

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Hayward Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 10775 Nyman Ave Hayward, WI 54843	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure resident (R) was cared for in a manner to enhance their quality of life (R1). Facility staff administered diuresis medication of Furosemide 80 mg (milligrams) at 8:48 AM and Furosemide 80 mg at 10:10 AM. before R1 was going to an appointment outside the facility premises where R1 could not properly be toileted when needed. R1 suffered 3 incontinent episodes and became emotionally upset and affected by the incontinence episodes. Findings include: R1 was admitted to the facility on [DATE] with diagnoses including, in part, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disorder (COPD), pleural effusion, acute respiratory failure with hypoxia, and hypertension. R1's Minimum Data Set (MDS) assessment, dated 07/16/26, indicated R1 had Brief Interview of Mental Status (BIMS) score of 15/15, which means intact cognition. R1's urinary incontinence related to decreased mobility and receiving large doses of diuretics during the day, care plan states: -Administer medication per provider orders initiated on 12/23/24. -Provide incontinent care as needed on 12/23/24. R1's Activities of Daily Living (ADL) care plan, states, in part: -Toileting: assist of 2 using bed pan initiated on 12/23/24. -Transfer: mechanical lift using XXL size sling initiated on 05/13/26. R1's physician treatment orders: -Furosemide Oral Tablet 40 MG (Furosemide), Give 2 tablet by mouth two times a day related to CHF started on 12/21/24. Facility schedule identified R1's counseling appointment was at 1:00 PM, with transportation pick up time at 12:30 PM. R1's Medication Administration Record (MAR) identified R1 was given Furosemide 80 mg on 07/13/26 at 8:48 AM and then second dose at 10:10 AM. On 07/28/26 at 11:01 AM, Surveyor entered R1's room to interview R1. Surveyor asked R1 if they asked facility not to give them the diuretic before their counseling appointment on 07/13/26. R1 reported to Surveyor they have been going to counseling once a month for the last year and nursing staff usually will hold the diuretic pill until they get back to the facility between 1:30-2:00 PM. On 07/13/26, a nurse gave R1 the diuretic pill before their counseling appointment which then led to R1 urinating in pants 3 times. R1 stated, There is no way for the counseling office to transport me, as I am a Hoyer lift. R1 returned to the facility upset. R1 stated, I get really emotional when I pee my pants, and I don't know why the nurse would do this to me. While R1 was speaking to Surveyor, Surveyor observed R1 become emotional and their eyes welling up with tears. Surveyor asked R1 if staff was upset or rude with them for the incontinent urine episode upon returning to facility with a wet brief. R1 reported to Surveyor the staff were not upset at all with them but were concerned about their skin condition. R1 reported to Surveyor facility staff changed them right away. On 07/28/26 at 11:37 AM, Surveyor entered Nursing Home Administrator (NHA) A's office with Regional Director of Nursing (DON) C, and DON B. Surveyor asked Regional DON C and DON B if Surveyor could have them review R1's MAR (Medication Administration Record) for 07/13/26 with Surveyor. Surveyor observed Furosemide 80 (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mg given at 8:48 AM and 10:10 AM. Surveyor asked DON B if administering R1's Furosemide 80 mg prior to their counseling appointment, was appropriate when where there was no way for the counseling center to transfer R1 to a toilet while at appointment. DON B reported to Surveyor R1's Furosemide should have been held prior to their appointment since they only last about an hour, then they would not have had to experience the incontinent episodes while out of the facility.