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	11/25/2024

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

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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** 43361 Based on staff interview and record review, the facility did not ensure a physician was notified when 1 resident (R) (R3) of 2 sampled residents was sent to the hospital. On 9/25/24, R3's Power of Attorney for Healthcare (POAHC) contacted Emergency Medical Services (EMS) to have R3 sent to the emergency room (ER). Staff did not notify R3's physician and R3 did not return to the facility. Findings include: The facility's Change in Condition policy, revised 11/13/24, indicates: To ensure prompt notification .of the attending physician of changes in the resident's physical, psychosocial, and/or mental condition or status. 2. Specific information that requires prompt notification includes, but is not limited to .a need to transfer the resident to a hospital/treatment center. 3. Notification of medical professional .will be documented in medical record. On 11/25/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE], received Hospice services, and had diagnoses including malignant neoplasm of middle lobe, bronchus or lung, secondary malignant neoplasm of right lung, secondary malignant neoplasm of bone, and secondary malignant neoplasm of brain. R3's Minimum Data Set (MDS) assessment, dated 9/17/24, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R3 had moderately impaired cognition. R3 had an activated POAHC. A progress note, dated 9/25/24 at 12:28 PM, indicated EMS was called by R3's POAHC because R3 was not behaving normally and had head pain. R3's vital signs were within normal limits. R3's POAHC did not notify facility staff about R3's change in condition or that EMS was notified. Hospice staff were updated. On 11/25/24, Surveyor requested documentation that R3's physician was notified when R3 was transferred to the hospital. (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	On 11/25/24 at 2:32 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated facility staff notified Hospice staff of R3's hospital transfer but did not notify R3's physician. NHA-A confirmed a resident's physician should be notified if a resident is transferred to the hospital. When NHA-A asked if notification of R3's Hospice provider was sufficient, Surveyor indicated R3's physician should have been notified in addition to Hospice staff.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 2 residents (R) (R1 and R2) of 13 sampled residents. R1 and R2 had resident-to-resident altercations on 10/11/24 and 10/13/24. The resident-to-resident altercations were not thoroughly investigated. Findings include: The facility's Abuse Prevention/Vulnerable Adult Plan policy, revised 10/29/24, indicates: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, neglect, mistreatment, or exploitation. The facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thorough investigations of allegations .Residents and staff will be monitored for protection .4. Investigation .G. Document resident behaviors at the time of the incident, as well as observations made of resident's behavior during the investigation. On 11/25/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including history of mental and behavioral disorders, dementia, psychotic disturbance, mood disturbance, and anxiety. R1's Minimum Data Set (MDS) assessment, dated 10/14/24, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R1 had severely impaired cognition. R1 had a legal guardian. On 11/25/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including early onset Alzheimer's disease, dementia, delusional disorder, generalized anxiety disorder, post-traumatic stress disorder, and cognitive communication deficit. R2's MDS assessment, dated 11/2/24, had a BIMS score of 3 out of 15 which indicated R2 had severely impaired cognition. R2 had an activated Power of Attorney for Healthcare (POAHC). On 11/25/24, Surveyor reviewed a facility-reported incident (FRI). The initial report, submitted to the State Agency on 10/13/24, stated on 10/11/24, R2 approached R1 in the dining room, yelled at R1, and used inappropriate language. Staff separated R1 and R2 and kept both residents safe. On 10/13/24, R2 again approached R1 in the dining room and yelled at R1. Staff again separated R1 and R2 and kept both residents safe. Staff notified local law enforcement as well as R1 and R2's representatives and R2's physician. Residents and staff were interviewed. The FRI indicated R2 was monitored via 15-minute checks until a psychiatric appointment on 10/15/24 when medication changes were initiated. Staff education was provided. On 11/25/24 at 3:04 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified staff completed 15-minute checks for R2 from 10/13/24 through 10/15/24. NHA-A indicated the 15-minute checks were documented on a log that NHA-A would provide to Surveyor. On 11/25/24 at 4:37 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated if a resident is placed on 15-minute checks, DON-B expects staff to complete and document the 15-minute checks. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 4:41 PM, Surveyor interviewed NHA-A who indicated NHA-A could not find documentation of R2's 15-minute checks.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure oral care was consistently completed for 3 residents (R) (R3, R5, and R6) of 7 sampled residents. Oral care was not consistently documented as completed, unavailable, or refused in R3's medical record. Oral care was not consistently documented as completed, unavailable, or refused in R5's medical record. Oral care was not consistently documented as completed, unavailable, or refused in R6's medical record. Findings include: The facility's Activities of Daily Living (ADLs) Policy and Procedures, dated 3/15/21, indicates: .1. A resident will be given the appropriate treatment and services to maintain or improve his or her ability to carry out ADLs. 2. The facility will provide care and services for the following ADLs: Hygiene - bathing, dressing, grooming, and oral care .3. Staff will document a resident's level of independence in performing ADLs .7. If a resident refuses care, this shall be reported to the nurse and the resident should be re-approached. Documentation of refusal shall be completed in the electronic medical record. 1. On 11/25/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE], received Hospice services, and had diagnoses including malignant neoplasm of middle lobe, bronchus or lung, secondary malignant neoplasm of right lung, secondary malignant neoplasm of bone, and secondary malignant neoplasm of brain. R3's Minimum Data Set (MDS) assessment, dated 9/17/24, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R3 had moderately impaired cognition. R3 had an activated Power of Attorney for Healthcare (POAHC). The MDS assessment also indicated R3 required partial/moderate assistance for oral care. R3 was transferred to the hospital on 9/25/24 and did not return to the facility. R3's medical record indicated oral care was not completed for two days while R3 was at the facility. Documentation for the other days indicated R3 refused oral care (4 days) or oral care was completed (9 days). On 11/25/24 at 4:37 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B expects staff to complete and document oral care daily for all residents. 2. On 11/25/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke affecting the right non-dominant side, diabetes type 2, depression, and anxiety. R5's MDS assessment, dated 11/7/24, had a BIMS score of 10 out of 15 which indicated R5 had moderately impaired cognition. R5 had a guardian for health care decisions. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oral care documentation in R5's medical record from 11/12/24 to 11/25/24 indicated R5 did not receive oral care on 1 of 14 days. On 11/14/24, there was no AM shift or night (NOC) shift documentation; Not Applicable (NA) was checked on the PM shift. On the other days, oral care was documented at least daily. On 11/25/24 at 3:50 PM, Surveyor interviewed DON-B who indicated DON-B expects staff to complete oral care at least daily. Surveyor reviewed R5's oral care documentation for 11/14/24 with DON-B who indicated if it was not documented, it was not done. DON-B was unsure why NA was documented on 11/14/24. 3. On 11/25/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including vascular dementia, oropharyngeal dysphagia, sepsis, and weight loss. R6's MDS assessment, dated 10/24/24, had a BIMS score of 7 out of 15 which indicated R6 had severely impaired cognition. R6 had a guardian for health care decisions. Oral care documentation in R6's medical record from 11/12/24 to 11/25/24 indicated R6 did not receive oral care on 2 of 14 days. On 11/13/24, there was no AM shift documentation; on the PM and NOC shifts, NA was documented. On 11/22/24, there was no AM shift documentation; on the PM and NOC shifts, NA was documented. On 11/25/24 at 3:50 PM, Surveyor interviewed DON-B who verified staff should complete and document oral care for residents once daily. DON-B was unsure why NA was documented on 11/13/24 and 11/22/24.