STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525568	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge Operations LLC	3014 Erie Ave Sheboygan, WI 53081

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 38793 Based on staff interview and record review, the facility did not ensure adequate supervision was provided for 1 Resident (R) (R1) of 3 residents reviewed for suicidal ideation. On 6/12/24, R1 went to the Emergency Department (ED) for suicidal ideation. An ED note instructed the facility to continue 1:1 supervision for R1, however, R1 returned to the facility without adequate supervision in place and no documented 1:1 supervision. On 6/13/24 at approximately 6:30 AM, R1 ran into the dining room and sat down near Certified Nursing Assistant (CNA)-G who left the dining room a short time later to assist other residents. R1 crawled out an open second story window without a screen, walked along a narrow ledge that was approximately 18 inches wide to a roof landing, and stood on the far ledge of the landing with R1's arms outstretched. R1 stated that R1 wanted to die. Registered Nurse (RN)-I went out the window, pulled R1 away from the ledge of the landing, walked R1 back along the same narrow ledge, and assisted R1 back through the window and into the facility. The facility's failure to supervise a resident who expressed suicidal ideation, experienced hallucinations, and recently returned from the hospital with a recommendation for 1:1 supervision created a reasonable likelihood for serious harm which lead to a finding of immediate jeopardy that began on 6/13/24. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 7/2/24 at 12:00 PM. The immediate jeopardy was removed on 7/2/24, however, the deficient practice continues at a scope/severity level D (potential for more than minmal harm/isolated) as the facility continues to implement its action plan. Findings include: The facility's Responding to Intent of Self-Harm or Suicide Threat policy, revised 3/17/23, states that any staff member who becomes aware of a resident's intent to self harm, including but not limited to suicidal ideation, suicidal attempt and/or parasuicidal behaviors/self-directed violence, is required to report the behavior immediately or as soon as possible given the situation. Staff may be requested to provide routine checks as directed by the Nursing Home Administrator (NHA) and/or Director of Nursing (DON) or as otherwise ordered by the physician. The checks are to be documented in the medical record. The routine checks are to continue until the designated staff or psychiatrist deems the checks no longer necessary. Continued documentation must be kept ongoing. Said documentation should include all plans, goals, interventions, and care plan updates when applicable. Always document efforts, situation, observations, dates and times, location, witnesses, staff members present, outcomes, who was contacted and who made the contact, as well as future plans for safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/1/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, vascular dementia with mood disturbance, schizoaffective disorder, anxiety, schizophrenia, insomnia, depression, and chronic pain. R1's most recent Minimum Data Set (MDS) assessment, dated 5/20/24, had a Brief Interview for Mental Status (BIMS) score of 1 out of 15 which indicated R1 had severe cognitive impairment. R1 was not interviewed for the Patient Health Questionnaire (PHQ-9) (an assessment tool used to assess the severity of depression) and the staff assessment was also not completed. The MDS also indicated R1 was independent with ambulation. R1's care plan, revised 2/26/24, indicated R1 received specialized psychiatric services for schizoaffective disorder and schizophrenia and exhibited behaviors such as disrobing, verbal aggression, refusing cares/medication, and wandering. R1's medical record contained the following information: ~ A nursing note, dated 2/6/24 at 9:49 AM, indicated R1 repeatedly stated, I'm a bad person. I made a lot of mistakes. I don't like myself. I don't want to live. ~ A nursing note, dated 6/3/24 at 10:59 PM, indicated R1 experienced a mental decline over the last 2 weeks, was unwilling to take medication, was more melancholy, talked less, was more apprehensive, and had a sadder look on R1's face. ~ A nursing note, dated 6/8/24 at 10:10 AM, indicated R1 sobbed loudly in R1's room and stated R1's dead baby was in Heaven and everyone else was going straight to Hell. R1 spoke about R1's self in the third person and preferred not to be called R1's name. The name R1 chose to call R1's self changed frequently. R1 also spoke and looked to R1's left with nobody there. The writer crushed medication in pudding and convinced R1 to take the medication. R1 thought writer was trying to poison R1. ~ A Psych Services Visit note, dated 6/10/24, indicated