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	03/19/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect all 42 residents residing in the facility.The facility did not ensure food prep areas and equipment were in clean and sanitary condition.The facility did not have internal thermometers in the reach-in cooler and walk-in freezer to accurately monitor temperatures.Findings include:Food Prep Areas/Equipment: The 2022 Federal Food and Drug Administration (FDA) Food Code documents at 4-602.12 Cooking and Baking Equipment: (A) The food-contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours.The 2022 FDA Food Code documents at 4-602.13 Nonfood-Contact Surfaces: Non-food contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residue.During an initial self-guided kitchen tour that began at 8:40 AM on 3/16/26, Surveyor observed the following:~ The reach-in cooler contained brown and white splashes on the front of both doors.~ The oven doors contained eggs, yellow and white splashes, and grease on both doors.~ The top and side of the double door oven contained dust and grease with matter that appeared to be food particles.~ A shelf next to the double door oven, a vinegar bottle, and seasonings contained brown/black grease.~ A peanut butter container on a shelf next to the double door oven contained peanut butter on sides, lid, and around the lid of the container.~ The dry storage room floor contained crushed crackers, cardboard pieces, and condiments under the shelving.During a continuous kitchen observation that began at 1:38 PM on 3/18/26, Surveyor noted the above items were in the same unclean condition. Surveyor interviewed Dietary Manager (DM)-D who indicated the kitchen had an issue with cleaning. DM-D stated DM-D spoke to staff frequently and attempted to correct the concerns. DM-D stated DM-D completed most of the kitchen cleaning while working and was unable to keep up with the tasks. DM-D confirmed the kitchen was not cleaned every 24 hours and the areas identified were not cleaned per policy. Internal Thermometers:The 2022 FDA Food Code documents at 3ˆ202.11 Temperature: Perishable food items must be stored at appropriate temperatures to prevent spoilage and reduce the risk of foodborne illnesses. Refrigerators should be set below 41 Fahrenheit (F) (5 Celsius (C)) and freezers at or below 0 F (-18 C).During an initial self-guided kitchen tour that began at 8:40 AM on 3/17/26, Surveyor noted the reach-in cooler and walk-in freezer did not contain internal thermometers. Outside temperature gauges indicated the reach-in cooler was 56.6 degrees F and the walk-in freezer was 0 degrees F. During a continuous kitchen observation that began at 1:38 PM on 3/18/26, Surveyor interviewed DM-D who confirmed the reach-in cooler and walk-in freezer did not contain internal thermometers. DM-D stated the walk-in freezer used to have an internal thermometer, but DM-D couldn't find it. DM-D indicated staff relied on the outside temperature gauge for the reach-in cooler. Surveyor noted the outside temperature gauge for the reach-in cooler indicated the cooler was 46.5 degrees F at the time of the interview.