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not provide care and treatment by professional standards of practice to maintain a resident's highest practicable level of physical well-being for 1 of 3 residents (R) reviewed (R1). Staff did not follow physician orders to manage R1's Congestive Heart Failure (CHF) diagnosis in managing fluid overload. Staff did not notify provider of R1's weight fluctuations as ordered. Findings include: R1 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disorder (COPD), pleural effusion, acute respiratory failure with hypoxia, and hypertension. R1's Minimum Data Set (MDS) assessment, dated 07/16/26, identified R1 had Brief Interview of Mental Status (BIMS) score of 15/15, which means intact cognition. R1's Activities of Daily Living (ADL) care plan states: -Toileting: assist of 2 using bed pan initiated on 12/23/24. -Transfer: mechanical lift using XXL size sling initiated on 05/13/26. R1's Edema/excess fluid volume as evidenced by need for scheduled diuretics care plan, states: -Report signs and symptoms of edema/fluid overload, such as change in mental status, weight gain, neck vein distention, abnormal lung sounds, and extremity swelling initiated on 12/23/24. -Weight three times weekly initiated on 01/14/25. R1's physician treatment orders: -Furosemide Oral Tablet 40 MG (Furosemide), Give 2 tablet by mouth two times a day related to CHF started on 12/21/24. R1's Medication Administration Record (MAR) identified: -R1 was given both AM and 12:00PM dose of Furosemide equaled to 160 mg on 01/12/26 at 1:31 PM. -R1 was given Furosemide 80 mg on 03/05/26 at 9:25 AM and then second dose at 12:10 PM. -R1 was given Furosemide 80 mg on 07/13/26 at 8:48 AM and then second dose at 10:10 AM. R1's weight identified: -On 07/06/26, R1 weighed 274.6 lbs. -On 07/08/26, R1 weighed 258.0 lbs. Surveyor could not find documentation that the facility staff notified provider of R1's weight loss. -On 07/10/26, R1 weighed 257.0 lbs. -On 07/13/26, R1 weighed 274.6 lbs. Surveyor could not find documentation that the facility staff notified provider of R1's weight gain of a 3lb increase in a day or 5lb increase in a week. -On 07/14/26, R1 weighed 278.6 lbs. Surveyor could not find documentation that the facility staff notified provider of further weight gain of a 3lb increase in a day or 5lb increase in a week. On 07/28/26 at 12:55 PM, Surveyor interviewed Certified Nurse Assistant (CNA) E and asked process for weighing residents on the wheelchair scale. CNA E reported to Surveyor CNA E's process is once a month the staff will weigh all residents' wheelchairs and document on a spreadsheet the current wheelchair weight. Then CNA E starts the shift with weights needed for the day and will gather weights from the residents. Surveyor asked CNA E how they weigh R1. CNA E reported wheelchair scale is zeroed out, then R1 is wheeled to the wheelchair scale, pulled onto scale backwards with pedals if it applies, and then a weight is taken for R1. Surveyor asked CNA E who reviews R1's weights. CNA E reported to Surveyor the nurse in charge reviews R1's weights. Surveyor asked CNA E if they worked yesterday on Monday 07/27/26. CNA E reported to Surveyor they did not work yesterday. Surveyor asked CNA E if they were aware R1 did not receive a weight as physician ordered to do so on Monday, Wednesday, and Friday, three times a week. CNA E reported to Surveyor they did not know R1 did not receive a weight yesterday on 07/27/26. Surveyor asked CNA E if it was in a report that R1 still needed a weight performed for accurate management of R1's CHF with diuretic administration. CNA E reported to Surveyor no one informed or reported to CNA E of the need to weigh R1 today on 07/28/26. On 07/28/26 at 1:00 PM, Surveyor interviewed CNA F and asked for the process for weighing residents on the wheelchair scale. CNA F reported to Surveyor their process is once a month the staff will weigh all residents' wheelchairs and document on a spreadsheet the current wheelchair weight. Then (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA F will gather weights from the residents throughout CNA F's shift. Surveyor asked CNA F who reviews residents' weights. CNA F reported to Surveyor the nurse in charge reviews all residents' weights. Surveyor asked CNA F who oversees calibrating the