STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525456	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheboygan Health Services	3129 Michigan Ave Sheboygan, WI 53082

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 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. 49563 Based on observation, staff and resident interview, and record review, the facility did not maintain a home-like environment with a comfortable temperature for 1 resident (R) (R6) of 14 sampled residents. The heating/air conditioning unit in R6's room did not work which resulted in an inability to control the temperature in R6's room. Findings include: The facility's Safe and Homelike Environment policy, dated 6/2022, indicates: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belonging to the extent possible .comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents .7. The facility will maintain comfortable and safe temperature levels. a. The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit (F) . From 12/2/24 to 12/4/24, Surveyor reviewed R6's medical record. R6 was admitted to facility on 12/8/11 and had diagnoses including venous insufficiency, chronic obstructive pulmonary disease (COPD), lymphedema, gout, and morbid obesity. R6's Minimum Data Set (MDS) assessment, dated 10/20/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R6 was not cognitively impaired. R6 was responsible for R6's healthcare decisions. On 12/2/24 at 12:39 PM, Surveyor interviewed R6 in R6's room. R6 indicated the heating/air conditioning unit did not work and R6's room got very cold in the winter. Surveyor noted the room felt cold and did not see a temperature control panel in the room. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 2:57 PM, Surveyor interviewed Maintenance Director (MD)-J who verified the heating/air conditioning unit in R6's room did not work and the temperature in R6's room was dependent on hall heat that filtered into the room and wall water heat. MD-J indicated the facility's heating/air conditioning units controlled two rooms. The unit that serviced R6's room also serviced a lounge next to R6's room. The lounge contained a temperature control unit for the two rooms. MD-J indicated the facility replaced 6 heating/air conditioning units in residents' rooms in 2024 and were budgeted in 2025 to replace 6 additional heating/air conditioning units that did not work. On 12/3/24 at 3:14 PM, Surveyor interviewed R6 who indicated R6 only received heat when the sun shone in R6's room. R6 stated the wall water heat register only worked when it was bitter cold. R6 stated the heating/air conditioning unit had not worked since last winter. R6 stated when R6 gets cold, R6 wears sweaters and crawls under the covers to warm up. R6 indicated R6 did not want to change rooms and would rather tolerate the cold. On 12/4/24 at 8:13 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and [NAME] President of Success (VPS)-C. NHA-A and VPS-C verified the heating/air conditioning unit in R6's room was not functional and indicated staff offered to move R6 to another room but R6 declined.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure the state mental health authority was notified in a timely manner following a significant change in mental illness for 2 residents (R) (R7 and R22) of 5 sampled residents. R7 was admitted to the facility on [DATE] with a diagnosed mental illness with corresponding medication. The facility did not update and submit R7's Preadmission Screen and Resident Review (PASRR) Level I for additional Level II screening following changes to R7's medications. R22 was admitted to the facility on [DATE] with a diagnosed mental illness with corresponding medication. The facility did not update and submit R22's PASRR Level I for additional Level II screening following changes in R22's medications. Findings include: According to the Centers for Medicare and Medicaid Services' (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual, dated October 2023, if a significant change in status (SCSA) occurs for an individual known or suspected to have a mental illness, intellectual disability, or related condition (as defined by 42 CFR 483.102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act .The nursing facility must provide the SMH/ID/DDA authority with referrals as described below, independent of the findings of the SCSA. PASRR Level II is to function as an independent assessment process for this population with special needs, in parallel with the facility's assessment process. Nursing facilities should have a low threshold for referral to the SMH/ID/DDA so that these authorities may exercise their expert judgment about when a Level II evaluation is needed .Referral should be made as soon as the criteria indicating such are evident - the facility should not wait until the SCSA is complete. In addition, a referral for Level II Resident Review Evaluations is required for individuals previously identified by PASRR to have mental illness, intellectual disability/developmental disability, or a related condition in the following circumstances: note: .A resident who exhibits behavioral, psychiatric, or mood-related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis) .A resident transferred, admitted , or readmitted to a nursing facility following an inpatient psychiatric stay or equally intensive treatment. 