Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on observation and staff and resident interview, the facility did not ensure a clean, comfortable, or home-like environment for 1 Resident (R) (R4) of 10 sampled residents. R4's wheelchair was visibly dirty. The facility did not have documentation that indicated R4's wheelchair was routinely cleaned. Findings include: On 8/19/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE]. R4's Minimum Data Set (MDS) assessment, dated 7/26/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R4 had intact cognition. On 8/19/24 at 12:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated night shift Certified Nursing Assistants (CNAs) should complete wheelchair cleaning. NHA-A indicated residents' wheelchairs should be cleaned on bath days and stated the task was listed on the bath schedule that night shift CNAs should check for the following day. NHA-A stated staff do not document when wheelchair cleaning is completed or if residents refuse wheelchair cleaning. NHA-A stated the facility will add a wheelchair cleaning task for night shift to sign off. NHA-A stated NHA-A expects staff to clean residents' wheelchairs weekly and as needed. On 8/19/24 at 1:05 PM, Surveyor observed R4 in a wheelchair in R4's room. Surveyor noted R4's wheelchair had dried debris on both wheels and a bar at the bottom of the wheelchair contained what appeared to be greasy layers of dirt. Surveyor donned a glove and wiped the bar to see if the dirt and debris would come off. Surveyor removed some dirt and debris with the glove; however, some dirt and debris remained. Surveyor interviewed R4 who stated R4 did not know if R4's wheelchair had been cleaned but didn't think so. R4 stated R4 would like R4's wheelchair cleaned. On 8/19/24 at 1:15 PM, Surveyor interviewed CNA-M who stated night shift staff are supposed to clean residents' wheelchairs; however, CNA-M was not sure if night shift staff documented wheelchair cleaning. When Surveyor asked CNA-M to look at R4's wheelchair, CNA-M confirmed R4's wheelchair was dirty and stated CNA-M noticed some wheelchairs in the facility that could be cleaned.

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: 525568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Sunny Ridge Operations LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure care and treatment were provided in a timely manner for 1 Resident (R) (R2) of 10 sampled residents. Staff did not notify R2's physician timely of a change in condition on 6/4/24. In addition, staff did not document completed assessments for R2's change in condition on 6/4/24. Findings include: The facility's Change in Condition policy, revised on 7/6/21, indicates: To ensure prompt notification of the resident, the attending physician, and Durable Power of Attorney/responsible party of changes in the resident's physical, psychosocial and/or mental condition and/or status .The physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden in onset, a change that is a marked difference in usual signs/symptoms .Specific information that requires prompt notification includes, but is not limited to: .i. Any unusual occurrence, accident or incident involving the resident .m. A need to alter the resident's medical treatment significantly .o. A need to transfer the resident to a hospital/treatment center .Nurse will complete assessment and document findings in resident record . The facility's Neurological Status Evaluation policy, revised on 3/13/24, indicates: The licensed nurse may perform the neurological status evaluation without a physician's order when there is concern over change in mental status functioning .Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures). This may be indicative of increasing intracranial pressure (ICP) . Neurological evaluation should be complete, specific, and compare the right side of the body with the left . On 8/14/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including anemia and diabetes mellitus. R2's Minimum Data Set (MDS) assessment, dated 5/23/24, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 had intact cognition. R2's medical record indicated R2 was responsible for R2's healthcare decisions. A progress note, dated 6/4/24 at 10:42 AM, indicated: The Director of Nursing (DON) received an order from an Nurse Practitioner (NP) to send R2 to the emergency room (ER) to be evaluated and obtain a head scan due to a fall that morning. A fall investigation, dated 6/4/24, indicated R2 was found face down on the floor between R2's bed and recliner. R2 had a forehead/top of scalp contusion and complained of right shoulder pain. A sheet was on the cushion in R2's recliner and the recliner was elevated. R2 stated R2 did not know what happened and must have been sleeping. R2 was assisted up with a lift. Neurological checks were initiated and vital signs were stable. An ice pack was applied to R2's forehead. The investigation indicated a Medical Doctor (MD) for R2's Primary Care Provider (PCP) was