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

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	03/19/2026

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide Pre-admission Screening and Resident Review (PASRR) services for 4 residents (R) (R23, R37, R1, and R6) of 5 sampled residents.The facility did not contact the state mental health authority when R23, R37, R1, and R6's PASRR Level I 30-day exemption expired or pursue further PASRR Level II screening.Findings include: The facility's Resident Assessment: Coordination with PASARR Program policy, dated [DATE], indicates: This facility coordinates assessments with the Pre-admission Screening and Resident Review (PASARR) program under Medicaid to ensure individuals with a mental disorder, intellectual disability, or related condition receive care and services in the most integrated setting appropriate to their needs .ii. Positive Level I Screen necessitates a PASARR Level II evaluation prior to admission .2. The facility will only admit individuals with a mental disorder or intellectual disability who the state mental health or intellectual disability authority has determined as appropriate for admission .4. Exceptions to the pre-admission screening program include those individuals who are .b.admitted directly from a hospital, require nursing facility services for the condition for which the individual received care in the hospital, and have been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services .5. If a resident was not screened due to an exception above (section 4) and the resident remains in the facility for longer than 30 days: a. The facility must screen the individual using the state Level I screening process and refer any resident who has or may have a mental health diagnosis or intellectual disability or a related condition to the appropriate state designated authority for Level II PASARR evaluation and determination. B. The Level II resident review must be completed within 40 calendar days of admission. 1. On [DATE], Surveyor reviewed R23's medical record. R23 was admitted to the facility on [DATE] and had diagnoses including depression, anxiety, and dementia with agitation. R23's Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R23 had severe cognitive impairment. R23 had an activated decision maker for healthcare decisions. R23's medical record indicated the the following: ~ A PASRR Level I Screen, dated [DATE], completed upon admission indicated R23 had a 30-day hospital exemption. ~ A PASRR Level I Screen, dated [DATE], indicated R23 had a 30-day hospital exemption. R23's medicasl record did not contain any other PASRR Screens, including a required PASRR Level II. (See interview under example 4.) 2. On [DATE], Surveyor reviewed R37's medical record. R37 was admitted to the facility on [DATE] and had diagnoses including major depressive disorder, anxiety disorder, and dementia with behavioral concerns and psychotic features. R37's MDS assessment, dated [DATE], had a BIMS score of 11 out of 15 which indicated R37 had moderately impaired cognition. R37 had an activated healthcare decision maker. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37's medical record indicated the following: ~ A PASRR Level I Screen, dated [DATE], indicated R37 had a 30-day hospital exemption. R37's medical record did not contain any other PASRR Level I or II Screens. (See interview under example 4.) 3. On [DATE] at 12:45 PM, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including cerebral palsy, cognitive communication deficit, and unspecified mental disorder due to known physiological condition. R1's MDS assessment, dated [DATE], had a BIMS score of 14 out of 15 which indicated R1 had intact cognition. R1 had an activated Power of Attorney for Healthcare (POAHC). R1's medical record included a PASRR Level I Screen that indicated R1 had an intellectual disability and a 30-day hospital discharge exemption that indicated R1 was expected to be in the facility for less than 30 days. A County Review of Nursing Home, Institution for Mental Disease (IMD) or Intermediate Care Facilities/Individual with Intellectual Disability (ICD/IID) Referrals document, dated [DATE], included a recommendation of institutional placement for R1 as nursing facility admission and hospital discharge exemption-30 day maximum. The form indicated a short-term exemption form Level II Screen applied and short-term exemptions may not be used consecutively to extend the time in a facility with a PASRR Level II Screen. R1's medical record did not contain any other PASRR Level I or Level II Screens. On [DATE] at 3:28 PM, Surveyor requested additional PASRR screening documents for R1 since R1's 30-day exemption had expired. No further PASRR screens were provided. (See interview under example 4.) 4. On [DATE], Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including anxiety, depression, mild cognitive impairment, and alcohol-induced dementia. R6's MDS assessment, dated [DATE], had a BIMS score of 14 out of 15 which indicated R6 had intact cognition. R6 had an activated POAHC. R6's medical record included a PASRR Level I Screen that indicated R6 had a diagnosis of a major mental disorder and a 30-day hospital discharge exemption which indicated R1 was expected to be in the facility for less than 30 days. R6's medical record did not contain any other PASRR Level I or Level II Screens. On [DATE] at 3:28 PM, Surveyor requested additional PASRR screening documents for R6 since R6's 30-day exemption had expired. No further PASRR screens were provided. On [DATE] at 9:26 AM, Surveyor interviewed Social Services Designee (SSD)-C who indicated R23, R37, R1 and R6 were all admitted prior to SSD-C's employment in October of 2025. SSD-C stated R23, R37, R1, and R6 had PASRR Level I Screens; however, it was discovered after SSD-C started that (continued on next page)

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	525456	A. Building B. Wing	03/19/2026

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASRR Level I Screens were not referred for PASRR Level II Screens as required. SSD-C indicated a performance improvement plan was initiated, including an audit to ensure all residents who required a PASRR Level II Screen received screening. SSD-C confirmed R23, R37, R1, and R6 should have had PASRR Level II Screens. On [DATE] at 4:05 PM, Surveyor interviewed [NAME] President of Success (VPS)-G who confirmed despite the initiation of a performance improvement plan, the facility did not submit the required PASRR Level II Screens for R23, R37, R1, and R6.

