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	01/20/2026

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 0684 Level of Harm - 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** Based on staff and resident interview and record review, the facility did not ensure care was provided in accordance with a physician order for 1 resident (R) (R9) of 16 sampled residents.R9 had a diabetic heel ulcer. An Apligraf (a bioengineered, bi-layered skin substitute that contains living human keratinocytes, fibroblasts, and bovine collagen commonly used to treat diabetic foot ulcers) was applied at a podiatry appointment on 11/3/25 with an order not to remove the graft. Staff removed the graft on 11/4/25 and did not inform the podiatry clinic. During a podiatry appointment on 11/11/25, it was noted that the Apligraf was missing and R9's ulcer had worsened. R9 was hospitalized for nine days and diagnosed with osteomyelitis (a bone infection). R9 required surgical debridement and both intravenous (IV) and oral antibiotics. The facility's lack of order entry process along with not following current orders/not clarifying orders with the physician resulted in the Apligraf being removed between 11/3/25 and 11/11/25. This resulted in R9 being admitted to the hospital for surgical debridement, IV antibiotics, insertion of a peripherally inserted central catheter (PICC) line (a thin tube inserted into a peripheral vein in the upper arm and threaded to a large vein near the heart for long-term intravenous access), and hospitalized for nine days. There was no sign of infection at the time the Apligraf was applied on 11/3/25.Findings include: The facility's Medication Orders policy, dated February 2025, indicates: The purpose of this procedure is to establish uniform guidelines in receiving and recording medication orders .Recording Orders: .6. Treatment Orders: When recording treatment orders, specify the treatment, frequency, and duration of the treatment .From 1/12/26 to 1/20/26, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including diabetes with polyneuropathy, peripheral artery disease, status post right below-the-knee amputation (BKA) (7/16/25), and chronic left posterior ankle diabetic ulcer with visible tendon. R9's Minimum Data Set (MDS) assessment, dated 1/7/26, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R9 had intact cognition. R9 made R9's own healthcare decisions.R9 had a diabetic ulcer on the left foot. Surveyor reviewed wound care notes and physician visit notes. (Of note: The location was referred to as heel and posterior ankle interchangeably.) A wound care note, dated 9/25/25, indicated R9's right BKA surgical stump wound was healed and the left heel wound included visible tendon.A note from a podiatry visit with Doctor of Podiatric Medicine (DPM)-P on 10/16/25 indicated: Cleanse wound with saline and gauze. Apply gentian (antiseptic dye that helps promote healing) to peri-wound and Adaptic (non-adherent wound dressing that protects regenerating tissue) to wound bed. Cover with ABD (gauze dressing that absorbs fluid from draining wounds). Secure with Kerlix (gauze bandage). Change three times weekly and as needed. R9 was being treated under an advanced wound care plan and with a plan to apply a graft.On 10/20/25, podiatry applied an Apligraf to R9's left heel. A wound care note, dated 10/27/25, indicated: Apligraf applied last week. Okay to remove Apligraf today. DPM-P plans to apply every other week with a one week break between applications. Will alternate wound care and podiatry appointments with wound care to remove graft and podiatry to apply. Will apply Hydrofera blue (antibacterial foam wound dressing) today. Left posterior ankle: Cleanse wound with saline and gauze. Apply saline-moistened Hydrofera blue to wound bed. Cover with ABD. Secure with Kerlix. (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	01/20/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Change 3 times weekly and as needed (PRN). On 11/3/25, podiatry applied Apligraf #2 to R9's left heel ulcer. A progress note by DPM-P indicated: The total wound surface area has continued to improve and is 11 centimeters squared (cm2). Apligraf application was discussed to help promote healing. Verbal consent was obtained. Home health will change the dressing once this week. They are not to disturb the Steri-Strips or Adaptic so as not to disturb the graft. R9 should follow-up with DPM-P next week. Apligraf 11 cm2 graft