facility wheelchair scale. CNA F reported to Surveyor, Maintenance Director D checks calibration of wheelchair scale and not the aides. On 07/29/26 at 1:04 PM, Surveyor interviewed Maintenance Director D and asked who calibrates wheelchair scale. Maintenance Director D reported company comes in yearly to recalibrate and last visit was 10/30/25. Maintenance Director D reported the last calibration resulted with only 4/10ths of a decimal off and the company recalibrated successfully with no issues. On 07/28/26 at 1:09 PM, Surveyor interviewed Director of Nursing (DON) B and asked about R1's weight discrepancies and expectation for staff if discrepancies are found. DON B reported to Surveyor, DON B's expectation would be the nurses reviewing R1's weights should and R1 should have been reweighed on 07/08/26, 07/13/26, and 07/14/26. Once reweighed and observed same weight in lbs., then the nurses should notify the provider on call right away so that there could be interventions put into place to manage R1's CHF and edema. DON B reported to Surveyor with the almost 20lb increase between 07/08/26 and 07/13/26, staff should have reweighed R1 and contacted a provider right away if this was accurate. Surveyor asked DON B if there was a reweigh for R1. DON B stated no.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure pharmaceutical services (including procedures that ensure the accurate administering of all drugs and biologicals) to meet the needs of each resident, for 1 of 1 resident (R) observed receiving the diuretic medication Furosemide (R1).-R1 was given both AM and 12:00 PM dose of Furosemide equaled to 160 mg on 01/12/26 at 1:31 PM.-R1 was given Furosemide 80 mg on 03/05/26 at 9:25 AM and then second dose at 12:10 PM.-R1 was given Furosemide 80 mg on 07/13/26 at 8:48 AM and then second dose at 10:10 AM.Findings include:Facility document titled Medication Error Reporting and Adverse Drug Reaction Prevention and Detection states in part, .Procedures: 1. The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis.R1 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disorder (COPD), pleural effusion, acute respiratory failure with hypoxia, and hypertension.R1's Minimum Data Set (MDS) assessment, dated 07/16/26, indicated R1 had Brief Interview for Mental Status (BIMS) score of 15 /15 indicating R1 had intact cognition.R1's physician treatment orders:-Furosemide Oral Tablet 40 MG (Furosemide), Give 2 tablet by mouth two times a day related to CHF started on 12/21/24.R1's Medication Administration Record (MAR) identified:-R1 was given both AM and 12:00 PM dose of Furosemide equaled to 160 mg on 01/12/26 at 1:31 PM.-R1 was given Furosemide 80 mg on 03/05/26 at 9:25 AM and then second dose at 12:10 PM.-R1 was given Furosemide 80 mg on 07/13/26 at 8:48 AM and then second dose at 10:10 AM.On 07/28/26 at 11:31 AM, Surveyor attempted to call Registered Nurse (RN) G to interview regarding reasoning for administering Furosemide medication so close together. Surveyor was unable to speak with RN G. On 07/28/26 at 11:37 AM, Surveyor entered Nursing Home Administrator (NHA) A's office with Regional Director of Nursing (DON) C, and DON B. Surveyor asked Regional DON C and DON B if Surveyor could have them review R1's MAR for the month of July with Surveyor. DON B observed on 01/12/26, R1 was given a double dose of Furosemide, on 03/05/26, R1 was given both AM and 12:00 PM dose of Furosemide within 2.5 hours apart, and on 07/13/26, R1 was given both AM and 12:00 PM dose of Furosemide within 1.25 hours apart. Surveyor asked DON C if the administrations of Furosemide given on 01/12/26, 03/05/26, and 07/13/26 were normal administration times and did facility recognize these as medication errors. DON B reported to Surveyor, a diuretic such as Furosemide medication for R1, should be staggered to at least 4 hours in between doses. DON B stated RN G should not have given R1 the second dose on 03/05/26 and 07/13/26. DON C stated to Surveyor upon review of R1's MAR, staff missed the medication error from 01/12/26 and staff should not have given a double dose of Furosemide together.		