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	525456	A. Building B. Wing	03/19/2026

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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. Based on observation, staff and resident interview, and record review, the facility did not ensure meals were served at regular times and in accordance with residents' preferences. This practice had the potential to affect more than 4 of the 42 residents residing in the facility.The facility consistently served meals later than posted mealtimes and residents' preferences.Findings include:On 3/17/26, Surveyor observed a document titled Meal Times posted in the dining room and outside the activity room that indicated the following: ~ Breakfast: 8:30 AM - Dining room; 8:45 AM - Room trays~ Lunch: 12:30 PM - Dining room; 12:45 PM - Room trays~ Dinner - 5:30 PM - Dining room; 5:45 PM - Room traysOn 3/17/26, Surveyor observed lunch in the dining room which started at 1:05 PM. The last resident seated in the dining room was served at 1:26 PM. Surveyor noted room trays left the dining room at 1:45 PM and the last tray was delivered at 2:00 PM. On 3/18/26 at 8:29 AM, Surveyor observed breakfast in the dining room. A beverage cart arrived at that time and residents were served beverages. Staff began to serve breakfast at 8:50 PM and began to deliver room trays at 9:06 AM. The last room tray was delivered at 9:24 AM.On 3/18/26 at 12:28 PM, Surveyor observed lunch in the dining room. A beverage cart arrived at that time and residents were served beverages. Staff began to serve lunch at 12:50 PM and began to deliver room trays at 1:02 PM. The last room tray was delivered at 1:13 PM. On 3/18/26, Surveyor reviewed the facility's grievance file. A grievance, dated 2/16/26, contained a complainant from a Resident Council meeting. The grievance indicated meals were not served as scheduled, meals were early or late, and residents were not always aware when meals would be served. The grievance form indicated Dietary Manager (DM)-D had trained a new Dietary Aide which was why meals were not served according to the posted times. The follow-up section of the grievance (dated 2/17/26) indicated meal times were getting better.On 3/18/26 at 11:31 AM, Surveyor interviewed R15 who stated R15 ate breakfast and dinner in the dining room and ate lunch in R15's room. R15 stated meal times in the dining room were 8:30 AM for breakfast and 5:30 PM for dinner. R15 stated serving times were not adhered to which was a concern. R15 stated room trays for lunch were served over an hour late at times. Dinner was served early at times and R15 had to wait until 9:00 AM or later for breakfast the next morning. R15 received insulin prior to meals and felt R15's blood glucose was too low at times when R15 waited a long time for meals to be served. R15 stated R15 regularly attended Resident Council meetings and reported the concern to staff who attended the meeting; however, meal service had not improved. (Surveyor reviewed 15's medical record and noted R15 had diagnoses including type 2 diabetes and chronic kidney disease. R15's Minimum Data Set (MDS) assessment, dated 1/25/26, indicated R15 had intact cogntion.)R15's medical record contained an order for 13 units of Humalog (a fast-acting insulin) at noon prior to meals.On 3/18/26 at 1:38 PM, Surveyor interviewed DM-D who was aware meals were not served at the posted times and residents had previously reported concerns at Resident Council meetings and during discussions about meal service. DM-D stated kitchen staff were allowed to be 15 minutes late with service.On 3/19/26 at 8:59 AM, Surveyor observed staff begin breakfast service in the dining room. Surveyor interviewed Regional Dietary Manager (RDM)-E who stated DM-D was instructed to start meal service on time because residents requested meals be delivered within the posted time frames. RDM-E indicated staff should start serving breakfast at 8:30 AM.

