STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525494	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Scandia Village	10560 Applewood Rd Sister Bay, WI 54234

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview and record review, the facility did not notify a physician when blood sugars were outside the ordered parameters for 3 residents (R) (R4, R3, and R1) of 3 sampled residents. R4 had an order to notify the physician of blood sugars above 450 milligrams/deciliter (mg/dL). The physician was not notified when R4's blood sugars exceeded 450 mg/dL on 1/3/26, 1/11/26, 1/15/26, 1/16/26, 1/19/26, 1/20/26, and 1/31/26.R3 had an order to notify the physician of blood sugars above 350 mg/dL. The physician was not notified when R3's blood sugars exceeded 350 mg/dL on 1/5/26 and 2/6/26. R1 had an order to notify the physician of blood sugars above 400 mg/dL. The physician was not notified when R1's blood sugar exceeded 400 mg/dL on 1/31/26. Findings include:The facility's Diabetes Policy, revised November 2020, indicates the physician will order desired parameters for monitoring and reporting information related to blood sugar management. Staff will incorporate such parameters into the Medication Administration Record (MAR) and care plan. The facility's Guidelines for Notifying Physicians of Clinical Problems policy, revised September 2017, indicates nursing observations that may require physician action would include significant fluctuations in blood sugar. 1. On 2/9/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes, stroke, and anxiety. R4's most recent Minimum Data Set (MDS) assessment, dated 12/26/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R4 had severe cognitive impairment. R4's comprehensive care plan, revised 10/3/25, indicated R4 had diabetes mellitus. The care plan contained an intervention to monitor for signs/symptoms of hyperglycemia.R4 had a physician order, dated 9/22/25, to call the physician if R4's blood sugar was over 450 mg/dL.Surveyor reviewed R4's blood sugar levels for the last two months and noted the following:~ On 1/3/26 at 8:59 AM, R4's blood sugar was 598 mg/dL.~ On 1/11/26 at 5:01 PM, R4's blood sugar was 477 mg/dL,~ On 1/15/26 at 5:23 PM, R4's blood sugar was 471 mg/dL.~ On 1/16/26 at 11:05 AM, R4's blood sugar was 481 mg/dL.~ On 1/19/26 at 8:01 AM, R4's blood sugar was 494 mg/dL.~ On 1/20/26 at 8:04 PM, R4's blood sugar was 535 mg/dL.~ On 1/31/26 at 10:43 AM, R4's blood sugar was 538 mg/dL.R4's medical record did not indicate R4's physician was notified of the blood sugars.(See interviews under example 3.)2. On 2/9/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including femur fracture and diabetes mellitus. R3's most recent MDS assessment, dated 1/7/26, had a BIMS score of 15 out of 15 which indicated R3 had intact cognition.R3's comprehensive care plan, revised on 12/18/25, indicated R3 had diabetes mellitus. The care plan contained a goal of no signs/symptoms of hyperglycemia and an intervention to monitor labs as ordered by the physician.R3 had a physician order, dated 12/17/25, to call the physician if R3's blood sugar was over 350 mg/dL.Surveyor reviewed R3's blood sugars for the last two months and noted the following:~ On 1/5/26 at 7:38 AM, R3's blood sugar was 481 mg/dL.~ On 2/6/26 at 12:09 PM, R3's blood sugar was 352 mg/dL. R3's medical record did not indicate (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	the physician was notified of the blood sugars.(See interviews under example 3.)3. On 2/9/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including metabolic encephalopathy, cirrhosis of the liver, history of stroke, and type 2 diabetes. R1's most recent MDS assessment, dated 1/14/26, had a BIMS score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 discharged from the facility on 2/1/26.R1's comprehensive care plan, revised on 1/14/26, indicated R1 had diabetes mellitus. R1 had a physician order, dated 1/20/26, to call the physician if R1's blood sugar was over 450 mg/dL.Surveyor reviewed R1's blood sugars for the last month and noted the following:~ On 1/31/26 at 5:28 PM, R1's blood sugar was 456 mg/dL.R1's medical record did not indicate the physician was