application #2 was applied to the wound. Adaptic was applied over the graft followed by Steri-Strips, a 4 x 4 (gauze), and an ABD. Kerlix and Coban (self-adherent plastic wrap used in wound care) were applied over the Steri-Strips and Adaptic. The graft should not be disturbed until R9 follows-up with wound care the following week. A new graft should be applied in 2 weeks. A progress note, dated 11/3/25 at 2:05 PM and written by Licensed Practical Nurse (LPN)-F, indicated R9 had a podiatry appointment with treatment: Wound graft #2 placed on left foot. DO NOT REMOVE. (Of note: The order (written on 11/3/25) was not entered into R9's Treatment Administration Record (TAR) until 11/4/25. A wound care note, dated 11/11/25, indicated when R9's heel dressing was removed, the Apligraf was gone. The left heel contained a significant amount of boggy, non-viable, hypergranulation tissue (excessive growth of friable, bright red or dark tissue that extends above the wound margin, often signaling stalled healing, infection, or chronic irritation). The wound edges were cauterized (a medical technique using heat chemicals (electrocautery), or cold (cryocautery) to seal blood vessels, stop bleeding, and remove abnormal tissue). R9 was admitted to the hospital for surgical debridement (a medical procedure that uses sterile instruments like scalpels or scissors to remove necrotic (dead), damaged, or infected tissue and foreign debris from a wound, facilitating faster healing) and IV antibiotics. (Of note: R9 reported to the wound care provider during the visit that a nurse removed the Apligraf a day after it was applied and later applied Adaptic and gauze. R9 did not inform anyone until the wound clinic visit on 11/11/25.) On 11/13/25, R9 was diagnosed with calcaneus (heel bone) osteomyelitis status post partial calcanectomy (removal of heel bone) and debridement and had a bone biopsy. R9 was diagnosed with Achilles tendon and calcaneus with abscess, calcaneal avulsion fracture (a rare heel bone injury where the Achilles tendon pulls a piece of the heel bone away) and a partial thickness tear of the Achilles tendon.On 11/20/25, R9 returned to the facility on IV antibiotics (vancomycin and ceftriaxone) and had orders for wound care.A vascular surgery note, dated 11/24/25, indicated R9 had adequate perfusion to the left heel wound and required surgical intervention for carotid stenosis (narrowing of the carotid arteries in the neck, usually from plaque buildup, which restricts blood flow and oxygen to the brain, significantly increasing stroke risk) to decrease the risk of stroke when there were no further signs of infection. R9 was cleared to wear a prosthetic and follow-up with a carotid duplex in 2 months.An Infectious Disease note, dated 12/2/25, indicated R9's surgical culture was positive for Proteus and diptheroids. The wound was closed with no signs of infection. R9 was to continue IV vancomycin until 12/25/25, complete a vancomycin trough (a lab to measure vancomycin levels) and weekly labs, and start Cefdinir (an antibiotic) 300 milligrams (mg) by mouth twice daily for 2 months starting 12/26/25.A podiatry note, dated 12/4/25, indicated R9's heel wound sutures were removed with no signs of infection. R9's foot was dressed with a dry sterile dressing. The note indicated to keep the dressing clean, dry, and intact and continue elevating. R9 could weight bear as tolerated with the prosthetic and progress with physical therapy.A wound care note, dated 12/30/25, indicated the wound was healed. It was recommended to cover the wound for protection for 2 weeks. R9 could weight bear and wear proper footwear. The note contained the following wound care order: Left posterior ankle: Cleanse with saline; pat dry; cover newly healed area with ABD and Kerlix padding the heel well. Change 3 times weekly and as needed. Continue pressure relief to the left heel and prevent friction to the area to prevent reopening.Surveyor reviewed R9's medical record and TAR for wound care orders for the left posterior ankle/heel and noted the following:~ Dressing change for left lower extremity (LLE): Per podiatry: Change outer bandage cautiously with gauze, ABD, Kerlix, and tape twice weekly. Once daily on Tuesday and Saturday. Special Instructions: ***DO NOT REMOVE ADAPTIC AND (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	01/20/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	STERI-STRIPS*** SKIN GRAFT TO REMAIN IN PLACE. (Start date: 10/20/25; End date: 10/28/25). (The order was documented as completed on 10/21/25 and 10/25/25.) ~ Cleanse wound with saline and gauze. Apply saline-moistened Hydrofera blue to wound bed. Cover with ABD. Secure with Kerlix. Once daily on Tuesday, Thursday, and Saturday (Start date: 10/28/25; End date: 11/4/25).