1. On 12/4/24, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, and major depressive disorder. R7's Minimum Data Set (MDS) assessment, dated 12/9/24, had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R7 was severely cognitively impaired. R7 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PASRR Level I Screen, dated 12/14/21, indicated R7 had a serious mental illness with corresponding medication of Zoloft (an antidepressant medication). R7 had a physician order for Zoloft 75 milligrams (mg) one time a day for depression (dated 7/4/24) and an order for quetiapine fumarate (an antipsychotic medication) 12.5 mg two times a day for major depressive disorder (dated 10/22/24). R7's medical record did not contain an updated PASRR Level I that included the addition of R7's antipsychotic medication. R7's medical record did not include a PASRR Level II Reevaluation for R7's mental illness with changes to R7's medications. 2. On 12/4/24, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including generalized anxiety disorder, major depressive disorder, and delusional disorder. R22's MDS assessment, dated 9/10/24, had a BIMS score of 9 out of 15 which indicated R22 had moderate cognitive impairment. R22 was responsible for R22's healthcare decisions. A PASRR Level I Screen, dated 8/19/21, indicated R22 had a serious mental illness with corresponding medications of Ativan (an antianxiety medication), and fluoxetine (an antidepressant medication). R22 had physician orders for buspirone (an antianxiety medication) 5 mg two times a day for anxiety (dated 10/8/24), escitalopram (an antidepressant medication) 10 mg one time a day for depression (dated 7/21/23), and Abilify (an antipsychotic medication) 2 mg one time a day for depression. R22's medical record did not contain an updated PASRR Level I that included the addition of R22's antipsychotic medication. R22's medical record did not include a PASRR Level II Reevaluation for R22's mental illness with changes to R22's medications. On 12/4/24 at 1:06 PM, Surveyor interviewed Social Service Coordinator (SSC)-I who had worked in SSC-I's current role for one month with no prior experience in Social Services. SSC-I verified SSC-I was responsible for completing PASRR requirements but had limited knowledge on PASRR requirements including when a Level I should be updated and when a Level II should be resubmitted. SSC-I confirmed SSC-I was not aware R7 and R22 needed an updated Level I and reevaluation of Level II by the state mental health authority. On 12/4/24 at 1:14 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and [NAME] President of Success (VPS)-C regarding PASRR expectations. VPS-C stated VPS-C was not aware R7 and R22's Level I Screens should have been resent for review for Level II Screens until Surveyor requested the documents. VPS-C stated it was the previous SSC's responsibility to ensure PASRRs were up-to-date with their quarterly review and confirmed it was also an expectation of SSC-I.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943 Based on observation, staff and resident interview, and record review, the facility did not ensure oral care was consistently completed for 1 resident (R) (R3) of 14 sampled residents. Oral care was not consistently documented as completed, unavailable, or refused in R3's medical record. Findings include: The facility's Oral Care Policy, dated 8/5/22. indicates: It is the practice of this facility to provide oral care to residents in order to prevent and control plaque-associated oral diseases. From 12/2/24 to 12/4/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including metastatic kidney cancer to pancreas status post pancreatectomy, status post left nephrectomy, status post thyroidectomy for thyroid gland metastasis, schizophrenia, and diabetes. R3's Minimum Data Set (MDS) assessment, dated 11/20/24, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R3 had moderate cognitive impairment. R3 had an activated Power of Attorney for Healthcare (POAHC). R3's activities of daily living (ADL) care plan, dated 3/30/24, indicated R3 had a self-care deficit related to decreased mobility and an inability to care for self. The care plan contained interventions to offer teeth brushing to R3 and assist as necessary. In addition, R3's plan of care indicated R3 had dental or oral cavity health problems as evidenced by dentures and contained interventions to assist with upper dentures and oral hygiene as needed. A provider note, dated 6/12/24, indicated R3 complained of oral pain but there was no obvious abnormality. Surveyor reviewed Certified Nursing Assistant (CNA) documentation related to the completion of oral care and noted the following: ~On 10/1/24, oral hygiene was not documented on the AM shift. ~On 10/4/24, oral hygiene was not documented on the PM shift (agency staff worked the PM shift). ~On 10/10/24, oral hygiene was not documented on the AM and PM shifts (agency staff worked both shifts). ~On 10/18/24, oral hygiene was not documented on the AM shift (agency staff worked the AM shift). ~On 10/20/24, oral hygiene was not documented on the AM or PM shifts. ~On 11/30/24, oral hygiene was not documented on the AM and PM shifts (agency staff worked both shifts). