship with R2 and did not have a comprehensive care plan with person centered interventions for an intimate relationshipBased on interview and record review the facility did not provide a comprehensive care plan for 3 (R1, R2, and R10) of 11 sampled residents reviewed for care plans*R1 had a history of trauma and did not have a comprehensive care plan with person centered interventions for trauma.*R2 had a history of trauma and did not have a comprehensive care plan with person centered interventions for trauma. R2 had been in an intimate relationship with R10 and did not have a comprehensive care plan with person centered interventions for an intimate relationship.*R10 had been in an intimate relationship with R2 and did not have a comprehensive care plan with person centered interventions for an intimate relationshipFindings include:The facility's undated Social Services policy and procedure documented: .k. Identifying and seeking ways to support resident's dignity in full recognition of each resident's individuality.6.The resident's plan of care will reflect any ongoing medically-related social service needs, and how these needs are being addressed.The facility's reviewed/revised 8/12/25 Trauma Informed Care documented: .6.The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well ad identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the resident's care plan.7.Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression and anxiety.8. The facility will evaluate whether the interventions have been able to mitigate(or reduce) the impact of identified triggers on the resident that may cause re-traumatization.1) R1 was admitted to the facility on [DATE] with diagnoses of Anxiety Disorder and Depression.R1's Annual Minimum Data Set (MDS) completed 5/15/26 documented R1's Brief Interview for Mental Status (BIMS) score to be 15, indicating R1 was cognitively intact for daily decision making.R1's Social Service Evaluation completed 5/12/26 documented R1 had experienced physical assault. The Trauma Informed Care assessment documented verbal and some physical abuse with husband. Surveyor reviewed R1's comprehensive care plan and noted that R1's care plan did not document R1's history of trauma and did not have a comprehensive care plan with person centered interventions for trauma.On 6/17/26, at 8:55 AM, Surveyor interviewed Social Worker (SW)-I in regard to the development of comprehensive care plans. SW-I informed Surveyor that SW-I was responsible for the development of smoking, behaviors, elopement, code status, mood, cognitive, trauma, and substance abuse comprehensive care plans. Surveyor asked SW-I if R1's trauma would be something that should be part of R1's comprehensive care plan. SW-I confirmed that R1's trauma should be documented in R1's comprehensive care plan including person centered interventions for R1's trauma.On 6/17/26, at 12:41 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R1's trauma was not part of R1's care plan and included person centered interventions care plan. NHA-A and DON-B understood the concern.2) R2 was admitted to the facility on [DATE] with diagnoses of Psychoactive substance abuse, Anxiety Disorder, and Depression.R2's Annual Minimum Data Set (MDS) completed 5/25/26 documented R2's Brief Interview for Mental Status (BIMS) score to be 15, indicating R2 was cognitively intact for daily (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decision making.R2's Social Service Evaluation completed 4/14/26 documented R2 had experienced physical assault and assault with a weapon. The Trauma Informed Care assessment documented physical assaults with a belt and loss of mom and aunt unexpectedly passed.R2's Intimacy and Sexual History completed 1/30/26 documented R2 was in an intimate relationship with another resident.Surveyor reviewed R2's comprehensive care plan and noted that R2's care plan did not document R2's history of trauma and did not have a comprehensive care plan with person centered interventions for trauma. Further, R2's care plan did not document that R2 was in an intimate relationship with R10 with person centered interventions for an intimate relationship.On 6/17/26, at 8:55 AM, Surveyor interviewed Social Worker (SW)-I in regard to the development of comprehensive care plans. SW-I informed Surveyor that SW-I was responsible for the development of smoking, behaviors, elopement, code status, mood, cognitive, psychosocial, trauma, and substance abuse comprehensive care plans. Surveyor asked SW-I if R2's trauma with person centered triggers would be something that should be part of R2's comprehensive care plan. SW-I confirmed that R2's trauma person centered triggers should be documented in R2's comprehensive care plan. SW-I also confirmed that R2's intimate relationship with R10 should have been part of R2's comprehensive care plan which included person centered interventions. SW-I agreed that an intimate relationship would be a psychosocial concern to be included in a comprehensive care plan.On 6/17/26, at 12:41 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R2's trauma was not part of R2's care plan and did not have an intimate relationship with person centered interventions care plan. NHA-A and DON-B understood the concern.3)R10 was admitted to the facility on [DATE] with diagnoses of Depression.R10's Quarterly Minimum Data Set (MDS) completed 4/1/26 documented R10's Brief Interview for Mental Status (BIMS) score to be 14, indicating R10 was cognitively intact for daily decision making. R10's Intimacy and Sexual History completed 1/30/26 documented R10 was in an intimate relationship with another resident.Surveyor reviewed R10's comprehensive care plan and noted that R10's care plan did not document R10's intimate relationship with person interventions for an intimate relationship. On 6/17/26, at 8:55 AM, Surveyor interviewed Social Worker (SW)-I in regard to the development of comprehensive care plans. SW-I informed Surveyor that SW-I was responsible for the development of smoking, behaviors, elopement, code status, mood, cognitive, psychosocial, trauma, and substance abuse comprehensive care plans. SW-I confirmed that R10's intimate relationship with R2 should have been part of R10's comprehensive care plan which included person centered interventions. SW-I agreed that an intimate relationship would be a psychosocial concern to be included in a comprehensive care plan.On 6/17/26, at 12:41 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R10 did not have an intimate relationship with person centered interventions care plan. NHA-A and DON-B understood the concern.