~ Left posterior ankle: Cleanse wound with saline and gauze. Apply saline-moistened Hydrofera blue to wound bed. Cover with ABD. Secure with Kerlix. Once a day on Tuesday, Thursday, and Saturday. DO NOT REMOVE SKIN GRAFT (under special instructions) (ordered by Medical Doctor (MD)-Q and created by LPN-F). (Start date: 11/4/25; End date: 11/6/25). (The order was documented as completed by LPN-F on 11/4/25 and LPN-G on 11/6/25).~ DO NOT REMOVE DRESSING AT LEFT ANKLE UNTIL SEEN AT WOUND CLINIC. NEW GRAFT PLACED 11/3/25. Frequency every shift. (Start date: 11/6/25; End date: 11/20/25). (The order was documented as completed on the 11/6/25 AM shift through the 11/11/25 AM shift.) ~ DO NOT REMOVE DRESSING AT LEFT ANKLE UNTIL SEEN AT WOUND CLINIC. NEW GRAFT PLACED 11/5/25. Frequency every shift. (Start date: 11/6/25; End date: 11/6/25). (The order was documented as not completed on 11/6/25 at 3:14 PM by LPN-G with a reason of other.) On 1/15/26 at 10:58 AM, Surveyor interviewed R9 regarding the left heel skin grafts. R9 stated the day after the second graft was applied, a nurse (who R9 described) looked at R9's left heel and stated, Eww. What's that? The nurse left the room, returned with supplies, wet the wound, and pulled pieces of the skin graft off. R9 did not have feeling in the left foot. R9 did not say anything but wondered why the nurse did that. R9 stated the same nurse came back later that day with another nurse. They unwrapped R9's left foot and re-did the dressing. R9 informed the provider at a wound clinic appointment on 11/11/25. R9 stated the provider verified the skin graft was gone. On 1/20/26 at 10:45 AM, Surveyor interviewed Wound Care Registered Nurse (WCRN)-J via telephone who worked with Wound Care Nurse Practitioner (WCNP)-K at the wound clinic. RN-J verified R9's 11/11/25 appointment was pre-scheduled and stated the wound clinic did not have any documented calls from the facility except notification that R9 had an X-ray on 11/11/25. WCRN-J stated WCRN-J was available for further information via fax request. On 1/20/26 at 10:55 AM, Surveyor interviewed Podiatry Registered Nurse (PRN)-O from the office where R9 received the heel skin grafts. PRN-O verified R9's medical record did not contain telephone encounters or questions from the facility.On 1/20/26 at 11:29 AM, WCRN-J called Surveyor and stated WCRN-J spoke with the nurse and provider who worked with R9 on 11/11/25. WCRN-J stated the facility did not contact the wound clinic prior to R9's visit on 11/11/25. WCRN-J stated R9 told DPM-P that staff removed the Apligraf, applied Hydrofera blue, and then came back and removed the Hydrofera blue. WCRN-J stated wound clinic staff removed an Adaptic dressing from R9's left heel on 11/11/25 which was the only dressing on the heel. WCRN-J stated the Apligraf was not on long enough to adhere and indicated it takes 48 hours to adhere to the wound and begin working. R9 reported that staff removed the graft (on 11/4/25) the day after it was applied (on 11/3/25). WCRN-J stated R9's left heel wound became infected and required surgical debridement. R9 was admitted to the hospital on [DATE] for surgical intervention and IV antibiotics. WCRN-J stated the skin graft looked like a non-transparent gelatinous, white, shiny tissue paper with a thick consistency and was visible on the wound. WCRN-J stated when a skin graft is applied, the ordered dressing change usually includes Adaptic and Steri-Strips. WCRN-J stated if a nurse removed the skin graft, the nurse would have noticed something different and would have had to remove the ABD and Steri-Strips to remove the graft. WCRN-J verified R9's graft should not have been removed and verified R9's 11/3/25 order stated no dressing changes. WCRN-J stated the provider sends new orders back to the facility with the resident. On 1/20/26 at 12:49 PM, Surveyor interviewed LPN-F via phone. LPN-F indicated the facility received orders to change R9's left heel wound outer dressing every other or every third day and not to remove the inner dressing, unless it was saturated and they contacted the provider. LPN-F stated LPN-F did not contact the provider. LPN-F also recalled a