STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525377	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Door County Memorial Hospital Snf	323 S 18th Ave Sturgeon Bay, WI 54235

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure an activated Power of Attorney for Healthcare (POAHC) and physician were notified timely of a change in condition for 1 resident (R) (R7) of 12 sampled residents.R7 sustained a skin tear of unknown origin on 6/7/25. R7's physician and POAHC were not notified of the injury until 6/10/25. Findings include:The facility's Notification of Changes in Condition or Status of Resident policy, revised 7/31/24, indicates: To assure that each resident receives prompt, high quality nursing service and medical care .Changes in a resident's condition or treatment are immediately shared with the resident and/or resident representative, according to their authority, and reported to the attending physician .1. Appropriate notification of the resident's physician .Resident and/or resident representative if any, and any other responsible person designated in writing .occurs in the event of the following: A. An unexpected or substantive change in the resident's physical, communicative, psychosocial, or functional status; B. An accident or injury that may involve physician intervention .1. Requirements for the notification of resident, their representative, and their physician: A. An accident involving the resident which results in injury and has the potential for requiring physician intervention .2. The nurse will immediately notify the resident, resident representative, physician, and as appropriate, the resident's Healthcare Power of Attorney (HCPOA) .An accident involving the resident which results in injury and has the potential for requiring physician intervention .4. If the attending physician or designated alternate is not available or does not respond appropriately, he/she must take further steps to obtain service for the resident. a. Notify the on- call physician. B. Notify Director of Nursing (DON) or designee .c. If the DON or designee is not immediately available, call the Medical Director .On 7/2/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including myasthenia gravis, hypertension, heart failure, and depression. R7's most recent Minimum Data Set (MDS) assessment, dated 6/24/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R7 had severely impaired cognition. On 7/2/25, Surveyor reviewed a facility-reported incident (FRI) that indicated R7 sustained a skin tear on the right upper arm which was identified on 6/7/25 between 7:00 and 7:45 PM. Registered Nurse (RN)-Q identified the skin tear during a skin assessment and prepared a physician update statement on 6/8/25 at 2:46 AM with instructions to send the fax to the physician with the update. On 7/2/25 at 12:11 PM, Surveyor interviewed RN-N who indicated RN-N sent a fax to the physician on 6/10/25 regarding R7's skin tear that was identified on 6/7/25. RN-N indicated the skin tear was small and if it had been larger, the on-call physician would have been notified. RN-N indicated the facility does not have a policy that indicates when a skin tear should be reported to the physician. RN-N indicated R7's POAHC was also notified of the skin tear on 6/10/25. On 7/2/25 at 1:00 PM, Surveyor interviewed RN-O who indicated it is up to the nurse's discretion when to notify the physician of a skin tear. RN-O indicated RN-O would only notify the on-call physician if the skin tear required medical attention such as stitches. RN-O indicated RN-O would update the physician on Monday if the skin tear occurred over the weekend if that was okay with the resident's POAHC. On 7/2/25 at 1:49 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility does not have a policy for reporting skin tears. NHA-A indicated a resident's POAHC should be notified immediately of a skin tear, usually within 24 hours. NHA-A indicated the on-call physician should be notified if a resident falls or hits their head, then clarified the physician should also be notified right away for skin tears. NHA-A indicated there are on-call physicians for weekends and nursing staff should follow-up with a fax to the resident's primary physician.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not report allegations of abuse and an injury of unknown origin to the State Agency (SA) for 3 residents (R) (R1, R10, and R7) of 4 sampled residents.R1 reported an allegation of abuse on 4/10/25. The facility did not report the allegation of abuse to the SA until 4/15/25. During an abuse investigation for R2, R10's Resident Representative ((RR)-E) reported an allegation of abuse involving Certified Nursing Assistant (CNA)-G and R10. The facility did not report the allegation of abuse to the SA. R7 had an injury of unknown origin that was discovered on 6/8/25. The facility did not report the injury of unknown origin to the SA until 6/11/25.Findings include: The facility's Prevention, Investigating, and Reporting Violations of Resident Rights Including Allegations of Abuse, Neglect, Misappropriation of Property and Injuries of Unknown Origin policy, revised 4/23/25, indicates: Any employee or contractor who witnesses or becomes aware of alleged misconduct, as defined in this policy, by another employee or contractor is to report such incident to the Nursing Home Administrator (NHA) and Director of Nursing (DON), Social Worker (SW), or Human Resources (HR) Department within 24 hours .Local law enforcement will also be notified of any situation where there is potential criminal offense .Notification of law enforcement and/or State Agency (SA) .as indicated .If the injury is unexplainable and if abuse is substantiated and if there is caregiver negligence or a therapeutic error that resulted in injury, a report must be made to Wisconsin Department of Health Services/Division of Quality Assurance within 24 hours of the findings. A. Within five business days of the original report, the NHA, DON, or SW will make a final decision regarding the outcome of the investigation .It is the policy of the facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property) are reported per federal and state law. The facility will ensure all alleged violations involving abuse, neglect, exploitation, mistreatment, and injuries of unknown origin are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the NHA or designee in accordance with state law. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility . 1. On 7/2/25, Surveyor reviewed a facility-reported incident (FRI) that alleged CNA-G pulled R1's hair in the dining room during lunch. The 24-hour report indicated the date discovered was 4/15/25 and the report was submitted on 4/16/25. The five-day investigation was submitted on 4/18/25. The investigation indicated CNA-K notified Registered Nurse (RN)-J on 4/10/25 at 5:30 PM that another resident had pulled R1's hair. RN-J interviewed R1 who indicated CNA-G had pulled R1s hair. Surveyor noted the incident occurred on 4/10/25 but was not reported to the SA until 4/15/25.On 7/2/25, Surveyor reviewed R1's medical record. R1 had diagnoses including bilateral leg weakness, cellulitis, lymphoma, and multiple sclerosis. R1's Minimum Data Set (MDS) assessment, dated 6/24/25, had a Brief Interview for Mental (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker.On 7/2/25 at 11:35 AM, Surveyor interviewed R1 who indicated CNA-G pulled R1's hair. R1 indicated it upset R1 at the time which is why R1 told another CNA and RN-J talked to R1 about the incident. R1 indicated CNA-G was kidding, however, R1 did not know CNA-G was kidding at first. R1 thought CNA-G pulled R1's hair to make R1 upset and swore at CNA-G when CNA-G pulled R1's hair twice. R1 indicated CNA-G should have told R1 that it was a joke and said, Who pulls someone's hair? Kids do that. On 7/2/25 at 2:26 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who reviewed the FRI and indicated the allegation of abuse was reported and documented on 4/10/25 and interviews were done on 4/10/25. NHA-A indicated NHA-A thought the incident was a joke and that R1 was not upset and knew CNA-G was joking. NHA-A thought R1 was fine with the incident and stated there was no indication of an issue until R1 spoke with Social Worker (SW)-C on 4/15/25 and indicated the incident had upset R1. NHA-A verified NHA-A did not follow-up with R1 about the incident on 4/11/25 and indicated the allegation of abuse should have been reported within 24 hours. 2. On 7/2/25, Surveyor reviewed a FRI, dated 3/10/25, regarding an allegation of abuse between R2 and CNA-L. The investigation included resident and family interviews. RR-E was interviewed on 3/10/25 and indicated RR-E was not concerned for the safety of residents, however, sometimes CNA-F talked roughly and R10 appeared tense around CNA-F. On 7/2/25 at 2:10 PM, Surveyor interviewed RR-E who indicated no one followed-up with RR-E regarding the allegation of abuse and the care provided to R10 by CNA-F. RR-E indicated

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure allegations of abuse and an injury of unknown origin were thoroughly investigated for 4 residents (R) (R1, R2, R10, and R7) of 8 sampled residents. R1 reported an allegation of abuse by Certified Nursing Assistant (CNA)-G on 4/10/25. The facility did not remove CNA-G from resident care pending an investigation or provide staff education regarding appropriate behavior with residents and professional boundaries. In addition, a skin assessment was not completed until two days after the allegation was reported.R2's family reported an allegation of abuse that involved CNA-L. The facility did not provide staff education on the facility's abuse policy or education on appropriate behavior during resident care. In addition, during the abuse investigation for R2, R10's Resident Representative ((RR)-E) reported an allegation of abuse involving R10 and CNA-F. The facility did not investigate the allegation of abuse.R7 had a skin tear that was discovered on 6/7/25. The facility did not provide thorough staff education regarding wearing jewelry, appropriate fingernail length, and selecting the correct sling size following the injury of unknown origin. Findings include:The facility's Prevention, Investigating, and Reporting Violations of Resident Rights Including Allegations of Abuse, Neglect, Misappropriation of Property, and Injuries of Unknown Origin policy, revised 4/23/25, indicates: The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention. The abuse policy will be reviewed on an annual basis .to identify the plan of investigation should such allegations or injuries occur and to protect the resident during the investigation .It is the policy of this facility to train employees, through orientation and ongoing sessions, on issues related to abuse and prohibition practices .Staff and volunteers will receive education about resident mistreatment, neglect, and abuse, including injuries of unknown source .upon first employment and annually after that. Staff will be trained to immediately report to the appropriate person all allegations of misconduct including abuse, neglect, misappropriation of client property, and injuries of unknown origin .Occurrences, patterns, and trends that may constitute abuse will be investigated .The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. The investigation form will include comments, insights from staff who worked the previous