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on interview and record review the facility did not ensure that 1 (R4) of 5 sampled residents reviewed for activities of daily living (ADL) assistance received the necessary services to maintain ability to practice good grooming and personal hygiene.*R4 did not receive weekly shower on 1/27/26 and 3/10/26.Findings include:The facility's policy titled, Resident Showers last revised 6/11/25 documents 1. Residents will be provided with showers as per request and within reasonable accommodation, or as per facility schedule protocols (at least offered weekly) and based upon resident safety.R4's admission Minimum Data Set (MDS) with an assessment reference date of 1/27/26 has a BIMS of 15 which indicates cognitively intact and R4 is not assessed as having any behavior. R4 is assessed as requiring partial/moderate assistance for shower/bath and chair/bed to chair transfer.On 6/16/26 at 9:37 a.m. and at 9:58 a.m., Surveyor spoke with anonymous family members. During these conversations, Surveyor was informed that R4 complained of not receiving showers. Family indicated they spoke to a nurse about R4 not receiving showers but was unable to provide Surveyor with the name of the nurse they spoke to.On 6/16/26, at 2:03 p.m., during record review surveyor was unable to locate evidence when R4 received a shower.On 6/16/26, at 3:21 p.m., Surveyor requested R4's shower sheets from Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B surveyor asked for shower sheets.On 6/17/26, at 8:36 a.m., surveyor reviewed R4's shower sheets. Surveyor noted the shower sheets dated 1/27/26, 2/3/26, 2/17/26, 3/3/26, 3/10/26, 4/7/26, 4/14/26, and 4/21/26 are blank and do not indicate whether R4 received a shower or refused.On 6/17/26, at 9:01 a.m., surveyor asked Certified Nursing Assistant (CNA)-F about resident showers. CNA-F explained there is a shower binder, every morning the nurse fills out the shower sheets, so they know who has a shower. CNA-F informed Surveyor if a resident refuses, they let the nurse know and would write on the shower sheet refused, or if agree shower or bed bath. Surveyor asked CNA-F if she ever provided R4 with a shower. CNA-F replied yes and explained R4 refused some showers and received some showers.On 6/17/26, at 11:37 a.m., Surveyor asked Unit Manager (UM)-D the process for resident showers. UM-D explained when a resident is admitted they are assigned shower by their room & bed, and this is put in the task section. UM-D informed Surveyor if a resident refuses the shower, it is documented on the sheet and the CNA has to chart under the task. Surveyor informed UM-D that R4's shower sheets had been reviewed and noted multiple days when the shower sheets do not indicate R4 received a shower or refused. UM-D informed surveyor she remembers R4 family said she hadn't had a shower but R4 refused it. UM-D informed surveyor she will look into R4's showers and get back to surveyor.On 6/17/26, Surveyor was provided with additional documentation regarding R4's showers. Surveyor was not provided with documentation for 1/27/26 and 3/10/26 as to whether R4 had received a shower or evidence R4 refused.

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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** Based on observation, interview, and record review, the facility did not ensure 2 (R3 of R7) of 4 residents had a comprehensive assessment and care plan to either prevent and/or heal pressure injuries.R7 had a deep tissue injury upon admission. On 4/2/26 Wound Physician-G assessed R7's pressure injury as a Stage 3 left buttocks pressure injury and ordered a treatment. The order wasn't picked up until 4/4/26 and was transcribed incorrectly. R7's pressure injury was documented as healed on 4/9/26. There was no update to the care plan to address the potential for impaired skin integrity. The pressure injury reopened on 4/23/26. The facility didn't revise R7's pressure injury care plan nor was there any evidence the facility reviewed the care plan and determined the care plan remained appropriate after R7's pressure injury reopened. R3's admission evaluation on 1/15/26 did not comprehensively assess wounds (skin tear and pressure injury) present upon admission with no documentation of characteristics/description of wound bed or staging. R3 was not adequately assessed until seven days later, on 1/22/26 when the pressure injury had worsened and new treatment physician orders were obtained. The facility did not contact the wound physician when pressure injury worsened. Findings: The facility's policy titled, Pressure Injury Prevention and Management, dated 2/14/23, states, .The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate .Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Findings should include the type of wound, wound measurements (measured upon discovery and at least weekly thereafter), other wound characteristics (color, exudate, odor, pain, tissue type in wound bed), and treatment and interventions implemented .After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. b. Interventions will be based on specific factors identified in the risk assessment (e.g. moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). 1) R7's diagnoses include functional quadriplegia, moderate protein calorie malnutrition and schizoaffective disorder bipolar type. R7's admission/readmission/routine head to toe assessment dated [DATE] completed by Registered Nurse (RN)-P under the skin integrity section, identifies site 23 (coccyx) as a Stage 2, 3.5 x (by) 3.5 cm (centimeter). R7's admission minimum data set (MDS) with an assessment reference date of 4/2/26 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R7 requires substantial/maximal assistance for roll left & right, and is dependent for toileting hygiene, chair to bed transfer & toilet transfer. R7 has an indwelling urinary catheter and is always incontinent of bowel. R7 is at risk for pressure injuries and is assessed as having one Stage 3 pressure injury which was present upon admission. