STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525335	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawano Health Services	1436 S Lincoln St Shawano, WI 54166

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation, staff interview, and record review, the facility did not ensure appropriate treatment to promote healing of a pressure injury was provided for 1 resident (R) (R6) of 1 sampled resident.R6 had a stage 2 pressure injury on the right heel which was present upon re-admission to the facility. During an observation of wound care, Registered Nurse (RN)-F used soiled scissors to cut a clean dressing that was applied to R6's right heel pressure injury. Findings include:The facility's Clean Dressing Change policy, revised 1/19/26, indicates: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross contamination.From 2/15/26 to 2/17/26, Surveyor reviewed R6's medical record. R6 had diagnoses including a stage 2 pressure injury on the right heel, diabetes, Alzheimer's disease, and venous insufficiency. R6's Minimum Data Set (MDS) assessment, dated 12/13/25, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R6's cognition was severely impaired.R6's medical record contained dressing change instructions (dated 2/3/26) for a stage 2 pressure injury on R6's right heel that indicated to cleanse the wound with antiseptic solution 0.25% moistened gauze, gently pat dry, cover with antibacterial foam dressing, cover with an ABD pad, wrap with Kerlix (gauze dressing), secure with tape, and change twice daily and as needed.On 2/16/26 at 9:32 AM, Surveyor observed RN-F provide wound care for R6's right heel. RN-F cut R6's soiled outer Kerlix dressing with scissors and set the soiled scissors outside of the clean field that contained R6's clean wound dressings. RN-F removed the soiled dressings and cleansed the wound. Without cleaning the scissors used to remove the soiled dressing, RN-F used the scissors to cut a clean antibacterial foam dressing to size, put the dressing over R6's wound, and completed wound care as ordered.On 2/16/26 at 9:48 AM, Surveyor interviewed RN-F who confirmed RN-F should have cleansed the scissors to prevent wound contamination prior to cuting the antibacterial foam dressing that was applied to the wound.On 2/16/26 at 1:29 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed RN-F should have cleansed the scissors between dirty and clean wound care procedures.

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R5) of 3 sampled residents received appropriate care and services to prevent urinary tract infections (UTIs).The facility did not provide catheter care for R5 in a manner that decreased R5's risk for infection. Findings include:The facility's Catheter Care policy, revised 3/15/23, indicates: It is the policy of this facility to ensure residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use .Privacy/dignity bags will be available and catheter drainage bags should be covered or shielded at all times while in use .On 2/15/26, Surveyor reviewed R5's medical record. R5 had diagnoses including benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, other obstructive and reflux uropathy, and personal history of malignant neoplasm of bladder. R5's Minimum Data Set (MDS) assessment, dated 11/13/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R5 had severe cognitive impairment. R5 had an activated healthcare decision maker.A care plan indicated R5 required an indwelling Foley catheter due to bladder cancer and BPH secondary to urinary obstruction. The care plan indicated R5's catheter collection bag should be in a dignity bag holder on R5's bed/wheelchair. The care plan also indicated R5 was at risk for infection due to an indwelling Foley catheter. The care plan contained an goal that R5 would be free from infection through the review date.R5's medical record indicated R5 was prescribed macrobid (an antibiotic) for five days for a UTI on 1/6/26.On 2/15/26 at 9:51 AM, Surveyor observed R5 asleep in a recliner. R5's catheter bag was hung from a Hoyer sling that was behind R5. Surveyor noted R5's catheter bag was in contact with the floor without a barrier or dignity bag. On 2/15/26 at 9:58 AM, Surveyor interviewed Registered Nurse (RN)-C who verified R5's catheter bag was in contact with the floor. RN-C indicated the catheter bag should be in a dignity bag and stated RN-C would ensure a dignity bag was provided and the bag was hung off of the floor.