notified at 6:45 AM, the DON was notified at 7:00 AM, R2's spouse was notified at 7:20 AM, an NP was notified at 10:09 AM, and R2's adult child was notified at 10:20 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Sunny Ridge Operations LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 1:50 PM, Surveyor interviewed NP-C via phone who stated R2's primary NP (NP-D) was out of the office but NP-C could review R2's clinic notes. NP-C stated R2's clinic notes contained an entry, dated 6/4/24 at 10:31 AM, from a clinic nurse to NP-D regarding three voicemails left by facility staff regarding R2's fall. The entry did not state what the voicemails said or what time the voicemails were received. NP-C stated NP-D responded to the entry at 11:10 AM and indicated NP-D had spoken with the facility's DON earlier on 6/4/24; however, the entry did not document the time of NP-D's conversation with the DON. On 8/14/24 at 2:45 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-E via phone. CNA-E verified CNA-E was one of the CNAs who found R2 on the floor on 6/4/24 and stated R2 slept in R2's recliner. CNA-E stated sometime after 4:00 AM on 6/4/24, CNA-E and CNA-F entered R2's room and found R2 face down on the floor between the recliner and the bed. R2's call light was fastened to the recliner and R2 had not activated the call light that shift. CNA-E stated the nurse was immediately notified and assisted the CNAs with repositioning R2 onto R2's back and transferring R2 to bed via mechanical lift. CNA-E stated, (R2) was talking jibberish. (R2) vomited and we had to clean (R2) up .there was blood .(R2) complained of pain in (R2's) back and hips. (R2) did not remember what happened. CNA-E stated the nurse brought in the vital signs machine and the CNAs left to attend to other residents. On 8/19/24, Surveyor reviewed the Medical Examiner's (ME) Report for R2, dated 6/8/24, which indicated R2's cause of death was sepsis due to urinary tract infection and malignant neoplasm (cancer) of colon. The ME Report indicated although the fall was recent in relation to R2's decline, the fall did not result in any injuries that would result in death, unlike the other natural medical diagnoses that were discovered during R2's hospital stay. On 8/19/24 at 9:39 AM, Surveyor interviewed NP-D who stated NP-D was unsure when facility staff left voicemails at the office but referenced NP-D's cell phone and stated NP-D had missed calls from the facility on 6/4/24 at 9:51 AM, 9:53 AM, and 10:02 AM. NP-D stated NP-D attempted to call the facility at 10:15 AM on 6/4/24 with no answer. NP-D then looked at text messages and stated NP-D received a text message from the facility at 10:08 AM that they wanted to send (R2) to the ER. NP-D texted back ok to send to ER. Following a discussion of the above scenario, NP-D stated facility staff should have contacted R2's PCP immediately after the fall to send R2 to the ER. When asked how facility staff contact the PCP or on-call provider, NP-D stated, When they call the office, it should have forwarded to whoever contacts the on-call physician. When asked what the expectation is if facility staff get the PCP or on-call provider's voicemail, NP-D said facility staff should have called NP-D's cell phone and stated, One would hope they would have just sent out to ER and gotten an order later. On 8/19/24 at 10:31 AM, Surveyor interviewed Registered Nurse (RN)-G who stated RN-G was on another floor on the 6/4/24 AM shift when RN-G was asked to look at R2 around breakfast time. RN-G stated RN-G had never seen R2 before. After RN-G saw R2's condition, RN-G asked DON-B to come and stated, Once I talked to (DON-B), they shipped (R2) out (to the ER). RN-G stated R2 had fallen during the night shift and when RN-G talked to RN-H (the night shift nurse), RN-H told RN-G that RN-H had spoken with a physician and was told to just monitor R2. On 8/19/24, Surveyor reviewed R2's electronic Medication Administration Record (eMAR) which contained the following note: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Sunny Ridge Operations LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ On 6/4/24 at 6:43 AM: R2 was found laying face down on the floor between R2's bed and recliner. R2 stated R2 did not know what happened. The recliner was elevated and R2 was sitting on a bedsheet over the cushion. R2 hit R2's head and had a contusion on the forehead. R2 was assisted up by staff with a mechanical lift. Neurological checks were initiated and within normal limits (WNL). Vital signs (VS) were stable. R2 complained of right shoulder pain. Range of motion (ROM) was WNL. The DON and on-call MD (MD-I) were notified. MD-I stated to wait and monitor R2's right shoulder pain and update R2's PCP. On 8/19/24 at 12:07 PM, Surveyor interviewed NP-D who stated MD-I was a nephrologist (kidney specialist) with a different medical group than R2's PCP. NP-D stated R2's PCP group had MD-J (same first name as MD-I but different last name) who sometimes took calls