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's pressure injury care area assessment (CAA) dated 4/3/26 documents that R7 has potential/actual skin impairment related to a number of diagnoses including functional quadriplegia, adult failure to thrive, intervertebral disc degeneration lumbar region with discogenic back pain only, pressure wound left buttock, trauma wound to BLE bilateral lower extremity. The care plan considerations section was not completed. R7'scare plan initiated and revised on 4/2/26 includes a problem area of, The resident has pressure injury left of the coccyx/buttock r/t (related to).history of ulcers, immobility, deconditioning, and weakness. The complete list of interventions were all initiated on 4/2/26: *Administer medications as ordered. Monitor/document the side effects and effectiveness. *Administered treatments as ordered and monitor for effectiveness. *Follow facility policies/protocols for the prevention/treatment of skin breakdown. *Inform the resident/family/caregivers of any new area of skin breakdown. *Monitor nutritional status. Serve diet as ordered, monitor intake and record. *Obtain and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow up as indicated. *Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. *The resident requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. * Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. *Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Wound Physician-G's assessment dated [DATE] for left buttocks documents for etiology Pressure Ulcer Stage 3. ~Wound bed assessment documents granulation 51-75%, slough 1-25%. Measurements were length 1.29 cm, width 0.89 cm and depth 0.10 cm. ~Treatment: Protect peri wound with skin prep. Cleanse with 1/2 strength Dakin's solution. Secondary dressings: Cover wound with Bordered foam. ~Dressing frequency: Change daily and PRN (as needed) soiling/saturation of dressing. Surveyor reviewed R7's April 2026 Treatment Administration Record (TAR). The TAR indicated R7's treatment of the pressure injury had a start dated of 4/4/26, which is 2 days after the order was placed. The treatment included, cleanse left buttocks wound with 1/2 strength Dakins solution and pat dry. Skin Prep peri wound. Cover wound with foam dressing. every day shift every Tue (Tuesday), (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Wound care is blank 5/27/26 and 6/2/26. 6/5/26-Present: Cleanse left buttocks wound with saline and pat dry. Skin prep peri wound. Cover wound with foam dressing every day shift for wound care related to pressure ulcer of left buttock, Stage 3. *Wound care is blank on 6/9/26, 6/11/26, and 6/12/26. On 6/17/26, at 11:40 a.m., surveyor asked UM-D how the nurses know what treatment they need to complete on their shift. UM-D informed surveyor it is documented on the TAR for them and they sign off on the treatment record. Surveyor asked what it means if the TAR does not have a check and initial. UM-D stated if it's not charted it's not done. 2) R3 was admitted to the facility on [DATE] with restlessness and agitation, malnutrition, and stroke. R3's comprehensive MDS (Material Data System) dated 1/21/26, documented, R3 was severely cognitively impaired, dependent on staff for mobility, incontinent of bladder and bowel, had 1 pressure injury and was at risk for pressure injuries. R3's Progress Note dated,1/15/2026 12:27 PM, documented, Resident arrived to facility .Resident has hx (history) of strokes and seizures .Resident a 0.5cm by 0.5cm OA (Open Area) to coccyx . R3's admission Head-to-toe Evaluation was completed by Licensed Practical Nurse (LPN)-Y dated 1/15/26, documented R3 is at risk for skin alterations and has skin alterations. R3 was identified as having a coccyx wound. The assessment did not include characteristics of the wound such as color, exudate, odor, pain, tissue type in wound bed. The assessment also does not include the stage of the pressure injury. R3's Physician Orders dated 1/15/26 included: ~clean coccyx with NS (normal saline) and place boarder foam 3x (times) a week T, TH, SAT (Tuesday, Thursday, and Saturday) for wound care one time a day . ~Weekly skin check by licensed nurse every day shift every Thu for Preventative Wound Care. ~Braden Scale is to be completed weekly for 4 weeks every day shift every Thu for 4 Weeks Please ensure a Braden Scale Assessment is opened and completed. R3's Physicain Orders were updated on 1/16/26 and included: ~FOOT CHECK (PVD): Visual check of skin condition of both feet, toes, and heels, including color and temperature. ~Air Mattress- Check functioning every shift every shift for Monitoring. R3's care plan dated 1/15/26 included a focus area of actual impairment to skin integrity. Interventions included: Assist to turn and/or reposition every 2-3 hours. Date initiated: 01/15/2026. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Date (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Initiated: 01/15/2026. Encourage good nutrition and hydration in order to promote healthier skin. Date Initiated: 01/15/2026. Float heels if resident cannot turn and reposition themselves. Date Initiated: 01/15/2026. Monitor skin during cares. Report to nurse any changes. Date Initiated: 01/15/2026. Pressure reduction mattress. Date Initiated: 01/15/2026. The resident needs pressure reducing cushion to protect the skin while up in wheelchair. Date Initiated: 01/15/2026. Weekly licensed nurse skin evaluation. Date Initiated: 01/15/2026. R3's Wound Summary dated 1/22/26, documented by Wound Registered Nurse (Wound RN)-E, stated R3 wound site was changed from Coccyx to Sacrum and clinically staged as unstageable. The tissue type was slough loosely adherent 100% with moderate-serous exudate. Wound measuring at 3.0 x1.2 x .10 and no signs and symptoms of infection. R3's Physician Order, dated 1/22/26, documented, Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to Sacral wound topically every evening shift for Wound care Cleanse wound to Sacrum with 1/2 strength Dakins solution and pat dry. Skin prep peri wound. Apply Santyl-Nickel thick to wound bed and cover with Bordered gauze. On 6/16/26 at 3:09 PM, Surveyor interviewed Director of Nursing (DON)-B and asked if there was any evidence of a comprehensive wound assessment upon R3's admission on [DATE]. DON-B stated that when R3 was admitted on [DATE], wound rounds had already been completed and the next time the Wound Physician and Wound Nurse would be at the facility would have been on 1/22/26. DON-B stated that was when the wounds were comprehensively assessed. DON-B was asked if a nurse was to asses R3's wounds upon admission and complete a comprehensive assessment to include measurements, wound bed characteristics/description and staging. DON-B stated the admitting nurse is responsible to assess all of this and it is not appropriate that this did not occur. On 6/17/26 at 9:04 AM, Surveyor asked DON-B if there was any additional information for R3's comprehensive assessment. DON-B stated that they could not find any evidence. DON-B stated it was an LPN who did the admission assessment for R3, so this is why the comprehensive wound assessment was not completed.