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~On 12/1/24, oral hygiene not documented on the AM or PM shifts. ~On 12/3/24, oral hygiene was not documented on the PM shift. On 12/2/24 at 10:00 AM, Surveyor interviewed R3 who indicated food was stuck in R3's bottom teeth and staff had not yet offered to help R3 brush R3's teeth. Surveyor observed a dry toothbrush in a basin by R3's sink. On 12/3/24 at 11:01 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B expects staff to brush residents' teeth during AM and PM cares and offer to brush residents' teeth after meals. DON-B indicated R3 often refused oral hygiene. On 12/4/24 at 9:40 AM, Surveyor and Registered Nurse (RN)-F observed food debris in R3's lower teeth. R3 stated R3's teeth were not brushed. RN-F indicated the food debris was probably from breakfast and RN-F would have a CNA provide oral care. On 12/4/24 at 11:46 AM, Surveyor interviewed DON-B who reviewed R3's oral hygiene documentation for October, November, and December (2024) and verified oral hygiene on the above dates was not documented. DON-B indicated if oral hygiene was not documented it indicated oral hygiene was not completed. DON-B indicated agency staff may have worked the shifts when oral hygiene was not documented. DON- B indicated agency staff don't have access to document in residents' electronic medical records. On 12/4/24 at 2:02 PM, Surveyor interviewed DON-B who indicated the facility did not complete the documentation review for agency staff who may have completed R3's oral hygiene because it was discovered the facility's own staff also did not complete the task.

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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. 45943 Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R2) of 3 sampled residents received the appropriate care and services to prevent urinary tract infections (UTIs). On 12/2/24, R2's uncovered nephrostomy tube drainage bag was observed on the floor. Findings include: The facility's Nephrostomy and Cystostomy Tube Care Policy, dated 7/21/22, indicates: A nephrostomy tube is a catheter or tube surgically inserted into the kidney to divert urine from the ureters or bladder .d. Interventions to prevent complication or promote dignity associated with the tube(s): .iv. Physical management of tubing and collection bag to prevent infection or dislodgement .7. Considerations for care .b. Maintain the drainage bag below the level of the kidney. Keep bags covered for dignity. From 12/2/24 to 12/4/24, Surveyor reviewed R2's medical record. R2 was hospitalized from 11/15/24 to 11/19/24 and had diagnoses including severe sepsis due to UTI, large staghorn right renal calculus (kidney stone) with mild hydronephrosis status post bilateral nephrostomy tube placement, multiple sclerosis (MS), diabetes, and neuromuscular dysfunction of the bladder. R2's Minimum Data Set (MDS) assessment, dated 11/23/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 was not cognitively impaired. R2 made R2's own healthcare decisions. On 12/2/24 at 1:36 PM and 1:53 PM, Surveyor noted R2's left uncovered nephrostomy bag was on the floor behind R2's wheelchair. On 12/2/24 at 1:54 PM, Surveyor interviewed Registered Nurse (RN)-F who verified R2's left uncovered nephrostomy bag was on the floor which could cause contamination. RN-F indicated R2's nephrostomy bags were usually covered under R2's sweater. RN-F indicated nephrostomy tubes should be in a dependent position and nephrostomy bags should be off the floor for infection control purposes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45943 Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R22) of 2 sampled residents received the necessary care and treatment for respiratory therapy. On 12/3/24, R22 received oxygen at a rate that was above the rate ordered by R22's provider. Findings include: The facility's Oxygen Concentrator policy, dated 6/27/22, indicates: To provide oxygen for therapeutic use by utilizing a concentrator that converts ambient air to a higher concentration level of oxygen. It is commonly used to provide oxygen therapy .9. Adjust the flow meter control knob to the flow setting prescribed by the physician. From 12/2/24 to 12/4/24, Surveyor reviewed R22's medical record. R22 had diagnoses including chronic obstructive pulmonary disease (COPD), thrombotic pulmonary embolism, pulmonary hypertension, anxiety, and dependence on supplemental oxygen. R22's Minimum Data Set (MDS) assessment, dated 9/10/24, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R22 had moderate cognitive impairment. R22 made R22's own healthcare decisions. R22 had a physician order, dated 11/3/24, for oxygen via stationary system for in-room activities at 1-4 liters per minute via nasal cannula daily to keep oxygen saturation level equal to or greater than 90% every shift. On 12/3/24 at 8:22 AM, Surveyor noted R22 was receiving 4.5 liters of oxygen via nasal cannula. On 12/3/24 at 2:12 PM, Surveyor and Licensed Practical Nurse (LPN)-E observed R22's oxygen concentrator and noted R22 was receiving oxygen at 5 liters. LPN-E indicated R22's flow rate was usually set at 3 liters. LPN-E adjusted R22's oxygen incrementally to 4 liters until R22's oxygen saturation level was at 92%.