for R2's PCP. NP-D called the clinic in the presence of Surveyor and asked which MD was on-call in the early morning of 6/4/24. Clinic staff informed NP-D that PCPs were responsible for call during all weekday hours and call rotation only covered weekend hours. Since 6/4/24 was a Tuesday, R2's PCP (MD-K) would have been on-call. NP-D stated NP-D would contact MD-J and MD-K and ask them to call Surveyor regarding if either received calls from the facility regarding R2's change in condition on 6/4/24. On 8/19/24, Surveyor reviewed a Neurological Observation Checklist for R2's fall on 6/4/24. Instructions at the top of the checklist indicated: This checklist should be used at the following intervals for follow-up of all falls. Any change in resident condition requires a phone call to the primary care physician. Initial assessment followed by every 15 minutes x 4, every 30 minutes x 2, every hour x 2, and once per shift for 72 hours. The checklist contained entries on the first page for 6/4/24 at 5:30 AM, 5:45 AM, 6:00 AM, 6:15 AM, 6:30 AM, and 7:15 AM. The second page contained entries that assessed R2's right arm strength at 5:30 AM, 5:45 AM, and 6:00 AM; entries that assessed R2's left arm strength at 5:30 AM and 5:45 AM; a set of vital signs at 5:30 AM that indicated R2's blood pressure was 128/64 (normal considered approximately 120/80), pulse was 120 (normal considered 60-100) and respirations were 20 (normal considered 12-20); and entries that assessed R2's pupil reaction time at 5:30 AM, 5:45 AM, 6:00 AM, and 6:15 AM. On 8/19/24, Surveyor reviewed R2's medical record for any additional vital signs obtained on 6/4/24. No additional vital signs were documented. On 8/19/24 at 1:59 PM, Surveyor interviewed Regional Director of Clinical Operations (RDCO)-K. Following a discussion of the above information regarding R2's fall and change in condition on 6/4/24, RDCO-K stated staff were expected to do a complete neurological assessment each time. RDCO-K verified more than one set of vital signs should have been obtained to assess for changes. RDCO-K verified 5:30 AM to 10:00 AM was a long time to wait before R2 was sent to theER on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 3:15 PM, Surveyor interviewed RN-H via phone. RN-H stated at approximately 5:00 AM on 6/4/24, CNAs notified RN-H that R2 was on the floor. RN-H assessed R2 and assisted the CNAs with transferring R2 from floor to bed with a mechanical lift. RN-H notified DON-B and the on-call physician. RN-H was surprised the on-call physician did not send R2 to the ER. RN-H said R2's mentation did not seem changed and stated, (R2) was always a little confused. RN-H denied seeing any vomit and did not recall being told that R2 had vomited. When asked why only one set of vital signs were obtained, RN-H indicated RN-H obtained multiple sets of vital signs and stated, I probably didn't get them in (documented) or didn't have enough time. When asked why RN-H called MD-I, RN-H stated RN-H referenced a printed notification of who was on-call. When RN-H was told MD-I was a nephrologist at a different medical clinic than R2's PCP, RN-H stated, That's interesting. When asked if RN-H was sure that RN-H spoke to MD-I on 6/4/24, RN-H stated, I specifically ask the name so I can write it in the notes. When asked if RN-H left messages on an answering machine at R2's PCP's clinic, RN-H stated, I don't remember that. On 8/19/24 at 3:46 PM, Surveyor interviewed CNA-F via phone. CNA-F verified CNA-F was with CNA-E when R2 was found on the floor on 6/4/24. CNA-F stated R2 was face down with R2's head pointed toward the end of the bed. CNA-F stated R2 had been in R2's recliner which was in a completely elevated position like a standing position when R2 was found on the floor. CNA-F stated the nurse assisted with rolling R2 over and transferring R2 to bed via mechanical lift. CNA-F denied seeing any vomit but noted bruising and bleeding on R2's face. CNA-F stated R2 did not seem more confused than usual. On 8/19/24 at 4:07 PM, Surveyor interviewed MD-K via phone. MD-K verified MD-K was R2's PCP and was on-call during the early morning hours of 6/4/24. MD-K stated MD-K did not receive any calls from the facility regarding R2 on 6/4/24. When asked about the call sheet referenced by RN-H in the above interview, MD-K stated the clinic does not send call sheets to facilities because the facility just needs to call the clinic number and the calls are automatically routed to a call center when the clinic is not open. Call center staff then contact the on-call physician to return the call to the facility. MD-K stated falls with head injuries should always be evaluated in the ER immediately which would have been MD-K's order had MD-K been contacted on 6/4/24. On 8/19/24 at 5:09 PM, Surveyor received a voice message from MD-J that indicated MD-J was not notified of R2's fall on 6/4/24 and there was no record at the clinic call center that the facility attempted to contact a physician at the clinic on 6/4/24.