standing order to change the outer dressing, but nothing else. LPN-F denied removing the inner dressing and stated LPN-F only changed the outer Kerlix or (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	01/20/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	ace bandage once but not because it was saturated. LPN-F denied changing or removing Steri-Strips or Hydrofera blue. LPN-F thought staff said one of the nurses removed the skin graft between 11/3/25 and 11/11/25 after the second graft was applied. LPN-F stated there was no oversight of wound care at the facility. Nurses entered orders when they received them and Director of Nursing (DON)-B usually verified new orders the next day. LPN-F stated DON-B asks staff at the start of their shift to verify DON-B's work as a third check. LPN-F stated if nurses have questions regarding order entry, they ask an RN from another unit to verify the order. LPN-F verified LPN-F wrote 11/3/25 progress note regarding Apligraf #2 and not to remove it which was the order sent back from R9's 11/3/25 appointment. (Of note: The order was not entered on R9's TAR on 11/3/25.) On 1/20/26 at 1:55 PM, Surveyor interviewed Scheduler (SCH)-H who stated a nurse told SCH-H that another nurse removed R9's Apligraf because the nurse did not see the new order. SCH-H thought LPN-G (who resigned from the facility before the end of November 2025) was the one who removed the graft. SCH-H was unsure if LPN-G knew what LPN-G had done because there was confusion with R9's orders. SCH-H stated the facility's former wound nurse may have known about the graft removal but no longer worked at the facility. SCH-H stated SCH-H may have been told about the graft removal on 11/6/25 but did not tell anyone and had not heard anything since. SCH-H was unsure if DON-B was aware but assumed the nurse who informed SCH-H informed DON-B. (Of note: SCH-H's description of the nurse who allegedly removed the Apligraf matched R9's description of the nurse.) On 1/20/26 at 2:14 PM, Surveyor interviewed Rehab Manager (RM)-I who stated LPN-G called RM-I to help figure out R9's wound care orders. RM-I reviewed R9's wound care orders and noticed R9's podiatry notes indicated R9 had a graft in place for one week. When RM-I observed R9's left heel with LPN-G, the graft was intact. RM-I stated an envelope with a progress note and medication list is sent back with the resident and usually contains new orders or the wound clinic sends new orders via fax. An RN or LPN enters a progress note with the new order, enters the order in the system, and initials and dates the paper order. RM-I stated the facility does not have a policy for second checks to ensure orders are entered correctly. RM-I stated the Health Unit Coordinator (HUC) thins charts and may remove orders from a resident's paper chart. On 1/20/26 at 2:39 PM, Surveyor interviewed LPN-G via phone who worked at the facility through November 2025. LPN-G recalled R9's TAR and stated LPN-G wrote R9's orders on a sticky note prior to entering R9's room to complete a dressing change. LPN-G stated R9's left heel contained Hydrofera blue and LPN-G applied Hydrofera blue. LPN-G stated if LPN-G signed the TAR, LPN-G completed the order. When Surveyor asked if LPN-G remembered changing R9's dressing on 11/6/25, LPN-G did not recall the exact date. When Surveyor asked if LPN-G remembered a skin graft on R9's left heel, LPN-G recalled two skin grafts with Steri-Strips. LPN-G stated LPN-G did not remove the Steri-Strips from R9's left heel because the instructions stated not to. LPN-G recalled confusion with R9's wound care orders but did not recall the date or what the confusion was about. LPN-G verified RM-I reviewed the orders and stated LPN-G had not heard that the Apligraf was removed.On 1/20/26 at 3:00 PM, Surveyor interviewed DON-B who was not aware that a nurse removed R9's Apligraf. DON-B verified a progress note stated not to remove the graft. DON-B stated unless DON-B notices something out of the ordinary with an order, DON-B does not double or triple check newly entered orders and it is not necessary for the oncoming nurse to do so either. DON-B reviewed the 11/3/25 entry on R9's TAR, the 11/3/25 paper order, and the 11/3/25 provider note in R9's medical record. DON-B also reviewed orders from the provider after the first graft was applied on 10/20/25. DON-B indicated R9's wound care orders were ambiguous. When Surveyor noted the 11/11/25 wound care note stated the