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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** 49563 Based on observation, staff and resident interview, and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of medication for 1 resident (R) (R16) of 4 sampled residents. R16 had an order for Artificial Tears ophthalmic solution 1 drop per eye 3 times per day for dry eyes. R16 did not receive 16 doses of the scheduled medication and was told the medication was unavailable. Findings include: The facility's Medication Administration policy, dated 1/2023, 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 .Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber .14. Medications are administered within 60 minutes of scheduled time . On 12/3/24, Surveyor reviewed R16's medical record. R16 was admitted to the facility on [DATE] and had diagnoses including spastic quadriplegic cerebral palsy, bipolar disorder, anxiety, and depression. R16's Minimum Data Set (MDS) assessment, dated 10/26/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R16 was not cognitively impaired. R16 was responsible for R16's healthcare decisions. On 12/2/24 at 1:35 PM and on 12/4/24 at 9:20 AM, Surveyor interviewed R16 who wore glasses and indicated staff had not provided R16's eye drops for 7 days. R16 indicated staff informed R16 that the facility was waiting on a pharmacy shipment. R16 indicated R16 cannot see the print on the television without the drops due to dryness which causes pain. R16 indicated on the third day without the eye drops, R16 reported to staff that R16's eyes hurt. Surveyor reviewed R16's medication orders and noted R16 was prescribed Artificial Tears ophthalmic solution 1 drop per eye 3 times per day for dry eyes on 8/13/24. Surveyor reviewed R16's November and December 2024 Medication Administration Records (MARs) which indicated the following: ~On 11/26/24, all three doses were not administered (medication not available). ~On 11/27/24, all three doses were not administered (medication not available). ~On 11/28/24, all three doses were administered. ~On 11/29/24, all three doses were administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~On 11/30/24, one dose was administered and two doses were not administered (medication not available). ~On 12/1/24, one dose was administered and two doses were not administered (medication not available). ~On 12/2/24, all three doses were administered. ~On 12/3/24, one dose was administered. On 12/3/24 at 12:43 PM, Surveyor interviewed Registered Nurse (RN)-H who indicated RN-H did not provide Artificial Tears to R16 on 12/3/24 or the previous weekend because the facility was waiting on a pharmacy shipment. RN-H indicated Director of Nursing (DON)-B ordered the medication, but it had not arrived and the facility was out. RN-H verified RN-H documented in error that the doses were administered. On 12/3/24 at 12:56 PM, Surveyor interviewed DON-B who indicated DON-B expects ordered medications to be provided as prescribed and MAR documentation to be accurate. On 12/3/24 at 2:00 PM, Surveyor interviewed [NAME] President of Success (VPS)-C who retrieved a box of Artificial Tears from downstairs which was shown to Surveyor. VPS-C was unsure why staff did not know to go downstairs to obtain the medication.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50988 Based on observation, staff and resident interview, and record review, the facility did not ensure food was served at a palatable temperature for 1 resident (R) (R18) of 1 sampled resident. On 12/2/24, Dietary Manager (DM)-G reheated a bowl of soup in the microwave and served the soup to R18 without checking the temperature. Approximately 14 minutes after being served, R18 indicated the soup was still too hot to eat. Findings include. The facility's Food Temperatures policy and procedure, revised 8/16/22, indicates hot food items may not fall below 135 degrees Fahrenheit (F) after cooking unless it is an item which is to be rapidly cooled to below 42 degrees F and reheated to at least a minimum of 165 degrees F (for a minimum of 15 seconds) prior to serving. Caution should be taken when serving food and liquids to avoid the risk of burns. On 12/2/24 at 1:00 PM, Surveyor observed DM-G microwave a bowl of soup for 1 minute and 30 seconds. DM-G removed the bowl from the microwave and handed the bowl to a Certified Nursing Assistant (CNA) to serve to R18. DM-G did not stir or temp the soup before the CNA served the soup to R18. Surveyor noted R18 was hesitant