notified of the blood sugar.On 2/10/26 at 9:46 AM, Surveyor interviewed Wound Registered Nurse (RN)-C regarding blood sugar parameters and physician notification. WRN-C verified that R4, R3, and R1's blood sugar orders were current and indicated staff should notify the physician as ordered for all blood sugars outside of parameters. WRN-C could not find documentation that R4, R3, and R1's physicians were notified of the above blood sugars.On 2/10/26 at 10:04 AM, Surveyor interviewed Director of Nursing (DON)-B regarding blood sugar parameters and physician notification. DON-B verified R4, R3, and R1's ordered blood sugar parameters were current and staff should notify the residents' physicians as ordered. DON-B provided Surveyor with an education binder that indicated nursing staff were educated on the facility's physician notification policy on 2/4/26 and 2/5/26; however, non-compliance was still present for R4 on 2/6/26.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 1 resident (R) (R12) of 4 sampled residents received the necessary pressure injury care and treatment to promote healing and prevent pressure injuries from worsening.R12 had a stage 2 sacral pressure upon admission that measured 6.2 centimeters (cm) (length) x 4.1 cm (width) x 0.2 (depth) cm. A wound clinic note included in R12's admission paperwork stated offloading was of the utmost importance and R12 should be repositioned side-to-side every two hours. If the sacral wound progressed, R12 should be started on an alternating air mattress as soon as possible. R12's sacral wound was documented as worsening on 1/21/26 and 1/28/26 and measured 9.1 cm x 7.9 cm x 0.1 cm with a reddened peri-wound and pain. As of 2/10/26, R12 did not have an alternating air mattress. In addition, R12 was admitted to the facility with a deep tissue injury (DTI) on the left heel that measured 1.8 cm x 1.3 cm. A wound clinic note stated to keep the site covered with a protective border dressing and use heel boots at all times to float R12's heels off the mattress. An assessment on 2/4/26 indicated the left heel DTI measured 2.5 cm x 3 cm. On 2/9/26 and 2/10/26, R12 was observed without heel boots in bed with both heels in contact with the mattress and the footboard. On 2/10/26, R12's protective dressing was dated 2/4/26 (6 days prior) but was supposed to be changed daily.The facility's Wound Care policy, revised June 2017, indicates: The purpose of the policy is to provide guidelines for the care of wounds to promote healing and to review the resident's care plan to assess for any special needs .The following information should be recorded in the resident's medical record: date and time wound care was given and if the resident refused the treatment. From 2/9/26 to 2/10/26, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure, anxiety, and type 2 diabetes. R12's most recent Minimum Data Set (MDS) assessment, dated 1/17/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R12 had intact cognition. The MDS assessment also indicated R12 had impaired mobility of both lower extremities and needed moderate assistance with rolling from side-to-side. R12's comprehensive care plan, revised 2/6/26, indicated R12 had current pressure injuries. The care plan contained interventions to reposition R12 at least every 2 hours and to float heels/heel boots on at all times.Surveyor reviewed R12's admission paperwork, including wound care notes. A visit note, dated 1/8/26, indicated R12 had a stage 3 sacral decubitus ulcer and offloading was of the utmost importance. The note indicated R12 should not lay directly on the sacrum and should be turned side-to-side every 2 hours. If R12's sacral ulcer progressed, R12 should be started on a group 1 alternating pressure pump mattress as soon as possible. Instructions for the left heel indicated to use offloading boots at all times and stated R12 would benefit from keeping R12's calves elevated on pillows while in bed to float heels off the mattress.Surveyor reviewed R12's coccyx wound assessments which indicated the following (Of note: The wound clinic identified the wound as a sacral wound and the facility identified the wound as a coccyx wound):~ On 1/14/26, R12 had a stage 2 pressure wound on the coccyx that measured 6.2 cm x 4.1 cm x 0.2 cm with 100% granulation tissue, a reddened peri-wound, and pain.