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50988 Based on observation, staff interview, and record review, the facility did not ensure appropriate catheter care and services were provided for 2 residents (R) (R9 and R3) of 7 sampled residents. On 11/25/24, R9's catheter tubing and uncovered drainage bag were observed on the floor. R3 had a Foley catheter upon admission. R3 did not have a physician order for catheter care or documentation related to catheter care and output. Findings include: The facility's Policy and Procedure for Foley Catheter Management, dated 3/1/24, does not address the positioning/placement of catheter tubing or drainage bags. The policy indicates catheter bags will be covered when in common areas for privacy and dignity. The policy indicates: Proper care will be provided for the management of a Foley catheter to drain urine from the bladder and to prevent reflux of urine back into the bladder .8. The resident's service plan will reflect the use of the catheter. The Centers for Disease Control and Prevention (CDC) guidelines for proper technique for urinary catheter maintenance indicate at section 111.B.2: Do not rest the urinary drainage bag on the floor. 1. On 11/25/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including history of multiple sclerosis and encounter for fitting and adjustment of urinary device. R9's Minimum Data Set (MDS) assessment, dated 11/13/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 was not cognitively impaired. On 11/25/24 at 2:30 PM, Surveyor observed R9's uncovered catheter drainage bag on the floor on the left side of R9's bed. On 11/25/24 at 2:40 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-C who verified the catheter bag should be covered with a privacy bag and should not be on the floor. On 11/25/24 at 3:30 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A needed to review the facility's policy and procedure for catheter care. 43361 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 11/25/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE], received Hospice services, and had diagnoses including malignant neoplasm of middle lobe, bronchus or lung, secondary malignant neoplasm of right lung, secondary malignant neoplasm of bone, and secondary malignant neoplasm of brain. R3's Minimum Data Set (MDS) assessment, dated 9/17/24, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R3 had moderately impaired cognition. R3 had an activated Power of Attorney for Healthcare (POAHC). The MDS assessment also indicated R3 had an indwelling catheter. R3 was transferred to the emergency room (ER) on 9/25/24 and did not return to the facility. R3's medical record indicated R3 had an indwelling Foley catheter upon admission on 9/11/24 but did not contain catheter care or output documentation. R3's catheter care plan was not initiated until 9/24/24. In addition, R3's baseline care plan did not address R3's catheter. On 11/25/24 at 2:15 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B did not work at the facility when R3 was a resident but would review R3's catheter orders and documentation. On 11/25/24 at 3:27 PM, Surveyor interviewed DON-B who indicated R3 had a catheter during R3's stay at the facility, however, there were no orders or documentation and a care plan was not initiated until 9/24/24. DON-B confirmed catheter care orders and a care plan should have been initiated upon admission. On 11/25/24 at 5:00 PM, Surveyor interviewed Nursing Home Administrator NHA-A who indicated the facility completed a mock survey in October (2024) and recognized there were residents in the facility who did not have catheter orders or care plans. NHA-A indicated nursing staff education was not yet completed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50988 Based on observation, staff interview, and record review, the facility did not provide a working call light for 1 resident (R) (R9) of 6 sampled residents. On 11/25/24, R9's call light was not in working condition. Findings include: The facility's Policy and Procedure for Call Light Use and Response, revised 7/18/23, indicates to assure the call system is in working order. On 11/25/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including history of multiple sclerosis, encounter for fitting and adjustment of urinary device, dysphagia, muscle wasting, and pressure ulcer of left buttock. R9's Minimum Data Set (MDS) assessment, dated 11/13/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 was not cognitively impaired. On 11/25/24 at 2:30 PM, Surveyor observed R9 in bed with a call light attached to a blanket within R9's reach. R9 indicated R9 activated the call light because R9 wanted to be repositioned. Surveyor noted R9's call light was not activated and asked R9 to push the call light a second time. Surveyor noted R9's call light did not activate. When Surveyor alerted Certified Nursing Assistant (CNA)-C, Surveyor and CNA-C returned to R9's room and verified R9's call light was not functioning. CNA-C repositioned R9 and stated CNA-C would contact maintenance staff to repair the call light. On 11/25/24 at 3:30 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated residents' call lights should be working at all times.