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide behavioral health services to ensure a resident received the highest practicable mental and psychosocial well-being. The facility did not implement person centered interventions for substance use disorder (SUD) for 1 of 1 resident (R2) reviewed for SUDs.Based on interview and record review, the facility did not provide behavioral health services to ensure a resident received the highest practicable mental and psychosocial well-being. The facility did not implement person centered interventions for substance use disorder (SUD) for 1 of 1 resident (R2) reviewed for SUDs.Findings include:The facility's undated Social Services policy and procedure documented: .k. Identifying and seeking ways to support resident's dignity in full recognition of each resident's individuality.5.The facility should provide social services or obtain needed services from outside entities during situations that include but not limited to the following:c.Abuse of any kind(e.g. alcohol or other drugs).The facility's reviewed/revised 8/12/25 Trauma Informed Care documented: .7.Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery.The Facility Assessment reviewed 4/27/26 documented:.The facility provided care to residents with psychosis, impaired cognition, mental disorder, depression, bi-polar disorder, schizophrenia, post-traumatic stress disorder(PTSD), history of alcohol abuse, anxiety disorder, expressions that need interventions.Manage medical conditions and medical-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment care of individuals with depression, trauma/PTSD, other psychiatric diagnosis, alcohol/drug abuse, intellectual or developmental disabilities, behavior contracts.R2 was admitted to the facility on [DATE] with diagnoses of Psychoactive substance abuse, Anxiety Disorder, and Depression.R2's Annual Minimum Data Set (MDS) completed 5/25/26 documented R2's Brief Interview for Mental Status (BIMS) score to be 15, indicating R2 was cognitively intact for daily decision making.Surveyor reviewed R2's comprehensive care plan:R2 presents with (history/current) of alcohol/drug abuse. R2 engages in this behavior(weekly). R2 is a risk for alcohol/drug abuse related complications.Initiated 2/17/23Interventions:-Notify social worker to assist with services and offer as needed 2/17/23-Staff should not pass judgement and offer reassurance to R2 2/17/23-Contact doctor for next steps 2/17/23-If R2 is found to be intoxicated staff should contact facility administrator right away 2/17/23-Nurse should ensure incident report is completed, progress note completed and all notifications are made in real time 2/17/23-R2 supplied with facility alcohol anonymous meeting calendar 11/3/23R2 is at risk for substance abuse related current/historical use of other psychoactive substance abuseInitiated 8/6/24Interventions:-Educate resident(R2) on ways to utilize coping skills to deal with feelings of desire for my(R2) preferred substance of choice 8/6/24-Report any suspected use of substances to my(R2) physician 8/6/24R2's Social Services Evaluation completed 4/14/26 documented:R2 had a history of alcohol use and family had a history of substance use. R2 currently or had a history of misusing prescription drugs.R2's Bedside Kardex as of 6/16/26 documented: .If you suspect R2 had been using non-prescribed substances, notify supervisor immediately.Surveyor reviewed R2's progress notes located in R2's electronic medical record.5/6/26, at 7:15 AM, R2 in dining room in wheelchair. Arms flaccid. Not responding to verbal stimuli. Mumbling with eyes closed. Shallow breaths. Narcan given for suspected overdose. 911 called. When EMTs arrived, R2 became more alert at this time. Transfer to emergency room for further evaluation and treatment.On 5/6/26, at 11:36 AM, R2 discharged to 911 transfer due to altered mental status possible overdose.R2's hospital Discharge summary dated [DATE] (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented:.R2 with known history of chronic pain issues who ingested some pain medications of sorts and quite somnolent and given intranasal Narcan while in the emergency room. R2 relates that R2 had been very tired and apparently takes oxycodone consistently R2 vapes and R2 also pockets pills and may have actually taken stronger dose than R2 was supposed to. Suicidal or homicidal. R2 denies any drug usage outside of what is prescribed. After Narcan R2 was awake and alert and responsive. R2 presented likely overmedicated or took excessive amounts of R2's pain medications and subsequently became obtunded and lethargic. Regardless R2 was given Narcan and improved significantly supporting the initial consideration.Surveyor noted R2's labs documented in R2's hospital discharge summary noted R2 tested positive for Barbiturates and Cannabinoids.On 5/8/26, Nurse Practitioner (NP)-L documented:.R2 had a history of opioid abuse who was seen today per the nurse's request with reports of opioid abuse. R2 took oxycodone-acetaminophen 325 mg every 6 hours as needed for chronic pain. R2 admits to pocketing the medication and had an overdose requiring Narcan.Plan:Opioid abuse: Monitor for withdrawal. Evaluate need. Assess for sweating, stomach pain, nausea, and emesis. Use Narcan as needed and discontinue the Percocet. Start Tramadol 100mg three times a day and refer to pain management.On 6/17/26, at 9:08 AM, Surveyor interviewed NP-M. NP-M was informed that R2 had been pocketing and snorting pills. NP-M did not want to jeopardize NP-M's license so switched R2 to Tramadol. NP-M informed Surveyor that NP-M was unaware of any prior history of opioid abuse.On 5/25/26, R2 was seen for an individual psychotherapy follow-up session by Psychologist Nurse Practitioner (Psych NP)-M. Psych NP-M documented .R2 has a history of opioid addiction and abuse. Currently has no access to these medications. Continue to monitor status.On 6/17/26, at 9:19 AM, Surveyor interviewed Psych NP-M via telephone. NP-M was aware that NP-M was aware that R2 had overdosed on medications and needed Narcan but did not believe it was a suicide attempt. NP-M was unable to inform Surveyor why NP-M had no documentation of the drug overdose being addressed.On 6/16/26, at 12:24 PM, Surveyor interviewed Resident Care Coordinator (RCC)-N. RCC-N was familiar with R2 but was surprised that R2 had a drug overdose and was not aware of any prior incident with alcohol or drugs.On 6/16/26, at 12:55 PM, Surveyor interviewed Unit Manager (UM)-J in regard to R2. UM-J believed R2's overdose was undetermined. UM-J was aware that R2 required a Narcan at the facility and at the hospital. UM-J believed the overdose was a Delta 8 and UM-J did report to NP-L. UM-J agreed that nursing staff should watch R2 take medications and should not be left at the bedside.On 6/16/26, at 1:12 PM, Surveyor interviewed Social Worker (SW)-I. SW-I was told that