Apligraf was missing when the dressing was removed and R9 required wound debridement, IV antibiotics, and hospitalization, DON-B indicated there was room for improvement. DON-B stated if DON-B was aware the graft was removed, DON-B would have initiated an investigation and sent R9 back to podiatry for a graft replacement. DON-B would have also provided education regarding order entry, transcription, double checks, and skin grafts. DON-B stated new orders sometimes go to the HUC who sends the orders to DON-B, RM-I, or the Hickory unit nurse. (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	01/20/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	The orders are entered by an LPN. When a resident returns from an appointment, the orders are written on paper and the unit nurse enters them in the resident's medical record and writes a progress note. The nurse puts the paper order in the resident's chart. The process is the same for faxed orders. Phone orders are written on order sheets and saved for the physician to sign. DON-B verified the facility's policy for order entry did not cover verifying or double-checking orders.On 1/21/26, Surveyor faxed DPM-P with questions per the clinic's request. Surveyor did not receive a response as of this writing.

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	01/20/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect all 57 residents residing in the facility. The microwaves on all three households contained dried food debris. Food items in the dry storage area were not label with use-by dates. Equipment in the main kitchen was not stored to prevent contamination. Findings include: On 1/13/26 at 2:09 PM, Surveyor interviewed Dietary Manager (DM)-R who stated the facility follows the Wisconsin Food Code. Microwave Cleanliness: The Wisconsin Food Code documents at 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. The Wisconsin Food Code documents at 4-602.12 Cooking and Baking Equipment: (B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. The facility's Cleaning Instructions: Microwave Oven procedure, dated 2013, states the microwave will be kept clean, sanitized, and odor free. The microwave interior should be cleaned after each use as needed, and at a minimum, after each meal service. On 1/12/26 at 6:26 PM, Surveyor conducted an initial tour of the kitchen and 3 separate household kitchens with Assistant Dietary Manager (ADM)-S. During a tour of the household kitchens, Surveyor noted the microwaves in all three kitchens contained dried food debris on the interior ceiling. ADM-S acknowledged the debris and stated microwaves should be cleaned after each use and at the end of the day. Dating: The facility's undated Food Dating Policy indicates the facility should date everything that is opened with a prepared date and/or use-by-date .5. Dry storage is checked bi-weekly. During the initial kitchen tour that began at 6:26 PM on 1/12/26, Surveyor observed the following: ~ Elbow macaroni noodles, not in the original container, with an open date of 12/4/25 and no use-by date~ Rice, not in the original container, with an open date of 12/12/25 and no use-by date~ Halved walnuts, in the original container, with an open date of 12/24/25 and no use-by date~ Halved walnuts, in the original container, with an open date of 11/18/25 and no use-by date On 1/13/26 at 2:09 PM, Surveyor interviewed DM-R who stated staff refer to a sheet that contains foods and their use-by dates for direction on when to discard items. DM-R stated the facility's policy is to label items with open and discard dates if the item is not in its original packaging. DM-R confirmed the items observed by Surveyor should contain open and use-by dates. On 1/20/26, Surveyor reviewed the facility's Produce Storage Cheat Sheet. Items listed on the sheet included fruits and vegetables. Surveyor noted the cheat sheet did not include dry foods. Kitchen Equipment:The Wisconsin Food Code documents at 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles: .B) Clean equipment and utensils shall be stored .(2) Covered or inverted.During the initial kitchen tour that began at 6:26 PM on 1/12/26, Surveyor and ADM-S observed two mixers and a slicer that were uncovered. ADM-S stated the slicer was used daily. The mixers were not used daily. ADM-S stated the equipment is not covered when not in use. On 1/15/26 at 9:45 AM, Surveyor interviewed DM-R who was not aware kitchen equipment should be covered when not in use.