~ On 1/21/26, R12 had a stage 2 pressure wound on the coccyx that measured 8.9 cm x 8.1 cm x 0.1 cm with 100% granulation tissue, a reddened peri-wound, and pain. Wound Registered Nurse (WRN)-C noted the wound had worsened.~ On 1/28/26, R12 had a stage 3 pressure wound on the coccyx that measured 9.1 cm x 7.9 cm x 0.1 cm with 100% granulation tissue, a reddened peri-wound, and pain. WRN-C noted the wound had worsened.~ On 2/4/26, R12 had a stage 3 pressure wound on the coccyx that measured 8.9 cm x 6.5 cm x 0.1 cm with 50% granulation tissue, 40% slough (stringy yellow/white non-healing tissue), 10% eschar (black/brown dead tissue), and pain. WRN-C (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	noted the wound had worsened. R12's medical record did not indicate an alternating air mattress was ordered as recommended by the wound clinic (on 1/8/26) when R12's coccyx wound worsened on 1/21/26, 1/28/26, and 2/4/26.Surveyor reviewed R12's left heel wound assessments which indicated the following:~ On 1/14/26, R12 had a deep tissue injury (DTI) on the left heel that measured 1.8 cm x 1.3 cm.~ On 1/21/26, R12 had a DTI on the left heel that measured 2.8 cm x 3.0 cm. The wound was larger in size and darker in color with pain. The note indicated R12 should wear heel boots at all times/heels floated in bed. WRN-C noted the wound had worsened.~ On 1/28/26, R12 had a DTI on the left heel that measured 1.8 cm x 2.5 cm with pain. WRN-C noted the wound was stable.~ On 2/4/26, R12 had a DTI on the left heel that measured 2.5 cm x 3 cm and was larger with a hardening center piece and pain. WRN-C noted the wound was stable.R12 had the following wound care orders:~ Stage 3 right - Remove old dressing, cleanse with wound wash, cover surrounding skin with skin prep, cover open areas with single layer Aquacel AG, cut to fit contours, secure with 4 x 4 foam border dressing in a diamond fashion; Change daily and as needed until resolved (dated 2/4/26)~ Stage 3 left - Remove old dressing, cleanse with wound wash, cover surrounding skin with skin prep, cover open areas with Medi-honey, secure with 4 x 4 foam border dressing in a diamond fashion; Change daily and as needed until resolved (dated 2/4/26)~ Left heel - Wound cleanser, blot dry, Betadine, cover with foam border; Change daily and as needed until resolved (dated 1/21/26)R12's January and February 2026 Treatment Administration Records (TARs) indicated R12's coccyx wound treatment was not completed on the following dates:~ 1/23/26, 1/24/26, 1/25/26, 1/26/26, 1/29/26, 1/31/26, 2/1/26, 2/2/26, and 2/3/26~ (Left) 2/6/26~ (Right) 2/7/26 and 2/8/26R12's January and February 2026 TARs indicated R12's left heel wound treatment was not completed on the following dates:~ 1/23/26, 1/24/26, 1/25/26, 1/26/26, 1/29/26, 1/31/26, 2/1/26, 2/2/26, 2/3/26, 2/7/26, and 2/8/26R12's January 2026 TAR indicated R12 was not repositioned every 2 hours and staff did not ensure R12's heels were free floating during 18 of 252 opportunities.R12's February 2026 TAR indicated R12 was not repositioned every 2 hours and staff did not ensure R12's heels were free floating during 10 of 116 opportunities.On 2/9/26 at 10:21 AM and 2:17 PM and on 2/10/26 at 9:41 AM, Surveyor observed R12 in bed on a regular pressure relieving mattress. R12 was not wearing heel boots (which were in the room) and both heels were in contact with the mattress and footboard. The dressing on R12's left heel was dated 2/4/26.On 2/10/26 at 9:43 AM, Surveyor interviewed R12 regarding repositioning, heel boots, and dressing changes. R12 stated R12 was usually receptive to wound care and heel boots and stated, If they offer, I don't say no.On 2/10/26 at 2:03 PM, Surveyor interviewed RN-D regarding R12's left heel dressing. RN-D stated RN-D changed R12's sacral dressing that day but did not change R12's heel dressing because it was not assigned on RN-D's (AM) shift. RN-D stated R12 refused cares at times which was documented in the TAR. RN-D did not recall if R12 refused to wear heel boots or reposition that day.On 2/10/26 at 3:12 PM, Surveyor observed