R2 had overdosed on gas station THC. SW-I confirmed that SW-I was not aware that the hospital discharge summary documented R2 had been pocketing R2's medications.On 6/16/26, at 3:20 PM, Director of Nursing (DON)-B informed Surveyor that the facility could not prove R2 had an overdose of pain medications. DON-B stated that Delta 8 was the cause of the overdose but agreed that Narcan would have only worked on an overdose of pain medications. DON-B informed Surveyor that DON-B was unaware that the hospital record indicated that R2 had hoarded medications and overdosed.On 6/17/26, at 8:07 AM, both Nursing Home Administration (NHA)-A and DON-B informed Surveyor that NHA-A and DON-B was unaware of what was written in R2's hospital discharge summary. DON-B stated UM-J completed an investigation but was not formal. The facility had no documented investigation of R2's drug overdose to provide Surveyor for review. UM-J made NP-L aware of the hospital documentation. Surveyor shared the concern that UM-J did not communicate the hospital documentation to administration of the facility. DON-B stated, I just found out about it last night. NHA-A stated, it is a problem that we did not know about the documentation from the hospital discharge summary.NHA-A informed Surveyor that a formal investigation should have been completed. Surveyor shared without a formal investigation it was not clear if R2 had been pocketing medications and nursing staff were not watching R2 take, or were they left at bedside. DON-B stated that R2 was always at the nurse's cart asking for R2's pain medications.On 6/17/26, at 8:55 AM, SW-I informed Surveyor that SW-I believed Psych-NP-M was aware of R2's overdose, but SW-I had no documentation to provide. SW-I again informed Surveyor that SW-I was not aware of the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital discharge summary documentation that R2 of R2's overdosing on pain medications. SW-I confirmed the facility was aware of a history of alcohol and opioid abuse.On 6/17/26, at 12:41 PM, Surveyor shared the concern that the facility was aware of R2's history of alcohol and opioid abuse. Interventions were not implemented and R2 had an overdose while a resident in the facility. Surveyor shared that a formal investigation was not completed and R2's overdose was not addressed upon R2's return from the hospital. NHA-A and DON-B understood the concern.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review, the facility did not ensure 2 (R1 and R11) of 4 sampled residents reviewed received medically related social services to address individual Resident needs in order to maintain the highest practicable physical, mental, and psychosocial well-being.*R1and R11were in an intimate relationship and the facility did not complete an Intimate and Sexual History and did not complete a comprehensive care plan with person centered interventions. Findings include:The facility's Social Services undated policy and procedure documented:.2.The facility, regardless of size, will provide medically-related social services to each resident, to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.3.The social worker, will complete an initial and quarterly assessment of each resident, identifying any need for medically-related social services of the resident. Any need for medically-related social services will be documented in the medical record.a.Advocating for residents and assisting them in assertion of their rights withing the facility.k.Identifying and seeking ways to support residents' individual needs through the assessment and care planning process.1)R1 was admitted to the facility on [DATE] with diagnoses of Anxiety Disorder, and Depression.R1's Annual Minimum Data Set (MDS) completed 5/15/26 documented R1's Brief Interview for Mental Status (BIMS) score to be 15, indicating R1 was cognitively intact for daily decision making.2)R11 was admitted to the facility on [DATE] with diagnoses of Anemia, Essential Hypertension, and Hypokalemia.R11's Annual Minimum Data Set (MDS) completed 5/19/26 documented R11's Brief Interview for Mental Status (BIMS) score to be 15, indicating R11 was cognitively intact for daily decision making.On 6/16/26, at 8:54 AM, Surveyor observed R1 and R11 holding hands in R1's room. Both R1 and R11 sitting in wheelchairs close together in the doorway of R1.On 6/16/26, at 10:55 AM, Surveyor interviewed R1. R1 informed Surveyor that R1 and R11 had been in a serious relationship since about October 2025. R1 shared that R1 and R11 sign up for private time in the conference room.On 6/16/26, at 12:24 PM, Surveyor interviewed Resident Care Coordinator (RCC)-N. RCC-N had been aware that R1 and R11 had been in a relationship.On 6/16/26, at 12:55 PM, Surveyor interviewed Unit Manager (UM)-J in regard to R1 and R11's relationship status. UM-J was aware that R11 is R1's boyfriend and had been for a while. UM-J displayed happiness for both R1 and R11 during the discussion with Surveyor.On 6/16/26, at 1:12 PM, Surveyor interviewed Social Worker (SW)-I. SW-I stated SW-I was aware that R1 and R11 had been spending more time together and had been getting closer in the past couple of weeks. SW-I was aware that R1 and R11 had been using the conference room for privacy. SW-I stated, I guess I will have to talk to them about their relationship. SW-I stated SW-I just started completing Intimacy and Sexual History assessments but everyone should have had one completed by now. SW-I stated the Intimacy and Sexual History assessments are completed on admission. SW-I stated a care plan would be initiated based on the outcome of the Intimacy and Sexual History assessment.Surveyor noted that both R1 and R11 did not have a completed Intimacy and Sexual History assessment and both R1 and R11 did not have a completed intimate relationship care plan initiated with person centered interventions.On 6/16/26, at 1:36 PM, Surveyor observed both R1 and R11 outside on the patio holding hands.On 6/16/26, at 3:38 PM, Surveyor interviewed Director of Activities (DA)-O in regard to R1 and R11. DA-O had been aware of R1 and R11's relationship and displayed happiness while discussing the relationship. DA-O stated R1 and R11 were very good together, very cute. DA-O stated R1 and R11 had been serious since about February and was very happy for R1 and R11's recent engagement.On 6/17/26, at 12:41 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that staff were aware that R1 and R11 were in an intimate relationship and both R1 and R11 did not have a completed Intimacy and Sexual History assessment and both R1 and R11 did not have a completed intimate relationship care plan initiated with person centered interventions.

