STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525598	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheboygan Senior Community Inc	3505 County Road Y Sheboygan, WI 53083

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure allegations of abuse were reported to the State Agency (SA) for 2 residents (R) (R4 and R6) of 7 sampled residents. On 11/22/24, R7 notified staff that R1 was physically aggressive toward R4 on 11/21/24. The facility did not report the allegation of abuse to the SA. On 11/22/24, R1 initiated a resident-to-resident altercation with R6. The facility did not report the allegation of abuse to the SA. Findings include: The facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and Exploitation policy, revised 5/2023, indicates: It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse . Residents will not be subjected to abuse by anyone, including but not limited to, facility staff, other residents . Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator. The Nursing Home Administrator or designee will report abuse to the State Agency per state and federal requirements . On 2/27/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's disease. R1's Minimum Data Set (MDS) assessment, dated 9/13/24, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R1 had severe cognitive impairment. R1's medical record indicated R1 had a Power of Attorney for Healthcare (POAHC) who was responsible for R1's healthcare decisions. R1 passed away at the facility on 12/1/24. R1's medical record contained a note, dated 11/22/24, that indicated R1 was yelling in the dining room. After staff redirected R1 to R1's room, R1 re-entered the dining room, grabbed the handles of another resident's wheelchair, shook the wheelchair and yelled, Come on let's go. Staff redirected R1 out of the dining room. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525598	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheboygan Senior Community Inc	3505 County Road Y Sheboygan, WI 53083

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25, Surveyor reviewed a grievance investigation, dated 11/22/24, that indicated R7 (whose MDS assessment, dated 12/23/24, indicated R7 was not cognitively impaired) reported to staff that R1 attempted to stab R4 but missed and threw a knife or a fork at R4 on 11/21/24. The investigation indicated staff reported the allegation of abuse to Nursing Home Administrator (NHA)-A and placed R1 on 1:1 supervision at all times. On 2/27/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including heart failure and major depressive disorder. R4's MDS assessment, dated 2/18/25, had a BIMS score of 9 out of 15 which indicated R4 had moderate cognitive impairment. R4's medical record indicated R4 had a POAHC who was responsible for R4's healthcare decisions. On 2/27/25 at 12:26 PM and 1:09 PM, Surveyor interviewed Director of Nursing (DON)-B and Social Worker (SW)-C. SW-C indicated the facility was informed that the incident involving R4 occurred in the evening on 11/21/24. SW-C indicated R6 was the resident in the wheelchair mentioned in the 11/22/24 note in R1's medical record. SW-C indicated R6 told SW-C that R1 swung out at (R6) but (R6) was able to move away. SW-C indicated decisions regarding reporting involve a group discussion with NHA-A who makes the final decision whether or not to report to the SA. SW-C indicated NHA-A chose not to report the above incidents. SW-C indicated the above incidents should have been reported to the SA from a regulation standpoint. DON-B indicated DON-B verbally re-educated staff regarding reporting requirements but did not document the education or which staff received the education. On 2/27/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure and asthma. R6's MDS assessment, dated 1/26/25, had a BIMS score of 13 out of 15 which indicated R6 was not cognitively impaired. R6's medical record indicated R6 had a POAHC who was responsible for R6's healthcare decisions. On 2/27/25, Surveyor reviewed handwritten notes that indicated SW-C reported R1's 11/22/24 incident of aggression toward R6 to NHA-A on 11/22/24. On 2/27/25 at 1:42 PM, Surveyor interviewed DON-B who indicated R4 and R6 were not physically harmed. DON-B indicated DON-B spoke with R4 a couple days after the 11/21/24 incident. DON-B indicated R4 told DON-B that R4 felt a little shaken up at the time (of the incident) but felt fine at the time of the discussion with DON-B.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525598	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheboygan Senior Community Inc	3505 County Road Y Sheboygan, WI 53083