R1 reported suffering every day but no suicidal ideation. ~ A nursing note, dated 6/11/24 at 11:30 AM, indicated R1 sang Oh God please send me to Hell at breakfast. R1 then screamed, walked swiftly to R1's bedroom without R1's walker, and slammed the door. R1 also tried to elope out the west exit door. R1 cried and told staff R1 wanted to leave the city so God could take R1 to Heaven and end R1's suffering. ~ A nursing note, dated 6/11/24 at 10:19 PM, indicated R1 was calm at the beginning of the shift but refused medication and then showed signs of agitation. Staff attempted to meet R1's needs and redirect and calm R1. At approximately 8:30 PM, R1 deteriorated to the point where R1 was yelling and screaming. R1 resisted redirection and attempts to calm, made statements that R1 wished R1 was dead, and put R1's finger in a socket. R1 was immediately placed on direct 1:1 observation to monitor and provide for R1's safety. Director of Nursing (DON)-B and Psych Services were notified. Staff attempted to contact Crisis Services with no response. The on-call physician ordered to R1 be sent to the ED for evaluation and treatment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ An ED note, dated 6/11/24, indicated R1 presented to the ED for psychiatric evaluation. Per Emergency Medical Services (EMS), R1 experienced suicidal ideation and stated I want to die several times. R1 stated R1 had a lot of physical and emotional pain which is why R1 wanted to die. R1 was not admitted to the hospital due to an activated guardianship and was discharged back to the facility. The note indicated facility staff should call Psych in the morning and continue 1:1 nursing. ~ A nursing note, dated 6/12/24 at 2:29 AM, indicated R1 returned to the facility at 2:00 AM. R1 was stable and calm but started crying and had hallucinations. R1 rested in bed with direct observation of staff at all times. ~ A nursing note, dated 6/12/24 at 6:46 AM, indicated R1 was tearful during the night and stated R1 did not want to live anymore. The writer and a CNA took turns sitting, talking, and praying with R1. ~ A Psych Services Visit note, dated 6/12/24, indicated R1 was acutely worsening/declining. Staff reported during the night (NOC) shift (10:00 PM - 6:00 AM) that R1 threw R1's self against a wall, acted out, was violent, and yelled. R1's Seroquel was restarted at 25 mg (milligrams) BID (twice daily.) ~ A nursing note, dated 6/13/24 at 7:15 AM, indicated at approximately 6:30 AM, R1 was sitting in the dining room with a CNA. R1 became agitated and displayed self-harming behavior. The writer went to the dining room toward R1 and instructed the CNA to get the charge nurse. The charge nurse immediately assisted R1 to safety and the writer notified management. The writer spoke to the Assistant Director of Nursing (ADON) and was advised to call 911. EMS and a police officer arrived at 7:00 AM. At 7:15 AM, R1 left with EMS to the hospital. The writer updated R1's guardian on R1's suicidal ideation and hospital transfer. ~ An ED note, dated 6/13/24, indicated R1 presented to the ED with altered mental status and suicidal ideation. R1 discharged from the ED at approximately 10:19 AM. ~ A Threats to Harm Self Summary, dated 6/13/24 at 5:17 PM, indicated Behavioral Consulting Services (BCS) followed R1 who recently had a gradual dose reduction (GDR) of Seroquel (an antipsychotic medication) which was decreased and ultimately discontinued. R1 did not tolerate the GDR and Seroquel was restarted last evening. R1 stated R1 wanted to die and end R1's suffering. R1 sang to God asked God to take R1 to Heaven. R1 had a clear plan to jump off a ledge/out the window. The following interventions were placed: 1:1 scheduled; Cords/call light removed from R1's room; Lock on bathroom door removed; Plastic utensils to be used with all meals; Window affixed not to open greater than 4-6 inches; Outlet covers on outlets; Shoelaces removed. ~ A nursing note, dated 6/14/24 at 3:22 AM indicated R1 slept for a short time at the beginning of shift but was awake, agitated, and spoke about wanting to die. Staff were at R1's side to reassure R1 and keep R1 safe. ~ A nursing note, dated 6/14/24 at 12:38 PM, indicated R1 stated to a Med Tech, I don't want to be alive anymore. The Med Tech alerted a nurse right away. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ A nursing note, dated 6/15/24 at 1:42 AM, indicated R1 continued on 1:1 supervision. R1 was agitated at the start of the shift and made frequent comments that R1 wanted to die. R1 refused medication. ~ A nursing note, dated 6/15/24 at 10:21 PM, indicated R1 was occasionally calm, generally anxious, often agitated, and sometimes stated R1 wished R1 could leave R1's body and go to Heaven. Approximately every 2 hours, R1 emitted a maximum volume scream that lasted 1-2 minutes. R1 was angry, grabbed at staff, and was hard to redirect. ~ A Psych Services Visit note, dated 6/17/24, indicated R1 climbed out a second story window last week with the intent to jump to R1's death. R1 continued to express a desire to end R1's life. R1 reported feeling possessed and experienced several delusions/hallucinations during the visit. Suicidal ideation was noted with 1:1 status as an intervention. ~ A nursing note, dated 6/20/24 at 10:20 PM, indicated R1 refused medication and was verbally and physically aggressive toward staff. ~ A nursing note, dated 6/24/24 at 1:19 PM, indicated R1 wept and screamed from R1's room to the lounge. R1 sat in a recliner in the lounge, was visibly upset, and spoke non-sensibly. R1 stated R1 wanted R1's hair short and begged the writer to cut R1's hair off. When the writer tried to explain to R1 that a professional should cut R1's hair, R1 screamed, hit R1's self in the head, and asked, Why can't I cut my hair off? R1 got out of a recliner, screamed, and walked at a fast pace down the hallway. ~ A Psych Services Visit note, dated 6/24/24, indicated R1 experienced hallucinations, was on 1:1 status, and continued to state that R1 wanted to die. The note also indicated R1 ran through the hallway and went in empty resident rooms. ~ A nursing note, dated 6/24/24 at 6:07 PM, indicated R1 pulled out a small chunk of hair. The writer called the Crisis line. Since R1 had no injury, staff were told to continue 1:1 supervision and call 911 if R1 injured R1's self. ~ A nursing note, dated 6/30/24 at 10:13 AM, indicated R1 continued on 1:1 supervision with increased confusion, agitation, psychosis, and increased aggression. On the previous shift, R1 bit a caregiver and attempted to go after 2 residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/1/24 at 10:56 A.M., Surveyor interviewed CNA-G regarding R1's incident on 6/13/24. CNA-G stated CNA-G was not told anything in morning report and did not see anything in R1's care plan that indicated R1 was on 1:1 direct supervision. CNA-G stated CNA-G had been in the dining room on the morning of 6/13/24 when R1 ran into the dining room and sat down. CNA-G verified there were no other staff or residents in the dining room at the time. CNA-G stated CNA-G left the dining room to assist other residents and saw Licensed Practical Nurse (LPN)-H and LPN-K prepare medications at the carts just outside the dining room and within eyesight of R1. CNA-G stated CNA-G was approximately 1 or 2 resident rooms away when CNA-G head staff yell for assistance. CNA-G also reported that during a recent 1:1 assignment on the morning of 6/30/24, CNA-G observed R1 enter an empty resident room with no safety precautions in place (i. e., removal of phone cords/call lights, etc.) CNA-G stated CNA-G waited outside the room and heard R1 rummage around/move something. CNA-G looked in the room and observed R1 attempt to slide a chair into the hallway. CNA-G stated CNA-D did not follow R1 into the empty room so R1 would not get agitated. On 7/1/24 at 1:01 PM, Surveyor interviewed LPN-H regarding R1's incident on 6/13/24. LPN-H stated LPN-H was told that R1 went to the ED during the NOC shift but was not told that R1 was on 1:1 supervision. LPN-H stated LPN-H was only told to keep an eye on R1. When asked what keep an eye on R1 meant, LPN-H stated R1 should be kept within eyesight but verified that did not happen due to lack of staff and no direct assignments. LPN-H stated LPN-H was preparing medication at the medication cart outside the dining room and saw R1 go into the dining room and sit down. LPN-H then saw CNA-G leave the dining room to assist other residents. While LPN-H looked at a computer and in the medication cart, R1 got up and started climbing out the second story window in the dining room. LPN-H verified that LPN-H looked away from R1 to prepare medication for a resident. LPN-H stated by the time LPN-H got across the dining room to the open window, R1 had climbed out onto the ledge and was moving toward the rooftop. LPN-H got RN-I and other staff to assist and called out the window for R1 to come back inside. LPN-H stated RN-I climbed out the window and walked along the ledge to the roof to get R1 to safety. LPN-H verified LPN-H had been assigned to R1's 1:1 supervision several times since the incident and had not been provided education regarding R1's supervision/suicidal ideation. On 7/2/24, Surveyor reviewed staff schedules from 6/11/24 through 7/2/24 and noted there were no staff assigned to be 1:1 with R1 until 6/13/24 at 11:30 AM. On 7/1/24 at 2:58 PM, Surveyor interviewed NHA-A and Regional Operations Manager (ROM)-L regarding R1's supervision. NHA-A and ROM-L verified R1 was not on documented/scheduled 1:1 supervision until R1 returned from the ED on 6/13/24 at approximately 10:30 AM. NHA-A stated staff were assigned to R1's 1:1 supervision and were to keep R1 in eyesight at all times, remain side-by-side with R1 when