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	525456	A. Building B. Wing	03/19/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 1 resident (R) (R19) of 3 sampled residents.R19 was at risk for elopement and had an intervention for a WanderGuard. The intervention was not consistently implemented.Findings include:The facility's Elopment/Unsafe Wandering policy, revised 8/9/22, indicates: This facility ensures residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care, addressing the unique factors contributing to wandering or elopement risk .2. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, monitoring for effectiveness, and modifying interventions as necessary .f. Supervision per the plan of care should be provided to help prevent accidents or elopement. g. Licensed nurses will monitor the implementation of interventions, response to interventions, and document accordingly.From 3/17/26 to 3/19/26, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] and had diagnoses including schizophrenia, obsessive compulsive disorder, and anxiety. R19's Minimum Data Set (MDS) assessment, dated 2/11/26, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R19 had intact cognition. R19 had an activated Power of Attorney for Healthcare (POAHC).R19's care plan, initiated 4/20/25 and revised 6/25/25, indicated R19 was at risk for behavior symptoms related to unspecified schizophrenia and fixated on certain ideas/thoughts, especially related to personal belongings. The care plan contained a goal to reduce the risk of behavioral symptoms and remain safe within the environment. The care plan contained the following interventions: Alert bracelet to walker for safety; Check alert bracelet functioning per facility guidelines; Check alert bracelet placement per facility guidelines.R19's medical record contained the following orders:~ Okay to place wander alert bracelet for elopement risk (dated 6/2/25).~ Check wander alert bracelet placement to walker every shift (dated 6/2/25).~ Check wander alert bracelet function and expiration date once daily (6/3/25).An Elopement Assessment, dated 3/15/26, indicated R19 was at moderate risk for elopement and had a WanderGuard (WG) in place. R19 had not attempted to elope and no longer fixated on the storage unit. An Elopement Assessment, dated 12/15/25, indicated R19 was at high risk for elopement and had a WG in place.R19's Treatment Administration Record (TAR) for December 2025 through March 2026 indicated the following:~ WG placement was not documented on the 12/30/25 evening shift.~ WG placement was not documented on the 1/24/26 night shift.On 3/17/26 at 12:26 PM, Surveyor noted R19 did not have a WG.On 3/18/26 at 11:44 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-I who stated there was a WG on R19's walker. LPN-I stated nursing staff test the WG and verify its placement once per shift and document in R19's medical record. On 3/18/26 2:44 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R19 had a history of attempting to leave the facility. DON-B stated an Elopement Assessment is completed every 3 months. DON-B stated R19's most recent Elopement Assessment indicated R19 was at moderate risk for elopement which had decreased from high risk. DON-B stated there was a WG on R19's walker and DON-B planned to discuss WG removal with R19's POAHC. DON-B stated R19 did not ambulate without the walker. DON-B stated staff attempted multiple times to put a WG on R19's ankle or wrist but R19 would not allow it. DON-B indicated staff decided to put a WG on the walker because R19 could not ambulate without the walker.Following the interview with DON-B, Surveyor observed R19 return from an activity with R19's walker. Surveyor did not observe a WG on the walker. Surveyor interviewed R19 who stated R19 was sick of the red light on the WG and removed the WG from the walker. A (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	03/19/2026

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Sheboygan Health Services	3129 Michigan Ave Sheboygan, WI 53082

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note, dated 3/18/26 at 3:07 PM by DON-B, now indicated R19 had not made any attempts to elope since the summer and no longer obsessed about personal belongings that were stored at R19's POAHC's house. The note indicated R19's POAHC was leery but approved of a trial to remove the WG. An order was received to remove the WG (Of note: R19's medical record did not contain an order to remove the WG.) The note indicated staff would assist R19 to R19's room from meals and activities for no less than 7 days.On 3/18/26 at 3:48 PM, Surveyor interviewed DON-B regarding R19's WG. DON-B stated DON-B observed a WG on R19's walker on 3/17/26. DON-B indicated R19 had a history of cutting off the WG and could have done so again.On 3/19/26 at 11:48 AM, Surveyor interviewed Registered Nurse (RN)-H who stated the WG was located on the horizontal bar of R19's walker because R19 refused to wear a WG on R19's person. RN-H verified R19 cut off the WG multiple times.