to eat the soup. On 12/2/24 at 1:14 PM, Surveyor interviewed R18 who indicated the soup was still too hot to eat. On 12/3/24 at 2:30 PM, Surveyor interviewed DM-G who indicated DM-G did not record the temperature of R18's reheated soup on the facility's temperature log. Surveyor reviewed the temperature log and verified there were no temperatures documented on 12/2/24 for R18's reheated soup. DM-G indicated the temperature was obtained after DM-G reheated the soup in the microwave but was not recorded. Surveyor did not observe DM-G obtain the temperature of the soup. On 12/3/24 at 3:03 PM, Surveyor received a Microwave Temp Log from DM-G. The log was back-dated for 12/2/24 and indicated yes to 'did the food reach 165 degrees'. The temperature was documented at 186 degrees and initialed by DM-G. The log also indicated how to safely reheat food in a microwave and read: Reheat food, then let sit for 2 minutes, remove the lid and stir with a clean utensil, wipe clean the probe of the food thermometer using single use food-grade wipes then insert food probe into food, so stem is covered, food is ready for consumption at 165 degrees F. On 12/4/25 at 12:57 PM, Surveyor interviewed DM-G who indicated DM-G had DM-G's backed turned to Surveyor on 12/2/24 when DM-G took the temperature of R18's soup. Surveyor indicated Surveyor observed DM-G hand the bowl of soup directly to a CNA without obtaining the temperature or stirring the bowl.

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NAME OF PROVIDER OR SUPPLIER Sheboygan Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 3129 Michigan Ave Sheboygan, WI 53082	

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 50988 Based on observation, staff and resident interview, and record review, the facility did not serve meals consistently at regular meal times. This practice had the potential to affect more than 4 of the 36 residents residing in the facility. On 12/2/24, breakfast service started approximately 38 minutes after the posted meal time. Staff served the last breakfast tray 1 hour and 12 minutes after the posted meal time. On 12/2/24, lunch service started approximately 30 minutes after the posted meal time. Staff served the last lunch tray 1 hour and 16 minutes after the posted meal time. Findings include: The facility's Frequency of Meals policy and procedure, revised 9/2017, indicates: The Dining Services Director will ensure that each meal is served within the designated time frame unless there is an emergency situation or resident request. Between 12/2/24 and 12/4/24, Surveyor reviewed the facility's Resident Council minutes. The Resident Council minutes from 9/10/24 indicated: Cold food on hot plate. Progress of concern: Ongoing. New concerns: Late meals. On 12/2/24 at 12:05 PM, Surveyor interviewed R24 who indicated R24 waited too long for meals. On 12/2/24 at 1:55 PM, Surveyor interviewed R31 who indicated meals arrived an hour after the posted meal times. On 12/2/24, Surveyor observed a posting outside the dining room that indicated: Breakfast 8:00 AM, Lunch 12:00 PM, and Supper 5:00 PM. On 12/2/24 at 8:14 AM, Surveyor began observing breakfast service in the dining room. On 12/2/24 at 8:32 AM, Dietary Manager (DM)-G completed food temperatures. On 12/2/24 at 8:38 AM, DM-G started plating meal trays. Surveyor noted breakfast service started 38 minutes after the posted meal time. On 12/2/24 at 8:53 AM, Surveyor noted the last dining room meal tray was completed. On 12/2/24 at 9:12 AM, Surveyor noted the last room tray was delivered 1 hour and 12 minutes after the posted meal time. On 12/2/24 at 12:27 PM, Surveyor began observing lunch service in the dining room. On 12/2/24 at 12:29 PM, DM-G completed food temperatures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525456	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheboygan Health Services	3129 Michigan Ave Sheboygan, WI 53082

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/2/24 at 12:30 PM, DM-G started plating meal trays. Surveyor noted lunch started 30 minutes after the posted meal time. On 12/2/24 at 12:47 PM, Surveyor noted the last dining room meal tray was completed. On 12/2/24 at 12:58 PM, Surveyor noted room room trays were plated and ready to deliver. On 12/2/24 at 1:16 PM, Surveyor noted the last room tray was delivered 1 hour and 16 minutes after the posted meal time. On 12/3/24 at 12:53 PM, Surveyor interviewed DM-G regarding meal timeliness. DM-G indicated breakfast in the dining room was at 8:15 AM and room trays were delivered at 8:30 AM. DM-G indicated lunch in the dining room was at 12:15 PM and room trays were delivered at 12:30 PM. When Surveyor asked about the posted meal times, DM-G indicated there was a communication problem and stated DM-G notified Nursing Home Administrator (NHA)-A who would take care of it. On 12/4/24, Surveyor observed a posting outside the dining room that still indicated: Breakfast 8:00 AM, Lunch 12:00 PM, and Supper 5:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Sheboygan Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 3129 Michigan Ave Sheboygan, WI 53082	