out of R1's room, and document in R1's medical record on an observation flow sheet. On 7/1/24, Surveyor observed the second floor dining room. Per staff interview, R1 climbed out the second window from the right. Surveyor noted the second window from the right did not have a screen and was bolted shut and unable to be opened. The window was approximately 18 inches high and opened downward at an approximate 45 degree angle. The ledge outside the window was approximately 18 inches wide and covered with aluminum siding. The ledge extended approximately 25 feet to the right onto a rooftop landing covered with gravel. There was a cement sidewalk below. Per staff interview, R1 went to the far ledge which was approximately 1.5 stories high with grass below and stood on the ledge with intent to jump. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/1/24 at 3:01 PM, Surveyor requested the facility's investigation for the incident on 6/13/24. The facility's incident report indicated staff observed R1 climb out the second floor dining room window and walk on a ledge toward a second landing while stating R1 wanted to die and end R1's suffering. The report indicated R1 had a recent failed GDR of Seroquel and the medication had been resumed on 6/12/24. The investigation included staff statements from RN-I, LPN-K, and CNA-J. NHA-A verified there were no written statements from LPN-H or CNA-G in the investigation file. ~ RN-I's statement indicated RN-I had come to work at approximately 6:30 AM and was working on the third floor. CNA-G came to the nurses' station and stated R1 had gone onto the roof. RN-I climbed out the open dining room window and walked along the ledge to the rooftop landing. RN-I hugged R1 from behind and pulled R1 back from the ledge of the landing. RN-I walked back along the ledge and went back through the open window with R1. RN-I assured that staff were with R1 before RN-I left to notify administration. ~ LPN-K's statement indicated LPN-K and LPN-H were preparing AM medication at medication carts just outside the dining room. LPN-K verified that after CNA-G walked away from R1, LPN-H observed R1 dart to an open window without a screen and climb out. LPN-K then heard LPN-H scream and ran to see what happened. LPN-K observed R1 outside the second floor window and observed RN-I go out the window and guide R1 back inside. LPN-K conducted a head-to-toe assessment of R1 with no injuries noted. LPN-K stated R1 returned to the facility from the ED at approximately 10:30 AM and LPN-K provided 1:1 supervision. ~ CNA-J's statement indicated shortly after CNA-J arrived at 6:00 AM, CNA-J observed R1 walk around the hallways/common areas while crying. CNA-J's statement indicated CNA-J was giving another resident a bath when R1 climbed out the window. On 7/1/24, Surveyor reviewed the facility's staff education: ~ On 6/13/24, the facility initiated education regarding notification of changes to [NAME] of Attorney (POAs)/administration/police/Medical Doctors (MDs)/etc., care plan revisions, and accidents/supervision. Administrative staff conducted a walk-through to ensure all windows were adjusted to not open more than 6 inches, including all common areas and resident rooms. All residents were reviewed for psychosocial behavior and suicidal ideation and their care plans were updated as needed. An audit tool was initiated to monitor compliance with notifications and revision of care plans related to threats of self harm and incident reporting. Audits were scheduled weekly x 4, bi-weekly x 2, and monthly x 1 to ensure compliance. ~ On 6/21/24, the facility initiated education regarding R1's care plan updates and 1:1 supervision expectations such as filling out the log and walking with R1 when out of R1's room. At the time of the survey, the facility had educated 34 of their 74 regular staff (~46% of staff). A comparison of the facility's schedules (including 1:1 supervision assignments) with the staff training revealed that at least 13 staff members who were assigned to R1's 1:1 supervision between 6/21/24 and 7/1/24 had not been educated. On 7/1/24, Surveyor reviewed the facility's Observation Flow Sheets for R1 and noted the log did not begin until 6/13/24 at 3:00 PM which was approximately four and a half hours after R1 returned from the ED. On 6/17/24 from 6:15 PM to 10:15 PM, the observation log indicated R1's location, but did not include initials for the staff member responsible for R1's 1:1 supervision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The failure to supervise a resident who had suicidal ideation, experienced hallucinations, and recently returned from the hospital, created a reasonable likelihood for serious harm which led to a finding of Immediate Jeopardy. The facility removed the jeopardy on 7/1/24 when it had completed the following: 1. Maintained 1:1 supervision for R1. 