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	01/20/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 3 residents (R) (R36, R37 and R63) of 5 sampled residents reviewed for unnecessary medication had documentation that indicated the resident and/or their legal representative were thoroughly informed of the risks and benefits of prescribed psychotropic medication. R36 was prescribed duloxetine (antidepressant medication). The facility did not ensure an Informed Consent for Medication form was thoroughly reviewed and completed with R36. R37 was prescribed lorazepam (antianxiety medication) and desipramine (antidepressant medication). The facility did not ensure Informed Consent for Medication forms were thoroughly reviewed and completed with R37. R63 was prescribed buspirone (antianxiety medication) and citalopram (antidepressant medication). The facility did not ensure Informed Consent for Medication forms were thoroughly reviewed and completed with R63. Findings include: The facility's undated Psychotropic Medication policy indicates: .1. The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the long-term care facility to include regular review for .side effects, risks and/or benefits .3. Document discussion with the resident and/or responsible party regarding the risks versus benefits of the use of these medications. Included in the discussion and documentation must be the presence of any black box warning or off label use of the medication affecting the prescribing of the medication to the resident. 1. From 1/12/26 to 1/20/26, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had diagnoses including vascular dementia with mood disturbance and anxiety disorder. R36's Minimum Data Set (MDS) assessment, dated 1/2/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R36 had intact cognition. R36 was responsible for R36's healthcare decisions. Review of R36's Informed Consent for Medication form for duloxetine indicated the medication was prescribed for depression. Surveyor noted that R36 only initialed and dated page 1. Pages 2 and 3 did not contain R36's initials, signature, or a date. In addition, questions 2 and 3 on page 1 were left blank. (See interviews under example 3) 2. From 1/12/26 to 1/20/26, Surveyor reviewed R37's medical record. R37 was admitted to the facility on [DATE] and had diagnoses including anxiety disorder and depression. R37's MDS assessment, dated 10/21/25, had a BIMS score of 15 out of 15 which indicated R37 had intact cognition. R37 was responsible for R37's healthcare decisions. Surveyor reviewed R37's Informed Consent for Medication forms for Ativan and desipramine and noted R37 only signed and dated the last page of both forms. Pages 1, 2, and 3 did not contain initials or dates. In addition, questions 2 and 3 on page 1 were left blank. (See interviews under example 3) 3. On 1/14/26, Surveyor reviewed R63's medical record. R63 was admitted to the facility on [DATE] and had diagnoses including anxiety and depression. R63's MDS assessment, dated 1/14/26, had a (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	01/20/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BIMS score of 13 out of 15 which indicated R63 had intact cognition. R63 made R63's own healthcare decisions. R63's medication orders included buspirone for anxiety and citalopram for depression. On 1/15/26 at 11:14 AM, Surveyor reviewed R63's Informed Consent for Medication forms for buspirone and citalopram. Surveyor noted R63 signed and dated the last page of both forms; however, all pages did not contain initials or dates. In addition, questions 2 and 3 on page 1 were left blank on both forms. On 1/20/26 at 12:30 PM, Surveyor interviewed Registered Nurse (RN)-M regarding the process of filling out Informed Consent for Medication forms. RN-M stated not all nurses have residents initial and date every page. RN-M indicated RN-M usually just has the resident sign and date the last page but should have residents initial and date all pages. On 1/20/26 at 12:35 PM, Surveyor interviewed Director of Nursing (DON)-B who stated it would be nice if all pages were initialed, dated, and completed; however, it was fine as long as the last page was signed and dated.