two and current shift, other residents, family, and visitors as determined reasonable .The charge person will immediately assess the resident's personal safety and potential of harm to other residents. If the alleged perpetrator is named, that individual should leave resident care areas immediately. A complete body assessment will be completed. An assessment of the victim for psychosocial changes will be completed and medical/psychosocial treatment and support will be provided as necessary .The Nursing Home Administrator (NHA) or designee with be notified and an investigation will be initiated immediately .The charge person and NHA will determine whether an accused caregiver or another alleged perpetrator may continue to have contact with residents when the investigation is complete .a. Procedures must be in place to provide the resident with a safe, protected environment during the investigation: .i. The alleged perpetrator will immediately be removed and the resident protected. Employees accused of alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation .Education will be provided as needed to all parties involved .1.On 7/2/25, Surveyor reviewed a facility-reported incident (FRI) that indicated R1 reported that CNA-G pulled R1's hair in the dining room during lunch. The 24-hour report indicated the discovery date was 4/15/25 and the report was submitted on 4/16/25. The five-day report was submitted on 4/18/25. The five-day report indicated Registered Nurse (RN)-J was notified by CNA-K on 4/10/25 at approximately 5:30 PM that another resident pulled R1's hair. RN-J spoke with R1 who indicated CNA-G pulled R1's hair. The FRI indicated education was provided to CNA-G by Social Worker (SW)-C on appropriate ways to interact with residents and professional boundaries. The FRI also indicated CNA-G was able to return to work after the education was provided. Surveyor noted the FRI did not include education for other staff and a skin assessment to check for injuries was not completed until after R1's weekly scheduled shower on 4/12/25. On 7/2/25, Surveyor reviewed R1's medical record. R1 had diagnoses including bilateral leg weakness, cellulitis, lymphoma, and multiple sclerosis. R1's Minimum Data Set (MDS) assessment, dated 6/24/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker On 7/2/25 at 11:35

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure medical records contained accurate and complete documentation for 2 residents (R) (R3 and R4) of 12 sampled residents.R4 hit R3 in the legs on 5/9/25. Neither R3 or R4's medical records contained documentation of the altercation. Findings include: On 7/2/25, Surveyor reviewed a facility-reported incident (FRI) that was submitted to the State Agency (SA) on 5/9/25 and indicated Certified Nursing Assistant (CNA)-I observed R4 hit R3 in the legs when CNA-I walked by R3's room. CNA-I indicated R3 was in bed and R4 was in a wheelchair in R3's room. CNA-I brought R4 out of R3's room and reminded R4 not to hit R3. R4 responded, I can. The nurse assessed R3's skin and found no injuries. R3 and R4's representatives were notified and had no concerns. Local law enforcement was notified and indicated no further action was necessary. The physician was informed of R4's increasing behaviors and prescribed sertraline (an antidepressant medication). R3 denied that anyone had hurt R3 and did not report any pain. Neither R3 or R4 could recall the incident. On 7/2/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's dementia, diabetes, and cerebrovascular accident (CVA) (stroke). R3's Minimum Data Set (MDS) assessment, dated 4/22/5, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R3 had severely impaired cognition. R3 had an activated Power of Attorney for Healthcare (POAHC). On 7/2/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including memory impairment gradual onset and osteoarthritis. R4's MDS assessment, dated 6/17/25, had a BIMS score of 3 out of 15 which indicated R4 had severely impaired cognition. R4 had an activated POAHC. Surveyor noted the altercation was not documented in R3 or R4's medical records, including where and what occurred, interventions implemented to deescalate of the situation, physical and psychosocial assessments of R3 and R4, whether R3 and R4's representatives were notified, and whether R3 and R4's care plans were reviewed or revised. Surveyor noted it was difficult to ascertain whether R3 and R4's care plans were reviewed or revised after the altercation because dates were not included with interventions that were handwritten on the care plans. R3's care plan indicated R3 had a diagnosis of Alzheimer's dementia (created 2/13/25). A handwritten intervention indicated: Staff will help redirect me when I'm unaware of going into other residents' personal space to help avoid others from being upset with me (the intervention was not dated and did not contain the initials of who made the addition). R4's care plan indicated R4 became more confused during the evening hours (created 1/30/25) and contained and intervention that indicated: During the evening hours, I become more confused. Historically, I have been concerned about safety and intruders coming into my home. With my confusion, I may feel threatened by others (in the evening was crossed out in pen and did not contain a date or initials to signify who made the change) due to this. Staff will ensure my safety and help me with distancing from others when I feel this way.On 7/2/25 at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was unsure if R3 and R4's care plans were reviewed or revised since revision dates were not clearly documented. NHA-A also verified R3 and R4's medical records did not contain documentation of the altercation.