2. Educated staff immediately or before their next scheduled shift on the requirements of 1:1 supervision, checking the schedule to determine who is assigned to 1:1 supervision, and referencing residents' care plans to see which residents require 1:1 supervision. 3. Conducted ongoing 1:1 shift audits to ensure adequate and safe supervision was provided. 4. Conducted ongoing staff interviews to ensure 1:1 supervision competency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50467 Based on observation, staff interview, and record review, the facility did not ensure medications for 10 Residents (R) (R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12) of 10 residents in 2 of 2 medications carts were stored, labeled or dated appropriately. The facility also did not ensure 1 of 1 refrigerator in the medication storage room that contained insulin vials maintained a temperature of 41 degrees Fahrenheit (F) or lower. In addition, the facility did not ensure 2 of 2 medication carts were locked when unattended. Medication carts contained unopened insulin vials that should remain refrigerated until opened. The carts also contained open, undated, and expired medications. Refrigerator temperature log sheets for the second floor medication room refrigerator contained temperatures greater than 41 degrees F. The log sheets indicated the temperature should be 41 degrees F or lower. On 7/1/24, the thermometer in the refrigerator read 44 degrees F. The refrigerator contained unopen insulin vials which should be stored between 36 degree and 46 degrees F to preserve the integrity of the medication. Treatment carts contained expired and unlabeled treatments and were not locked when left in areas accessible to residents and visitors. Findings include: The Glargine insulin manufacture [NAME] Lilly insert labeled 16.2 Storage indicates: Store unused Insulin Glargine in a refrigerator between 36 F and 46 F (2 C (Celsius) and 8 C). Do not freeze. Discard Insulin Glargine if it has been frozen. Protect Insulin Glargine from direct heat and light. The insert also indicates that an in-use vial or open SoloStar (insulin pen) is good for 28 days refrigerated or room temperature. The Diabetes Disaster Response Coalition states in Safe Storage of Insulin pamphlet Pdf. dated 2018: According to the product labels from all three U.S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36 F to 46 F. This is recommended for unopened insulin. The ipratropium bromide and albuterol nebulizer packaging indicates: Storage Conditions: Protect From Light. Unit-dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within two weeks. Discard if the solution is not colorless. The facility's Medication Storage policy, with a revision date of 2/12/24, indicates under general guidelines: 4. Expired medications are to be removed from medication carts prior to or at the time of expiration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Compartments containing medications should be locked when not in use. Trays or carts used to transport such items should not be left unattended. 9. Medications requiring refrigeration should be stored in the refrigerator. The policy indicates for multi-dose vials: 2. Insulin vials may not be stored at temperatures that exceed 75 degrees F. The policy indicates for stock medications: 1. Medications will be stored in accordance with manufacturer guidance and not exceed expiration dates unless a shortened shelf-life once opened. On 7/1/24 at 10:01 AM, Surveyor observed the 2 [NAME] medication cart and noted the following: 1. R6's Glargine insulin 100u/ml (milliliters) was opened on 5/23/24. Per the manufacturer label, the insulin expires 28 days after opening. 2. Unopened lispro insulin was stored unrefrigerated. 3. An open and undated vial of Lantus insulin for R6. 4. R7's ipratropium bromide and albuterol nebulizer was undated and out of the foil packaging. The start date indicated 5/2/23. 5. Calcium carbonate 500 mg (milligram) chewable antacid with an expiration date of 6/2024. 6. Chondroitin sulfate 400 mg with an expiration date of 9/2023. 7. Iron 27 mg with an expiration date of 4/2024. 8. A povidone iodine swab stick with an expiration date of 1/2024. 9. A non-adherent pad (dressing) with an expiration date of 3/2024. 10. An open, undated, and unlabeled bottle of ultra eye drops for R6. 11. An open, undated, and unlabeled bottle of ultra eye drops for R8. 12. An open and undated bottle of Ketorolac eye drop solution 0.5% for R8. 13. A Ziplock bag labeled Flonase sensimist 27.5 mg nasal spray for R9 that contained a Kirkland brand fluticasone proprionate without a name or open date. 14. An open and undated fluticasone nasal spray for R1. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/24 at 10:35 AM, Surveyor confirmed the open, undated, and expired medications with Licensed Practical Nurse (LPN)-E. On 7/2/24 at 10:38 AM, Surveyor observed the 2 East medication cart and noted the following: 1. Once daily multivitamins with an expiration date of 6/2024. 