R12 with WRN-C. WRN-C verified R12's heel dressing was dated 2/4/26 and was supposed to be changed daily. WRN-C also verified R12's heels should be floated off the mattress with heel boots or pillows. When WRN-C asked if it was okay to put heel boots on, R12 was agreeable. WRN-C indicated if a resident refuses treatment/repositioning, staff should document the refusal in the TAR and notify WRN-C or Director of Nursing (DON)-B. On 2/10/26 at 3:28 PM, Surveyor interviewed WRN-C regarding R12's wound clinic note from 1/8/26. WRN-C stated WRN-C did not review the note prior to survey and if WRN-C had reviewed the note upon admission, WRN-C would have called the wound clinic to clarify what progresses meant. WRN-C stated the facility does not currently have any alternating air mattresses but has the ability to order them if needed. WRN-C stated R12's family was considering Hospice care and a room change which caused a delay in providing R12 with an alternating air mattress. WRN-C verified an (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	alternating air mattress was discussed during R12's care conference on 2/4/26. WRN-C was not sure if the mattress was ordered and was waiting for R12's family to decide if R12 would enroll in Hospice care.On 2/10/26 at 4:22 PM, Surveyor interviewed DON-B regarding the alternating air mattress that was discussed on 2/4/26. DON-B stated it typically took a few days to receive an alternating air mattress once ordered. DON-B stated R12 was signing on to Hospice care with a first visit on 2/12/26 and an alternating air mattress would be ordered through the Hospice agency.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **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 residents with orders for a consistent carbohydrate (CCHO) diet received their prescribed diet. This practice had the potential to affect 12 residents (R) (R1, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14) of 12 sampled residents. R1's hospital discharge orders indicated R1 should have a low carb diet (60 grams of carbohydrates per meal). The order in R1's medical record indicated R1 should have 90 grams of carbohydrates per meal.R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14 had orders for a CCHO diet and did not receive what was on the CCHO diet lunch menu on 2/10/26.Findings include:The facility's undated Controlled Carbohydrates policy indicates: .Carbohydrates balanced consistently at each meal providing a range of 70-80 grams of carbohydrates. These diets can be used for the diabetic resident with glucose control concerns following regular and low-concentrated sweets are not omitted but planned into the total carbohydrate allowance for the meal.1.On 2/9/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes. R1's most recent Minimum Data Set (MDS) assessment, dated 1/20/26, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R1 had moderate cognitive impairment. R1's hospital discharge orders, dated 1/14/26, indicated R1 should have a carb-controlled diet with 60 grams of carbohydrates per meal. A follow-up section on the discharge orders indicated: Follow up, next physician nursing home rounds: Instructions: Monitor chronic medical problems, diabetes on high dose of insulin, running high. R1's medical record contained an order (dated 1/14/26) for a CCHO, no added salt (NAS) 90 gram carbohydrate diet. On 2/10/26 at 12:30 PM, Surveyor interviewed Dietary Manager (DM)-E who was not aware that R1's diet order specified 90 grams of carbohydrates. DM-E was not sure how many grams of carbohydrates were provided on a CCHO diet on the facility's menu and indicated Registered Dietitian (RD)-F would review that. DM-E did recall that R1 had a preference for no juice or sweet desserts and that R1 liked cottage cheese and yogurt. On 2/10/26 at 1:00 PM, Surveyor interviewed RD-F who stated a carb-controlled diet is usually 55-70 grams of carbs per meal. RD-F stated if R1 was admitted with more carbohydrates identified in the order per meal, the facility should provide additional carbohydrates to follow the order. RD-F indicated an order for a specific number of carbohydrates per meal should be given to the Dining Director so the