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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 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** 49563 Based on staff interview and record review, the facility did not ensure medical records contained accurate and complete documentation for 2 residents (R) (R16 and R31) of 14 sampled residents. R16's Medication Administration Record (MAR) indicated six doses of Artificial Tears were provided when the medication was unavailable for administration. R31 received dialysis three times per week. R31's medical record did not contain a physician's order for dialysis. Findings include: The facility's Medication Administration policy, dated 1/2023, 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 .Documentation: 1. The individual who administers the medication dose records the administration on the resident's MAR immediately following the medication being given .4. The resident's MAR/Treatment Administration Record (TAR) is initialed by the person administering the medication in the space provided under the date and the on the line for that specific medication dose administration and time. Initials on each MAR/TAR are verified with a full signature in the space provided or on the nursing care center's master employee signature log . 1. On 12/3/24, Surveyor reviewed R16's medical record. R16 was admitted to the facility on [DATE] and had diagnoses including spastic quadriplegic cerebral palsy, bipolar disorder, anxiety, and depression. R16's Minimum Data Set (MDS) assessment, dated 10/26/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R16 was not cognitively impaired. R16 was responsible for R16's healthcare decisions. Surveyor reviewed R16's medication orders and noted R16 was prescribed Artificial Tears ophthalmic solution 1 drop per eye 3 times per day for dry eyes on 8/13/24. Surveyor reviewed R16's MAR which indicated the following: ~On 11/26/24, all three doses were not administered (medication not available). ~On 11/27/24, all three doses were not administered (medication not available). ~On 11/28/24, all three doses were administered. ~On 11/29/24, all three doses were administered. ~On 11/30/24, one dose was administered and two doses were not administered (medication not available). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Sheboygan Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 3129 Michigan Ave Sheboygan, WI 53082	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~On 12/1/24, one dose was administered and two doses were not administered (medication not available). ~On 12/2/24, all three doses were administered. ~On 12/3/24, one dose was administered. On 12/3/24 at 12:43 PM, Surveyor interviewed Registered Nurse (RN)-H who indicated RN-H did not provide Artificial Tears to R16 on 12/3/24 or on the previous weekend because the facility was waiting on a pharmacy shipment. RN-H verified RN-H documented in error that RN-H had administered the doses and R16's MAR was inaccurate. On 12/3/24 at 12:56 PM, Surveyor interviewed Director of Nurses (DON)-B who indicated DON-B expects staff to provide accurate documentation in a resident's MAR. 2. On 12/3/24, Surveyor reviewed R31's medical record. R31 was admitted to the facility on [DATE] and had diagnoses including end stage renal disease-dialysis dependent, diabetes, and coronary artery disease. R31's MDS assessment, dated 9/15/24, had a BIMS score of 15 out of 15 which indicated R31 was not cognitively impaired. R31 was responsible for R31's healthcare decisions. Surveyor reviewed R31's physician orders and noted R31 did not have an order for dialysis, however, R31 received dialysis three times per week on Tuesdays, Thursdays, and Saturdays. On 12/3/24 at 2:07 PM, Surveyor interviewed DON-B who reviewed R31's physician orders and verified R31 did not have a physician's order for dialysis. DON-B indicated R31 should have a dialysis order.