2. Fish oil with an expiration date of 3/2024. 3. Lanta regular strength antacid and anti-gas with an expiration date of 4/2024. 4. Open and undated Budesonide 0.5 mg/2 mL nebulizer vial (3 foil packs) for R3. 5. Open an undated ipratropium bromide and albuterol nebulizer (3 foils packs) for R3. 6. An open and undated vial of Glargine insulin for R4. 7. An open, undated, and unlabeled Glargine insulin pen for R4. 8. An open and undated Lantus insulin pen for R5. 9. An unused and unrefrigerated Lantus insulin pen for R5. 10. A bag of two open and undated vials of Glargine insulin for R5. 11. Seven open and undated vials of ipratropium bromide and albuterol nebulizer for R7 that were not in the foil packaging. 12. A bag of 2 open and undated vials of ipratropium bromide and albuterol nebulizer for R5 that were not in the foil packaging. 13. An open and undated vial of Lantus insulin for R11. On 7/2/24 at 11:05 AM, Surveyor confirmed the open, undated, and expired medications with LPN-E. On 7/2/24 at 11:08 AM, Surveyor interviewed Registered Nurse (RN)-D who confirmed a red and black cart in between the medication carts was a treatment cart. RN-D indicated the cart was never locked but contained residents' treatments for the East and [NAME] halls. On 7/2/24 at 11:08 AM, Surveyor observed the treatment cart and noted the following: 1. [NAME] pain relief gel labeled with a resident's first name. 2. A box of 9 Saline Jet vials with the top ripped off and no visible expiration date. 3. A container of petroleum jelly with an expiration date of 6/2024. 4. Hydrocortisone cream with an expiration date of 5/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525568	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge Operations LLC	3014 Erie Ave Sheboygan, WI 53081

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/24 at 11:21 AM, Surveyor verified the above expired and unlabeled treatment supplies with LPN-E. On 7/1/24 at 11:20 AM, Surveyor entered a locked medication storage room with LPN-E who stated night shift staff were responsible for checking refrigerator temperatures. Surveyor observed the refrigerator temperature record sheet and noted temperatures that were out of range. The record sheet stated Record temperature daily. Temperature to be 41 degrees Fahrenheit or lower. If temperature is above 41 degrees report it to maintenance immediately. Remove items and place in another refrigerator until temperature is at 41 degrees or lower . Surveyor noted the temperature of the refrigerator was 44 degrees F per the thermometer on the top shelf. LPN-E confirmed the temperature. Surveyor noted the June 2024 record sheet contained 5 missing temperatures on the 20th, 22nd, 23rd, 25th, and 30th, and noted 3 temperatures were out range. The temperature on the 17th was 42 degrees and temperatures on the 18th and 19th were 50 degrees. Surveyor noted the May 2024 record sheet contained 4 missing temperatures on the 5th, 23rd, 30th, and 31st, and noted 3 temperatures were out of range. Temperatures on the 14th and 15th was 42 degrees and the temperature on the 16th was 45 degrees. On 7/1/24 Surveyor observed the medication storage area and noted the following: 1. A bottle of hand sanitizer gel with an expiration date of 7/2022. 2. Two bottles of sterile water for irrigation with expiration dates of 11/3/23. 3. A box of Bisacodyl suppositories with an expiration date of 6/2024. On 7/1/24, Surveyor verified the expired supplies/medication with RN-D. On 7/1/24 at 12:43 PM, Surveyor noted the third floor treatment cart was unlocked in a common area. The following items were on top of the cart: Dermal wound cleanser, [NAME] oil, and an Aquaphor jar with a label for R12. Medication Tech (MT)-F confirmed the treatment cart was not locked and could be accessed by residents or visitors. On 7/1/24 at 3:15 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed nebulizers should be kept in foil and should be kept per manufacturer's recommendations. DON-B indicated opened insulin should be dated, stored in the medication cart, and disposed of after 28 days unless otherwise stated. DON-B stated unopened insulin vials and pens should be stored in the refrigerator. DON-B indicated when eye drops and insulin are opened, staff should label the items with an open date, and staff should use the expiration date noted on bulk medication bottles. DON-B stated night shift staff were responsible for checking medication refrigerators. DON-B confirmed the facility had not been tracking if maintenance was notified of out-of-range temperatures or if the refrigerators had been checked by maintenance when temperatures were found out of range. DON-B confirmed the missing and out-of-range temperatures per the temperature record sheets labeled May and June of 2024.