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	03/19/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure weight monitoring was provided for 1 resident (R) (R7) of 5 sampled residents.R7's weights were not obtained using a consistent device and re-weights were not obtained for weight loss/gain of greater than 5 pounds (lbs). In addition, R7's physician and Power of Attorney (POA) were not notified regarding R7's weight loss/gain of greater than 5 lbs.Findings include:The facility's Weight Monitoring policy, revised 12/21/22, indicates: The Interdisciplinary Team (IDT) will strive to prevent, monitor, and intervene for undesirable weight change for our residents .5. Team members will follow a consistent approach to weighing and use an appropriately calibrated and functioning scale (e.g., wheelchair scale or bed scale). Since weight varies throughout the day, a consistent process and technique (e.g., weighing the resident wearing a similar type of clothing, at approximately the same time of the day, using the same scale, either consistently wearing or not wearing orthotics or prostheses, and verifying scale accuracy) can help make weight comparisons more reliable. 6. Any weight change of five pounds or more since the last weight assessment will be taken for confirmation .8. The threshold for significant weight change will be based on the following criteria where percentage of body weight change = (usual weight - actual weight)/(usual weight) x 100): a. 1 month - 5% weight change is significant; greater than 5% is severe. b. 3 months - 7.5% weight change is significant; greater than 7.5% is severe. c. 6 months - 10% weight change is significant; greater than 10% is severe .10. Nursing staff will notify the individual or responsible party, physician and Registered Dietitian (RDN) or designee of any individual with an unintended significant weight change .2. The undesired weight change will be discussed with the resident and/or responsible party.From 3/17/26 to 3/19/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including dysphagia following other non-traumatic intracranial hemorrage, hemiplegia and hemiparesis, type 2 diabetes, and Body Mass Index (BMI) of 19.9 or less. R7's Minimum Data Set (MDS) assessment, dated 2/16/26, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R7 had intact cognition. R7 had an activated Power of Attorney for Healthcare (POAHC).A care plan, initiated 12/15/25, indicated R7 was at risk for nutritional status change related to increased fluid demands as evidenced by constipation, protein/calorie malnutrition, type 2 diabetes, iron deficiency anemia, significant weight gain (+6%, -8#) over 1 month (dated 3/16/26), and significant weight loss (-7%, -10#) over 1 month (dated 1/14/26). The care plan contained a goal to gain weight and maintain as evidenced by no significant weight changes. The care plan contained the following interventions: Review weights and notify Registered Dietitian, provider, and responsible party of significant weight change; Record weight per facility protocol/provider orders; Parenteral nutrition per provider orders; Provide additional calories/protein at meals per R7's preference.R7's medical record contained the following orders:~ Weight on admit, daily x 2, weekly x 3, monthly; obtain re-weight if change of 5 lbs since last weight (dated 1/5/26)~ Boost two times daily for supplement 120 milliliters (ml) (dated 1/6/25)~ Tube feed - 480 ml Osmolite 1.2 calorie at 320 ml/hour (hr) at bedtime (dated 1/6/26)~ Weekly weights in the morning every Monday for history of weight loss (dated 3/2/26)A provider note, dated 3/12/26, indicated R7 was initially admitted in September of 2025 following a left basal ganglia intracranial hemorrhage in July of 2025 complicated by right hemiparesis, dysphagia requiring a percutaneous endoscopy (PEG) tube, urinary retention requiring a Foley catheter, and insulin-dependent type 2 diabetes with recurrent hypoglycemia.~ On 3/5/26 at 2:33 PM, R7 weighed 135.0 lbs (wheelchair scale) ~ On 2/11/26 at 1:25 PM, R7 weighed 142.4 lbs (standup scale) (3/5/26 at 1:33 PM disputed value; No re-weigh 2/11/26)~ On 2/10/26 at 1:47 PM, R7 weighed 133.0 lbs (standup scale) ~ On 2/2/26 at 2:51 PM, R7 weighed 132.8 lbs (wheelchair scale) A Nutrition Assessment, dated 2/23/26, indicated R7's average meal intake was between 51-100% with several refusals. R7 received nutritional supplements (including Boost twice daily) and/or fortified foods. R7's (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	03/19/2026