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	525318	A. Building B. Wing	06/18/2026

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	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility did not provide pharmaceutical services to meet the needs of each resident for 1 (R4) of 1 sample resident.R4's blood sugar was not monitored to determine whether R4 required Novolog sliding scale three times daily and R4's Lantus 4 units at bedtime was not administered on 2/6/26 and 3/18/26.Findings include:R4's diagnoses include type 1 diabetes mellitus with diabetic neuropathy and type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema.R4's physician orders with an order date 1/21/26 documents Lantus Subcutaneous Solution 100 unit/ml (milliliter) (Insulin Glargine) Inject 4 unit subcutaneously at bedtime for DM (diabetes mellitus).R4's physician orders with an order date of 1/21/26 documents Novolog injection solution 100 unit/ml (Insulin Aspart) Inject as per sliding scale: if 0-150 = 0 units; 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units and call MD (medical doctor), subcutaneously with meals for DM.On 6/18/26, at 12:33 p.m., Surveyor reviewed R4's January 2026, February 2026, March 2026 and April 2026 MARs (medication administration record)Surveyor noted for R4's Novolog sliding scale on 1/30/26 at 8:00 a.m. and 12:00 p.m. the blood sugar is documented as NA. On 1/31/26 at 8:00 a.m. the blood sugar is documented as NA. Surveyor did not note any code on the MAR for NA.On 2/6/26 R4's scheduled Lantus 4 units at 2000 (8:00 p.m.) documents BS. According to chart codes on the February MAR, BS (blood sugar) no coverage required per scale. Lantus is a scheduled insulin and not sliding scale.Surveyor noted during February 2026 for R4's Novolog sliding scale blood sugar documents the following:On 2/2/26 8:00 am the blood sugar is documented as NA and 12:00 p.m. the blood sugar is blank.On 2/3/26 at 1200 the blood sugar is documented as NA.On 2/4/26 at 8:00 a.m. the blood sugar is documented as NA and 12:00 p.m. the blood sugar is blank.On 2/5/26 at 8:00 a.m. the blood sugar is documented as NA.On 2/9/26 at 8:00 a.m. the blood sugar is documented as NA.On 2/10/26 at 8:00 a.m. the blood sugar is documented as NA and at 12:00 p.m. the blood sugar is blank.On 2/13/26 at 8:00 a.m. the blood sugar is documented as NA.On 2/16/26 at 12:00 p.m. the blood sugar is blank.On 2/18/26 at 12:00 p.m. the blood sugar is documented as NA.On 2/23/26 at 8:00 a.m. the blood sugar is documented as NA.On 2/27/26 at 12:00 p.m. the blood sugar is documented as NA.On 2/28/26 at 0800 a.m. the blood sugar is documented as NA.On 3/18/26 R4's scheduled Lantus 4 units at 2000 (8:00 p.m.) is blank.Surveyor noted during March 2026 for R4's Novolog sliding scale the following:On 3/2/26 at 8:00 a.m. the blood sugar is documented as NA.On 3/5/26 at 8:00 a.m. and 1700 (5:00 p.m.) the blood sugar is documented as NA.On 3/9/26 at 12:00 p.m. the blood sugar is documented as NA.On 3/10/26 at 8:00 a.m. and 12:00 p.m. the blood sugar is documented as NA.On 3/16/26 at 12:00 p.m. the blood sugar is blank.On 3/17/26 at 8:00 a.m. the blood sugar is NA.On 3/18/26 at 12:00 p.m. the blood sugar is blank.On 3/19/26 at 8:00 a.m. the blood sugar is documented as NA and at 12:00 p.m. the blood sugar is blank.On 3/24/26 at 12:00 p.m. the blood sugar is blank.On 3/27/26 at 12:00 p.m. the blood sugar is blank.On 3/28/26 at 8:00 a.m. and 12:00 p.m. the blood sugar is blank.On 3/30/26 at 8:00 a.m. and 12:00 p.m. the blood sugar is blank.Surveyor noted during April 2026 for R4's Novolog sliding scale blood sugar documents the following:On 4/1/26 at 12:00 p.m. the blood sugar is blank.On 4/2/26 at 8:00 a.m. the blood sugar is documented as NA and at 12:00 p.m. the blood sugar is blank.On 4/4/26 at 12:00 p.m. the blood sugar is blank.On 4/6/26 at 8:00 a.m. and 12:00 p.m. blood sugar is blank.On 4/7/26 at 12:00 p.m. the blood sugar is blank.On 4/13/26 at 8:00 a.m. and 12:00 p.m. the blood sugar is blank.On 4/20/26 at 8:00 a.m. the blood sugar is documented as NA.On 4/21/26 at 12:00 p.m. the blood sugar is documented as NA.On 4/28/26 at 8:00 a.m. the blood sugar is documented as NA, at 12:00 p.m. the blood sugar is blank and at 1700 (5:00 p.m.) the blood sugar is documented as NA.On 4/30/26 at 8:00 a.m. and 12:00 p.m. the blood sugar is documented as NA.On 6/18/26, at 1:46 p.m., Surveyor spoke with Director of Nursing-B (DON). Surveyor asked DON-B why R4's blood sugars were documented as NA. DON-B informed surveyor Novolog is in their contingency medications. DON-B (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed Surveyor she was looking at R4's MAR and then R4's nurses notes and stated to surveyor I can't even answer. I can look into this and get back to you. Surveyor then informed DON-B on 2/6/26 R4's Lantus which is scheduled has no coverage. DON-B informed surveyor she will look into this. Surveyor then informed DON-B of the dates for February & March when R4's blood sugar is documented as NA or blank. DON-B informed surveyor this is not acceptable, blank is also a problem R4's a type 1, if it's not documented it's not done. On 6/18/26 at 2:49 p.m. DON-B telephoned surveyor. DON-B informed surveyor every single one of those dates are one nurse. DON-B informed Surveyor she called and interviewed LPN-C who told her R4's blood sugars were always below parameters, NA is not administered, and there are no nurses' notes including the 3/18/26 Lantus. DON-B informed Surveyor the nurse she didn't know she had to document the actual blood sugar number. DON-B informed Surveyor there were times when it was done correctly. DON-B indicated LPN-C reported it takes too much time to pull up the progress note and write everything as she is very busy in the morning and afternoon. DON-B stated to Surveyor all she can say is, it's deficient practice.On 6/18/26 at 3:04 p.m., surveyor interviewed LPN-C on the telephone. LPN-C informed Surveyor she always checked R4's blood sugar and her blood sugars usually ran low. LPN-C informed Surveyor she clicked on not applicable. LPN-C informed surveyor that she didn't put in a progress note and the blank ones may have been an oversight.