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	01/20/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not notify the State Long-Term Care Ombudsman of an emergent hospital transfer for 1 resident (R) (R10) of 6 sampled residents.R10 was transferred to the Emergency Department (ED) on 11/25/25 for evaluation. The Ombudsman was not notified of the transfer. In addition, Social Worker (SW)-L was not aware of the need to notify the Ombudsman of hospital transfers if the resident returned to the facility.Findings include:The facility's undated Discharge policy did not include Ombudsman notification of hospital transfers.From 1/12/26 to 1/15/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes mellitus and peripheral artery disease. R10's Minimum Data Set (MDS) assessment, dated 1/5/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R10 had intact cognition.R10's medical record indicated R10 was transferred to the ED on 11/25/25 for evaluation.On 1/14/26 at 10:04 AM, Surveyor reviewed Ombudsman notification for 11/1/25 to 11/30/25 and noted R10's 11/25/25 ED transfer was not included on the list.On 1/15/26 at 11:42 AM, Surveyor interviewed SW-L who verified R10 was transferred to the ED and returned to the facility. SW-L stated since R10 was not discharged , SW-L did not notify the Ombudsman of the transfer. SW-L stated SW-L thought Ombudsman notification was only necessary when residents were discharged from the facility.

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	01/20/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure Minimum Data Set (MDS) assessments were accurate for 3 residents (R) (R36, R1, and R28) of 16 sampled residents.R36's MDS assessments, dated 1/2/26 and 12/3/25, indicated R36 received hypnotic medication. R36 was not prescribed a hypnotic medication.R1's MDS assessment, dated 10/13/25, indicated R1 received parenteral feeding. R1 did not receive parenteral feeding. R28's MDS assessment, dated 11/20/25, did not indicate R28 was on dialysis. R28 was on dialysis since admission to the facility on 8/14/25. Findings include: The facility's Minimum Data Set (MDS)/Health Information Process policy, dated September 2025, indicates: .3. (Named Company) will upload all relevant information including the resident's history and physical, hospital discharge summary, medical visits, imaging, and labs. (Named Company) completes authorizations, updates, audits, and coding .6. Section K is completed by the Registered Dietitian .8. Sections H, I, J, M, N, O, and P are input by (Named Company) and reviewed/signed by the Director of Nursing (DON) .9. The DON will sign verify that the MDS is completed. 1. From 1/12/26 to 1/20/26, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had diagnoses including vascular dementia with mood disturbance and anxiety disorder. R36's MDS assessment, dated 1/2/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R36 had intact cognition. R36 was responsible for R36's healthcare decisions. On 1/13/26, Surveyor reviewed the facility's matrix for providers which indicated R36 was prescribed a hypnotic medication. R36's Quarterly MDS assessment, dated 1/2/26, and Significant Change MDS assessment, dated 12/3/25, indicated R36 received hypnotic medication. R36's physician's orders did not include hypnotic medication. On 1/14/26 at 9:42 AM, Surveyor interviewed Minimum Data Set Coordinator (MDSC)-N who was responsible for coding Section N of the MDS assessments. MDSC-N was unsure why the MDS assessments indicated R36 received hypnotic medication. MDSC-N stated the assessments may have been coded in error. On 1/15/26 at 2:33 PM, Surveyor interviewed DON-B who stated R36 was prescribed Remeron (antidepressant medication); however, the indications for use had changed since admission. DON-B stated R36 received Remeron for appetite stimulation, depression, and insomnia. DON-B stated Remeron should be coded as an antidepressant medication and not a hypnotic medication on the MDS assessments and confirmed R36's MDS assessments were coded in error. 