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight on 2/11/26 was 142.4 lbs via standup scale. R7's BMI was 19.9. R7 had a significant weight gain of 6.8% in 1 month that was an increase of 9 lbs. The note contained an instruction to obtain re-weight for 3 consecutive days related to recent significant weight gain in one day (2/11/26). ~ On 2/1/26 at 12:54 PM, R7 weighed 141.6 lbs (standup scale) (2/3/26 at 9:48 AM disputed value; No re-weigh 2/1/26)~ On 1/31/26 at 10:20 AM, R7 weighed 133.2 lbs (standup scale) ~ On 1/29/26 at 3:06 PM, R7 weighed 134.0 bs (standup scale) ~ On 1/24/26 at 11:31 AM, R7 weighed 133.0 lbs (wheelchair scale) (weight down 9 lbs) ~ On 1/23/26 at 1:14 PM, R7 weighed 142.0 lbs (standup scale) ~ On 1/22/26 at 2:48 PM, R7 weighed 139.8 lbs (standup scale) ~ On 1/21/26 at 2:47 PM, R7 weighed 140.6 lbs (wheelchair scale) (weight up 7.2 lbs) ~ On 1/20/26 at 2:01 PM, R7 weighed 133.4 lbs (wheelchair scale) ~ On 1/16/26 at 2:25 PM, R7 weighed 131.4 lbs (wheelchair scale) ~ On 1/15/26 at 1:37 PM, R7 weighed 134.2 lbs (wheelchair scale) (weight up 6.2 lbs) ~ On 1/13/26 at 1:42 PM, R7 weighed 128.0 lbs (standup scale) (weight down 5.4 lbs) ~ On 1/12/26 at 11:05 AM, R7 weighed 133.4 lbs (wheelchair scale) ~ On 1/11/26 at 2:41 PM, R7 weighed 132.0 lbs (standup scale) (weight down 5.2 lbs) ~ On 1/10/26 at 1:45 PM, R7 weighed 137.2 lbs (wheelchair scale) On 3/19/26 at 11:37 AM, Surveyor interviewed Registered Nurse (RN)-H who indicated Certified Nursing Assistants (CNAs) complete weights and give them to the nurses. RN-H stated it is the nurses' responsibility to compare daily weights to previously documented weights. RN-H stated a re-weigh is required if there is a 3 to 7 lb weight variation. RN-H stated if the re-weight is greater or less than 3 lbs from the previous weight, the nurse is required to call the physician. RN-H stated the nurse then writes a progress or assessment note in the resident's medical record. RN-H acknowledged the weight discrepancies in R7's medical record and verified re-weighs were not completed. RN-H stated RN-H did not observe any nursing notes related to weight in R7's medical record.On 3/19/26 at 12:04 PM, Surveyor interviewed [NAME] President of Success (VPS)-G who stated R7's weights were obtained with a wheelchair or stand-up scale and verified the method of obtaining R7's weights was inconsistent. VPS-G confirmed staff are required to contact the physician and POA if there is a change in weight of 5 lbs in one week. VPS-G confirmed R7's medical record did not indicate re-weights, physician, and POAHC notifications were completed.