facility can provide the right amount of carbs and address the changes on the meal ticket. RD-F was not sure how many carbs per meal the facility's menu provided. RD-F indicated the Dining Director sends RD-F the menus for the menu cycle and RD-F reviews them. 2. On 2/9/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes. During a previous admission to the facility, R6's MDS assessment, dated 1/6/26, had a BIMS score of 15 out of 15 which indicated R6 had intact cognition. R6 had an order for a CCHO diet.On 2/10/26 at 10:50 AM, Surveyor interviewed R6 who indicated R6 prefers to follow a CCHO diet but does not always receive a CCHO diet. R6 stated R6 is served a lot of potatoes and bread and would prefer to not get so many carbohydrates. On 2/9/26, Surveyor reviewed R14's medical record. R14 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes. R14's MDS assessment, dated 2/10/26, had a BIMS score of 15 out of 15 which indicated R14 had intact cognition. R14 had an order for a CCHO diet. On 2/10/26 at 11:25 AM, Surveyor interviewed R14 who indicated R14 prefers to follow a CCHO diet but does not always receive a CCHO diet. R14 indicated R14 chooses to either eat smaller portions of what is provided or not eat what R14 feels does not fit a CCHO diet. On 2/9/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had a (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnosis of type 2 diabetes. R4's MDS assessment, dated 12/26/25, had a BIMS score of 0 out of 15 which indicated R4 had severe cognitive impairment. R4 had an order for a CCHO diet. On 2/9/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes. R5's MDS assessment, dated 11/15/25, had a BIMS score of 8 out of 15 which indicated R5 had moderate cognitive impairment. R5 had an order for a CCHO diet. On 2/9/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes. R7's MDS assessment, dated 12/13/25, had a BIMS score of 15 out of 15 which indicated R7 had intact cognition. R7 had an order for a CCHO diet. On 2/9/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had a diagnosis of stroke. R8's MDS assessment, dated 12/16/25, had a BIMS score of 4 out of 15 which indicated R8 had severe cognitive impairment. R8 had an order for a CCHO no added salt (NAS) diet. On 2/9/26, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes. R9's MDS assessment, dated 12/22/25, had a BIMS score of 4 out of 15 which indicated R9 had severely impaired cognition. R9 had an order for a CCHO diet. On 2/9/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes. R10's MDS assessment, dated 12/18/25, had a BIMS score of 3 out of 15 which indicated R10 had severe cognitive impairment. R10 had an order for a CCHO diet. On 2/9/26, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes. R11's MDS assessment, dated 1/27/26, had a BIMS score of 15 out of 15 which indicated R11 had intact cognition. R11 had an order for a CCHO diet. On 2/9/26, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes. R12's MDS assessment, dated 1/17/26, had a BIMS score of 14 out of 15 which indicated R12 had intact cognition. R12 had an order for a CCHO NAS diet. On 2/9/26, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had a diagnosis of type 2 diabetes. R13's MDS assessment, dated 11/13/25, had a BIMS score of 15 out of 15 which indicated R14 had intact cognition. R13 had an order for a CCHO NAS diet. On 2/10/26 at 11:51 AM, Surveyor observed lunch service from the kitchen. Surveyor reviewed the lunch menu which indicated residents on a CCHO diet should receive: 3 ounces (oz) of baked ham; 4 oz of scalloped potatoes; 4 oz of buttered green beans; 1 dinner roll; and a half slice of Boston cream pie. When Surveyor entered the kitchen area, the dining room trays were pre-set and included a meal ticket, drinks, dessert, and silverware. Surveyor observed slice of pie on each tray which were all approximately the same size. On 2/10/26 at 12:10 PM, Surveyor interviewed DM-E regarding the observation that residents on a CCHO diet did not receive a half piece of pie on their tray and all pie slices appeared to be the same size. DM-E stated DM-E noticed that also and verified residents on a CCHO diet should receive a half piece of pie.