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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 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 observation, staff and resident interview, and record review, the facility did not provide pharmaceutical services to meet the needs of 3 residents (R) (R2, R42, and R1) of 7 sampled residents.R2 received a 750 milligram (mg) calcium carbonate chewable tablet during the 3:00 PM medication pass on 2/15/26. R2 should have received a 500 mg calcium carbonate chewable tablet.R42's polyethylene glycol 3350 was left at the bedside on 2/16/26. R42 did not have a self-administration of medication assessment or a physician's order that indicated R42 could safely and accurately self-administer the medication. R1 had an order for ipratropium-albuterol inhalation solution 0.5-2.5 mg inhaled via nebulizer four times daily for chronic obstructive pulmonary disease (COPD). On 2/15/26, R1 administered the nebulizer independently. R1 did not have a self-administration of medication assessment or a physician's order that indicated R1 could safely and accurately self-administer the medication. Findings include: The facility's Medication Administration General Guidelines policy, dated January 2025, indicates: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices, and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medication Administration: 1. Medications are administered in accordance with the written orders of the prescriber .5. The person who prepares the dose for administration is the person who administers the dose .15. Residents are allowed to self-administer medication when specifically authorized by the prescriber, the nursing care center's Interdisciplinary Team (IDT) and in accordance with procedures for self-administration of medication and state regulations. 1. From 2/15/26 to 2/17/26, Surveyor reviewed R2's medical record. R2 had diagnoses including dementia, dysphagia, chronic obstructive pulmonary disease (COPD), heart failure, depression, anxiety, and gastroesophageal reflux (GERD) without esophagitis. R2's Minimum Data Set (MDS) assessment, dated 12/16/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had intact cognition. R2 had a legal Guardian who assisted with decision making. R2's medical record contained an order for calcium carbonate 500 mg chewable tablet by mouth four times daily for GERD (started on 12/18/25). On 2/15/26 at 3:04 PM, Surveyor observed Registered Nurse (RN)-G put a 750 mg chewable calcium carbonate tablet in a medication cup to administer to R2. RN-G verified the medication was a 750 mg fruity chewable tablet. At approximately 3:05 PM, Surveyor observed RN-G administer the tablet to R2. On 2/16/26 at 1:25 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R2 should have received a calcium carbonate 500 mg chewable tablet instead of a 750 mg chewable tablet. 2. From 2/15/26 to 2/17/26, Surveyor reviewed R42's medical record. R42 had diagnoses including progressive multiple sclerosis, paraplegia, hypertension, and depression. R42's MDS assessment, dated 2/9/26, had a BIMS score of 12 out of 15 which indicated R42 had moderately impaired cognition. R42 made R42's own medical decisions. R42's care plan, dated 2/9/26, did not indicate R42 could self-administer medication. R42's medical record did not contain an order or assessment for self-administration of medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/26 at 7:20 AM, Surveyor observed Licensed Practical Nurse (LPN)-H leave polyethylene glycol 3350 mixed with water in a cup at R42's bedside. LPN-H left R42's room and continued to administer medication to other residents. On 2/16/26 at 8:27 AM, Surveyor returned to R42's room and noted the cup of polyethylene glycol 3350 was empty and on R42's breakfast tray. On 2/16/26 at 8:31 AM, Surveyor interviewed LPN-H who stated LPN-H was not sure if R42's polyethylene glycol 3350 could be left at the bedside. On 2/16/26 at 1:26 PM, Surveyor interviewed DON-B who verified R42 did not have an order or assessment for self-administration of medication and polyethylene glycol should not have been left at the bedside. 3. On 2/15/26, Surveyor reviewed R1's medical record. R1 had diagnoses including COPD and chronic respiratory failure with hypoxia. R1's MDS assessment, dated 12/2/25, had a BIMS score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker. A care plan indicated R1 had an activities of daily living (ADL) deficit and nursing staff should visually inspect R1's mouth after medication administration to ensure medications were swallowed. The care plan also indicated R1 received steroid therapy to treat congestive heart failure (CHF)/COPD exacerbation and was at risk for adverse effects. The care plan contained an intervention to administer steroid therapy per physician orders. R1's medical record contained an order for ipratropium-albuterol inhalation solution 0.5-2.5 mg inhaled orally via nebulizer four times daily for COPD. The order did not indicate R1 could self-administer the medication. R1's medical record did not contain a self-administration of medication assessment. On 2/15/26 at 9:31 AM, Surveyor observed R1 in a recliner administering a nebulizer treatment independently. There were no nursing staff in the room or in the hallway. On 2/15/26 at 10:03 AM, Surveyor interviewed R1 who stated staff set up the nebulizer, R1 administers the medication, and staff return after the treatment is completed. On 2/15/26, Surveyor requested a self-administration of medication order and assessment for R1 from Nursing Home Administrator (NHA)-A. On 2/15/26 at 5:44 PM, Surveyor received email from NHA-A that indicated the facility did not have a self-administration of medication order or assessment for R1 and all medication should be administered by nursing staff. On 2/16/26 at 1:27 PM, Surveyor interviewed DON-B who indicated in order to self-administer medication, R1 should have a self-administration of medication assessment that indicates R1 can safely and accurately self-administer medication. DON-B confirmed R1 did not have a self-administration of medication assessment and stated nursing staff should remain with R1 while the nebulizer is administered.