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review the facility did not ensure a resident's physician was promptly notified of laboratory results that fall outside of clinical reference ranges for 1 (R4) of 1 sample resident.R4's physician was not notified of abnormal laboratory results on 4/10/26 and 4/21/26.Findings include:The facility's policy titled, Provider Lab Notification and last revised 05/07/26 under guideline documents It is the expectation of this facility to ensure the timely receipt, review, interpretation, and communication of laboratory results, and prompt notification of the provider (physician, physician assistant, nurse practitioner, or clinical nurse specialist) in accordance with professional standards of practice and resident condition. Under explanation and compliance guidelines documents 1. The facility must promptly notify provider of lab results that fall outside of clinical reference ranges and/or critical labs per ordering physician's orders. Delayed notification may contribute to delays in changing the course of treatment or care plan. 4. If lab results are outside of clinical reference range, indicated on lab result report, provider will be notified within 4-8 hours of receiving results. Notifications and recommendations will be documented in the medical record. If new orders are received, orders will be entered into the medical record and new orders implemented as directed.R4's diagnoses include hyperkalemia and chronic kidney disease, stage 4.R4's physician order dated 3/3/26 documents BMP (basic metabolic panel) every 2 weeks r/t (related to) hypokalemia, sodium levels.R4's nurses note dated 4/8/26 at 11:19 a.m. written by Unit Manager (UM)-J documents K+ (potassium) noted at 6.2. Writer spoke with MD (medical doctor) and N.O. (new order) for Kayexalate obtained. Order placed. First dose obtained from contingency. Repeat BMP 4/10.On 6/16/26 surveyor reviewed R4's medical record and was unable to locate R4's BMP from 4/10/26On 6/16/26, at 3:21 p.m., during the end of the day meeting surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B surveyor was unable to locate R4's BMP in the medical record for 4/10/26 and asked for R4's lab results.On 6/17/26, at 8:22 a.m., Surveyor reviewed R4's comprehensive metabolic panel results dated 4/9/26 which were not within clinical reference range for potassium 5.3 (3.4-5.1), chloride 120 (97-110), carbon dioxide 14 (21-32), glucose 140 (70-99), BUN 67 (6-20), creatinine 5.34 (0.51-0.95), glomerular filtration rate 11 (>= (greater equal) 60) and calcium 7.2 (8.4-10.2). Surveyor was unable to locate in R4's medical record that R4's physician was notified of these results.Surveyor reviewed R4's comprehensive metabolic panel results dated 4/21/26 which were not within clinical reference range for potassium 5.8 (3.4-5.1), chloride 121 (97-110), carbon dioxide 13 (21-32), BUN 60 (6-20), creatinine 5.47 (0.51-0.95), glomerular filtration rate 10 (>= 60) and calcium 7.5 (8.4-10.2). Surveyor was unable to locate in R4's medical record that R4's physician was notified of these results.On 6/17/26, at 9:17 a.m., Surveyor asked Licensed Practical Nurse (LPN)-C asked about resident's labs. LPN-C informed surveyor the unit managers are handling the labs right now. Surveyor asked LPN-C who would notify the physician of resident's labs. LPN-C informed surveyor if the labs are critical she would. If abnormal not critical name of Unit Manager (UM)-D would.On 6/17/26, at 9:20 a.m., Surveyor asked UM-D to explain the facility's lab process. UM-D informed surveyor everyone is suppose to have a log for the lab but for whatever reason some floor nurses don't initiate the log. UM-D informed surveyor when the nurse gets an order for labs, they give it to her, and she puts the lab orders in. Surveyor asked where lab results are received. UM-D explained the labs are faxed to the printer by the receptionist. Sometimes the floor nurses will get the lab results and sometimes they are in her mailbox. Surveyor asked UM-D who notifies the physician when the lab results are abnormal. UM-D informed surveyor the floor nurse once they get the results. Surveyor informed UM-D that LPN-C reported Surveyor UM-D completes the notification. UM-D replied no, explaining it's the floor nurse. Surveyor informed UM-D R4's labs were not within range on 4/9/26 and 4/21/26 and Surveyor was unable to locate when R4's physician was notified of these abnormal labs. UM-D informed surveyor she will look into this and get back to (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor.On 6/17/26, at 9:47 a.m., UM-D informed surveyor she didn't see anything charted regarding R4's abnormal labs on 4/9/26 and 4/21/26.