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 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** 40342 Based on staff interview and record review, the facility did not ensure allegations of abuse were thoroughly investigated for 2 residents (R) (R4 and R6) of 7 sampled residents. On 11/22/24, R7 notified staff that R1 was physically aggressive toward R4 on 11/21/24. The facility did not thoroughly investigate the allegation of abuse. On 11/22/24, R1 was physically aggressive toward R6. The facility did not thoroughly investigate the allegation of abuse. Findings include: The facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and Exploitation policy, revised 5/2023, indicates: The facility will immediately begin a thorough investigation of any reported incident, collect information that corroborates or disproves the incident and document the findings for the incident .A root cause investigation and analysis will be completed. A thorough investigation is an investigation that adequately addresses the circumstances of the allegation. The investigation will include the facts necessary to form a reasonable conclusion as to what happened. The facility will document the investigation and the reasons for the conclusion. The information gathered is given to Administration and the Grievance Officer . On 2/27/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's disease. R1's Minimum Data Set (MDS) assessment, dated 9/13/24, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R1 had severe cognitive impairment. R1's medical record indicated R1 had a Power of Attorney for Healthcare (POAHC) who was responsible for R1's healthcare decisions. R1 passed away at the facility on 12/1/24. R1's medical record contained a note, dated 11/22/24, that indicated R1 was yelling in the dining room. After staff redirected R1 to R1's room, R1 re-entered the dining room, grabbed the handles of another resident's wheelchair, shook the wheelchair, and yelled, Come on let's go. Staff redirected R1 out of the dining room. On 2/27/25, Surveyor reviewed a grievance investigation, dated 11/22/24, that indicated R7 (whose MDS assessment, dated 12/23/24, indicated R7 did not have impaired cognition) reported to staff that R1 attempted to stab R4 but missed and threw a knife or fork at R4 on 11/21/24. The investigation indicated staff reported the allegation to Nursing Home Administrator (NHA)-A and placed R1 on 1:1 supervision at all times. On 2/27/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including heart failure and major depressive disorder. R4's MDS assessment, dated 2/18/25, had a BIMS score of 9 out of 15 which indicated R4 had moderate cognitive impairment. R4's medical record indicated R4 had a POAHC who was responsible for R4's healthcare decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525598	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheboygan Senior Community Inc	3505 County Road Y Sheboygan, WI 53083

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 12:26 PM and 1:09 PM, Surveyor interviewed Director of Nursing (DON)-B and Social Worker (SW)-C. SW-C indicated the facility was informed on 11/22/24 that the incident involving R4 occurred in the evening on 11/21/24. SW-C indicated the facility was not aware of the 11/21/22 incident until R7 reported it to staff on 11/22/24. When asked about the 11/22/24 note in R1's medical record, SW-C indicated the facility did not have an investigation aside from SW-C's handwritten notes. DON-B indicated DON-B thought a Dietary Aide witnessed the 11/21/24 incident and reported it to a nurse. SW-C indicated R6 was the resident in the wheelchair mentioned in the 11/22/24 note in R1's medical record. SW-C indicated R6 told SW-C that R1 swung out at (R6) but (R6) was able to move away. On 2/27/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure and asthma. R6's MDS assessment, dated 1/26/25, had a BIMS score of 13 out of 15 which indicated R6 was not cognitively impaired. R6's medical record indicated R6 had a POAHC who was responsible for R6's healthcare decisions. On 2/27/25, Surveyor reviewed five pages of handwritten notes that indicated SW-C reported R1's 11/22/24 incident of aggression toward R6 to NHA-A on 11/22/24. The handwritten notes contained a few dates and times. On the page that mentioned the stabbing attempt between R1 and R4, the word sobbing was written. The note did not indicate who was sobbing. On the page that mentioned R6, the words swung out and move away were written next to R6's name. On 2/27/25, Surveyor reviewed a grievance investigation, dated 11/22/24, that indicated R6 reported R1 swinging out but (R6) was not hurt and able to move away from (R1). The investigation was started on 11/25/24. On 2/27/25 at 1:42 PM, Surveyor interviewed DON-B and SW-C. DON-B indicated the forms used to document R1's 1:1 intervention were not filed in R1's medical record. DON-B stated, I assume staff threw the forms away. SW-C verified SW-C completed the grievance investigation, dated 11/22/24, regarding the incident against R6 on 2/27/25 and backdated the form to 11/22/24. SW-C stated, I had my notes, just put it in grievance format today. When asked about the 11/25/24 investigation start date on the grievance investigation, SW-C thought the 11/25/24 date was written in error by SW-C. Surveyor observed SW-C review SW-C's handwritten notes. SW-C indicated SW-C was confused regarding the dates and times. SW-C stated, I think we were called over the weekend. When asked if a thorough investigation was completed, SW-C indicated the documents did not contain details and timeframes. When asked if an investigation was not started until 11/25/24, SW-C indicated the incidents were reported to NHA-A on 11/22/24.