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview, and record review, the facility did not ensure physician-ordered diets and menus were followed to meet nutritional needs for 3 residents (R) (R22, R14, and R5) of 3 sampled residents.R22, R14 and R5 had orders for a pureed diet. Staff did not ensure the required serving size of pureed items were served to meet R22, R14, and R5's nutritional needs.Findings inlcude:The facility's (contracted company's) Therapeutic Diets policy, revised 9/2017, indicates: All residents have a diet order, including regular, therapeutic, and texture modification, that is prescribed by the attending physician, physician extender, or credentialed practitioner in accordance with applicable regulatory guidelines .Diets are prepared in accordance with the guidelines in the approved diet manual and the individualized plan of care .On 2/16/26, Surveyor reviewed R22's medical record. R22 had diagnoses including dementia and type 2 diabetes mellitus. R22's Minimum Data Set (MDS) assessment, dated 2/26/26, had a Brief Interview for Mental Status (BIMS) score of 3 out of 3 which indicated R22 had severely impaired cognition. R22 had a court-ordered Guardian for healthcare decisions.A care plan indicated R22 was at risk for nutritional status change related to altered mental status, type 2 diabetes, and obesity and required a mechanically-altered diet. The care plan indicated R22 had significant weight loss on Hospice care and had increased nutrient needs related to wound healing, including an open area on the right buttock and a blister on the right lateral foot. The care plan contained a goal that R22 would experience no significant weight changes x 30-180 days per MDS criteria. The care plan contained an intervention to provide diet as ordered.R22's medical record contained an order for a pureed diet.A nutritional assessment, dated 2/3/26, indicated R22 had an order for a mechanically-altered diet and had skin conditions, including an abrasion on the right elbow, a fluid-filled blister on the right lateral foot, and an open area on the right buttock.R22's total caloric daily need was 1400-1700 calories and total protein daily need was 69-83 grams. R22's average meal intake average was 51%-100%.On 2/16/26, Surveyor reviewed R14's medical record. R14 had diagnoses including Alzheimer's disease, type 2 diabetes mellitus, dysphagia, and unspecified severe protein-calorie malnutrition. R14's MDS assessment, dated 1/23/26, had a BIMS score of 0 out of 15 which indicated R14 had severely impaired cognition. R14 had an activated healthcare decision maker.A care plan indicated R14 was at risk for nutrition related to Alzheimer's disease, major depressive disorder, type 2 diabetes, and anemia and had a history of significant weight loss and a need for pureed-texture meals and honey-thickened liquids. The care plan contained goals that R14's skin would show signs/symptoms of healing by the review date and R14 would maintain weight as evidenced by no significant weight changes (>/= 5% in 30 days, >/= 7.5% in 90 days, or >/= 10% in 180 days). The care plan contained an intervention to provide diet as ordered. The care plan also indicated R14 was at risk for nutritional status change related to Alzheimer's/dementia, dysphagia, hypertension, and Hospice care and indicated R14 had inadequate oral intake related to poor appetite and significant weight loss in the past month.R14's medical record contained an order for a pureed diet.A nutritional assessment, dated 1/20/26, indicated R14 had an order for a mechanically-altered diet and weight maintenance was beneficial. R14 had skin conditions, including moisture-associated skin damage (MASD) on the right buttock. R14's total caloric daily need was 1300-1600 calories and total protein daily need was 65-78 grams. R14's meal intake average was 51%-100%.On 2/16/26, Surveyor reviewed R5's medical record. R5 had diagnoses including Alzheimer's disease, dementia, and dysphagia. R5's MDS assessment, dated 11/29/25, had a BIMS score of 0 out of 15 which indicated R5 had severely impaired cognition. R5 had an activated healthcare decision maker.A care plan indicated weight management was beneficial related to Hospice care and R5 was at risk for nutritional status change related to Alzheimer's/dementia, dysphagia, hypertension, and Hospice care. The care plan indicated R5 had an inability to manage self-care related to dementia and Alzheimer's disease and inadequate oral intake related to poor appetite as evidenced by significant weight loss in (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the last month (dated 1/6/26). The care plan contained an intervention to provide diet as ordered.R5's medical record contained an order for a pureed diet.A nutritional assessment, dated 11/18/25, indicated R5 had an order for a mechanically-altered diet. R5's total caloric daily need was 1400-1700 calories and total daily protein need was 69-83 grams. R5's average meal intake was 25-100%.On 2/16/26 at 7:22 AM, Surveyor observed [NAME] (CK)-E serve breakfast from the steam table. Surveyor observed CK-E serve R22, R14 and R5 pureed egg bake with a 3 ounce (oz) scoop. The menu indicated the serving size for pureed egg bake was 4 oz. During an observation that began at 11:27 AM on 2/16/26, Surveyor observed CK-E prepare pureed food for lunch. CK-E put three 4 oz scoops of ravioli in a food processor to puree. CK-E indicated CK-E takes three 4 oz scoops of food for each resident on a pureed diet and uses the scoop to put an appropriate amount on each resident's plate. CK-E then portioned ravioli on plates for R22, R14, and R5 with a 4 oz ladle. The menu indicated the serving size for ravioli was 6 oz.On 2/16/26 at 1:00 PM, Surveyor interviewed Dietary Manager (DM)-D who confirmed CK-E served lunch to R22, R14, and R5 with the wrong size scoop and provided R22, R14, and R5 with the wrong portion of ravioli.