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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. Based on observation, interview, and record review the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 1 (R7) of 2 Residents.*Staff were not wearing gowns during care observations for R7 who is on EBP (enhanced barrier precautions) and appropriate hand hygiene was not observed during pressure injury treatment. Findings include:The facility's policy titled, Enhanced Barrier Precautions and last revised 9/9/25 under guidelines documents It is the guideline of this facility to implement enhanced barrier precaution for the prevention of transmission of multidrug-resistant organisms. Under explanation and compliance guidelines for 3. Implementation of Enhanced Barrier Precautions documents.b. PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact resident care activities include a. Dressing; b. Bathing; c. Transferring; d. Proving hygiene; e. Changing linens; f. Changing briefs or assisting with toileting; g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) lines, midline catheters; h. Wound care: any skin opening requiring a dressing.The facility's policy titled, Hand Hygiene and last revised 3/27/25 under guidelines documents All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Under 6. Additional considerations documents a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.R7's diagnoses include functional quadriplegia and schizoaffective disorder bipolar type.R7's physician orders dated 3/27/26 documents Enhanced Barrier Precautions r/t (related to) wound.R7's admission minimum data set (MDS) with an assessment reference date of 4/2/26 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R7 requires substantial/maximal assistance for roll left & right, and is dependent on toileting hygiene, chair to bed transfer & toilet transfer. R7 has an indwelling urinary catheter and is always incontinent of bowel. R7 is at risk for pressure injuries and is assessed as having one Stage 3 pressure injury which was present upon admission.On 6/16/26, at 10:12 a.m., Surveyor observed an enhanced barrier precaution sign posted outside R7's room.On 6/16/26, at 10:50 a.m., Surveyor observed Certified Nursing Assistant (CNA)-F in the process of providing morning cares for R7. CNA-F handed R7 a washcloth and R7 washed their own face. After R7 face was washed, CNA-F positioned R7 on the left side, washed R7's back and removed the incontinence product. Surveyor observed CNA-F is not wearing appropriate Personal Protective Equipment (PPE) as CNA-F has gloves on but is not wearing a gown. CNA-F removed the dressing from R7's left buttocks, washed R7's buttocks and placed an incontinent product under R7.On 6/16/26, at 10:56 a.m., Licensed Practical Nurse (LPN)-C entered R7's room, placed a gown on, washed her hands, and placed gloves on. LPN-C placed the treatment supplies on the overbed table. Surveyor observed LPN-C did not disinfect the overbed table prior to placing the treatment supplies on the overbed table. LPN-C opened her treatment supplies and asked CNA-F to turn R7 on the side. LPN-C cleansed R7's left buttock pressure injury with normal saline, padded the wound bed with gauze and asked R7 if he was okay. LPN-C did not remove her gloves and perform hand hygiene. LPN-C applied skin prep around the peri wound stating it's going to be a little cold. LPN-C removed her gloves and placed gloves on. LPN-C did not perform any hand hygiene. LPN-C placed a border foam dressing over R7's pressure injury, removed her gloves, reached into her pocket for a marker & dated the dressing.At 11:03 a.m., R7 was positioned on their back and CNA-F pulled the incontinence product up between R7's legs. R7 spoke to CNA-F about the foley catheter and then CNA-F asked LPN-C if she could do R7's foley. LPN-C replied I can, stated she needed an alcohol wipe, removed her PPE and left R7's room. Surveyor observed LPN-C did not perform any hand hygiene prior to leaving R7's room. At 11:05 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., LPN-C entered R7's room and placed appropriate PPE on. LPN-C cleaned the end of R7's foley catheter, flushed the catheter and then stated okay now I'm done. LPN-C removed her PPE, washed her hands, and left R7's room. CNA-F fastened R7's incontinence product, placed pants & shirt on R7, and a Hoyer sling under R7. CNA-F removed her gloves & washed her hands. CNA-F returned with a Hoyer lift and CNA-Q entered R7's room shortly after. Surveyor observed CNA-F & CNA-Q only had gloves on and are not wearing a gown. The sling was attached to the Hoyer lift and CNA-F & CNA-Q transferred R7 into the wheelchair. CNA-Q placed the Hoyer lift in the hallway and did not return to R7's room. CNA-F placed R7's feet on the foot pedals, brushed R7's hair and placed R7's wheelchair alongside the bed. CNA-F removed her gloves, washed her hands and left R7's room.On 6/16/26, at 11:21 a.m., Surveyor asked CNA-F why she wasn't wearing a gown when she was providing cares & transferring R7 into the wheelchair. CNA-F replied I'm pretty sure it's for bed B and he's in the hospital.On 6/17/26, at 7:48 a.m., Surveyor observed CNA-F in R7's room. Surveyor observed CNA-F was not wearing a gown. CNA-F stated we're finished and placed pants on R7. CNA-F stated to R7 we're going over and R7 was positioned from side to side to place a Hoyer sling under R7.At 7:51 a.m., CNA-F left R7's room with soiled items in a bag.At 7:53 a.m., CNA-F and CNA-R entered R7's room with a Hoyer lift and placed gloves on. Surveyor observed CNA-F & CNA-R were not wearing a gown. The Hoyer sling was attached to the lift and R7 was transferred into the wheelchair. CNA-R placed the Hoyer lift in the hallway, removed his gloves & washed his hands. CNA-F brushed R7's hair, removed her gloves and wheeled R7 out of the room towards the dining room.On 6/17/26, at 11:51 a.m., Surveyor asked Unit Manager (UM)-D how a CNA is aware a resident is on enhanced barrier precautions. UM-D informed surveyor there is PPE outside the door and a sign on the door. Surveyor informed UM-D of the observations with CNA-F, CNA-Q & CNA-R not wearing appropriate PPE and CNA-F informing Surveyor she believed it was R7's roommate who is on enhanced barrier precautions and that resident is in the hospital. Surveyor asked UM-D after a pressure injury is cleansed with normal saline should the nurse remove her gloves & perform hand hygiene and after removing gloves should hand hygiene be performed. UM-D replied yes. Surveyor asked UM-D where a nurse should place treatment supplies in a resident's room. UM-D informed surveyor the nurse should clean off the over bed table before placing treatments supplies on the overbed table. Surveyor informed UM-D of the observations of UM-D not performing hand hygiene and not disinfecting the overbed table prior to placing treatment supplies on the overbed table.