STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525575	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Lane Nursing Care Center	1235 S 24th St Manitowoc, WI 54220

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the resident environment was as free of accident hazards as possible for 1 resident (R) (R52) of 4 sampled residents. When staff lowered R52's bed on 4/28/26, the bed became caught on a radiator below the windowsill which caused the bed to tilt at an angle. The positioning of the bed was not reported to administration or addressed in R52's care plan. The following day, R52 fell out of bed and sustained a skin tear on the right forearm that required 6 sutures. R52's bed was caught on the radiator and tilted at a 30 degree angle at the time of the fall. This example is being cited at past non-compliance.Findings include: The facility's Fall Policy, dated 6/2016, indicates: The facility is committed to minimizing resident falls to maximize mental and psychosocial well-being .It is the facility's policy to facilitate as safe an environment as possible .The facility must ensure the resident environment remains as free from accident hazards as possible to include identifying hazards and risks. R52 was admitted to the facility on [DATE] and had diagnoses including age-related cognitive decline, diabetes, osteoarthritis, and edema. A Significant Change Minimum Data Set (MDS) assessment, dated 2/4/26, stated R52's Brief Interview for Mental Status (BIMS) score was 3 out of 15, indicating severe cognitive impairment. The assessment also indicated R52 had limited range of motion in both upper and lower extremities and required moderate staff assistance for rolling left to right in bed. R52 passed away at the facility on 5/4/26. A fall risk assessment, dated 1/30/26, indicated R52 was at moderate risk for falls. A health status note on 4/29/26 at 5:30 AM indicated R52 rolled out of bed and was on the floor alongside the bed in a prone position. R52 had a cut on the right arm from the call light. Staff treated the wound with an ABD pad and gauze wrap and notified Hospice. An ER visit note on 4/29/26 at 6:19 AM indicated R52 fell out of bed and sustained a Y-shaped laceration that was approximately 15 centimeters (cm) in length on the right hand/wrist from a call light clip. A laceration repair procedure note on 4/29/26 at 7:00 AM indicated R52 had a skin tear on the right hand/wrist that was 15 cm long and 3 cm deep. The wound was repaired with 6 sutures and strips of Mepitel. A health status note on 4/29/26 at 7:37 AM indicated R52 would return to the facility soon and had injuries on the right temple, right and left forearms, and had sutures in the right arm. A note at 7:25 PM indicated R52 was moaning when repositioned. Tylenol was administered. A health status note on 4/30/26 at 3:29 AM indicated R52 experienced intermittent pain in the right arm. PRN morphine was administered. R52's right arm was elevated with a pillow for comfort and to decrease swelling in the hand. A note at 9:23 PM indicated R52 received PRN morphine due to increased pain in the left thumb and an ice pack was somewhat effective. A health status note on 5/1/26 at 1:30 PM indicated R52 moaned in response to questions and had a swollen and bruised left thumb. A note at 9:03 PM indicated R52 had pain with movement related to injury. PRN morphine was administered. A Hospice note on 5/3/26 at 9:11 AM indicated Hospice would fax an order for scheduled morphine every four hours to keep R52's pain under control. A Hospice note at 3:05 PM indicated Hospice was updated regarding R52's uncontrolled pain. R52 received PRN Ativan and morphine at 1:30 PM and had been moaning, wincing, and crying. A one-time order was received for an increased dose of morphine. A Hospice note at 3:58 PM indicated R52 (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 0689 Level of Harm - Actual harm Residents Affected - Few	continued to cry out, moan, and wince in pain. A Hospice note at 5:45 PM indicated a Hospice nurse saw R52 and updated their medication orders. A fall investigation root cause analysis form, dated 4/29/26, indicated R52's bed was slanted sideways. R52 was last toileted at 1:10 AM during which time R52 appeared to be resting with no concerns. On 6/24/26, Surveyor reviewed a facility-reported incident (FRI) submitted to the State Agency (SA) regarding the fall with injury. The investigation indicated R52's bed was tilted at a 30 degree angle (due to being caught on a radiator) at the time of the fall and staff were aware it had also happened prior to the fall on 4/29/26. Certified Nursing Assistant (CNA)-C's written statement on 4/29/26 indicated they last saw R52 at approximately 1:10 AM when they changed R52's brief. CNA-C stated R52's bed always looked lopsided and the remote control did not work well. CNA-C stated they did not move the bed up or down during incontinence care and left the bed at waist height. CNA-C stated R52's bed looked like it usually did at 10:00 PM and 1:10 AM, slightly lopsided and at waist height with R52 positioned in the middle. CNA-C stated R52's bed was completely tilted at 3:50 AM and they were unable to fix the bed position at that time. CNA-E's undated written statement indicated on 4/28/26 (one day prior to R52's fall with injury), CNA-E and CNA-F positioned R52 in bed after lunch and noticed R52's bed was tilted away from the window and toward the door. CNA-E stopped moving the bed and notified Medication Technician (MT)-H. MT-H helped CNA-E pull the bed away from the wall where the frame was catching on the window sill/radiator and causing the bed to go sideways. CNA-E indicated the bed worked fine after that. CNA-F's undated written statement indicated on 4/28/26, CNA-F noted R52's bed was not properly fixed and asked MT-H for help. The bed was moved away from the window with no further concerns that shift. CNA-G's written statement on 4/30/26 indicated R52's bed got stuck on the window once in a while but staff moved the bed over. MT-H's written statement on 4/30/26 indicated MT-H was informed on 4/28/26 that R52's bed was tilting. MT-H observed the bed with CNA-E and noted the bed was slanted away from the window and toward the door. The bed was caught on the window sill/radiator and when pulled away worked fine. MT-H suspected that when doing cares/positioning R52, staff leaned into the bed and pushed it back against the wall/window sill. MT-H informed the oncoming PM shift to watch for it in case it happened again. LPN-D's written statement on 4/30/26 indicated they were not aware of any concerns with R52's bed prior to the fall on 4/29/26. LPN-D verified R52's bed was tilted toward the floor and away from the window/radiator after the fall. Registered Nurse Supervisor (RNS)-I's written statement on 5/1/26 indicated R52's bed appeared to be tilted away from the wall with the window/radiator. RN-J's written statement on 5/7/26 indicated they heard in report on 4/29/26 that R52 had fallen out of bed and sustained a large skin tear from the call light clip. RN-J asked how CNA-C and LPN-D did not notice R52's bed was tilted at a 30 degree angle. RN-J was not aware the bed could be lowered onto the window sill/radiator until after the incident. As a result of the investigation, Director of Nursing (DON)-B updated R52's care plan to include a high/low bed and provided education to all nursing and CNA staff to ensure positioning of beds, use caution when lowering beds, and notify maintenance and/or administration of equipment concerns. DON-B also completed audits to ensure beds were arranged for safety and proper functioning. R52 was moved to a larger room and given a different bed. On 6/23/26 at 12:58 PM, Surveyor observed R52's former room and noted several large dark scuff marks on the top edge of the radiator. On 6/23/26 at 12:24 PM, Surveyor interviewed DON-B who verified education was provided to all facility and agency staff following the incident. DON-B indicated they would have liked to know that R52's bed was catching on the window sill/radiator sooner so they could have rearranged the room for safety. DON-B indicated they were not aware of the issue until after R52's fall on 4/29/26. On 6/23/26 at 1:12 PM, Surveyor interviewed Service Representative (SR)-K who verified a service technician was at the facility on 4/29/26 to check the bed. The technician indicated R52's old bed had caught on the window sill and no longer worked properly.