2. From 1/12/26 to 1/15/26, Surveyor reviewed R1's medical record. R1 was admitted to facility on 8/4/21 and had diagnoses including dementia, cognitive impairment, delusional disorder, and communication deficit. R1's MDS assessment, dated 10/13/25. had a BIMS score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated Power of Attorney (POA) since 1/30/24. (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	01/20/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/12/26 ,Surveyor reviewed the facility's matrix which indicated R1 received parenteral feeding. Surveyor noted R1's 10/13/25 MDS assessment also indicated R1 received parenteral feeding. On 1/14/26 at 12:02 PM, Surveyor observing R1 eating at a table in the dining room. When Surveyor asked Licensed Practical Nurse (LPN)-F if R1 also received parenteral feeding, LPN-F indicated R1 never received parenteral feeding. On 1/15/26 at 2:32 PM, Surveyor interviewed DON-B who verified that R1 did not receive parenteral nutrition and R1's MDS assessment was coded in error. 3. From 1/12/26 to 1/15/26, Surveyor reviewed R28's medical record. R28 was admitted to the facility on [DATE] and had diagnoses including end stage renal disease and dependence on renal dialysis. R28 received hemodialysis related to renal failure at an outside dialysis center 3 times weekly (Monday, Wednesday, and Friday). R28's MDS assessment, dated 11/20/25, had a BIMS score of 13 out of 15 which indicated R28 had intact cognition. R28's MDS assessment, dated 11/20/25, did not indicate R28 received dialysis. On 1/14/26 at 9:43 AM, Surveyor interviewed MDSC-N who confirmed R28's 11/20/25 MDS assessment did not indicate R28 received dialysis. MDSC-N indicated dialysis was also missed on the 11/20/24 MDS assessment. MDSC-N was unsure why it was missed and confirmed R28 had been on dialysis since admission.

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	01/20/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure care and services to prevent pressure injuries from developing and/or promote healing was provided for 2 residents (R) (R8 and R36) of 6 sampled residents.On 11/20/25, R8 was noted to have a stage 1 pressure injury on top of the head. The facility did not ensure preventative measures were implemented to prevent further skin breakdown which resulted in a stage 2 pressure injury on top of R8's head.On 12/26/25, R36 was re-admitted to the facility from an acute hospital stay with a stage 2 pressure injury on the left buttock. On 1/3/26, the facility documented that R36 developed a stage 2 pressure injury on the right buttock. The facility did not ensure initial evaluations and/or wound assessments were completed to monitor R36's pressure injuries.Findings include:The facility's undated Pressure Injuries Overview/Staging policy indicates avoidable means the resident developed a pressure ulcer/injury and that one or more of the following was not completed: Evaluation of the resident's clinical condition and risk factors; Definition or implementation of interventions consistent with resident needs, resident goals, and professional standards of practice; Monitoring or evaluation of the impact of the interventions; or Revision of the interventions as appropriate.1. From 1/12/26 to 1/20/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including dementia, Parkinson's disease, abnormal involuntary movements, and abnormal posture. R8's Minimum Data Set (MDS) assessment, dated 11/1/25, indicated R8 was rarely to never understood/understands. A staff interview for mental status indicated R8 had severe cognitive impairment. R8 had an activated Power of Attorney for Healthcare (POAHC) who assisted with healthcare decisions.A pressure injury care plan, dated 7/26/23, indicated R8 had the potential for alteration in skin integrity secondary to decreased functional mobility and frequent involuntary movements from Parkinson's disease. A progress note, dated 11/20/25, stated staff notified nursing that when they got R8 up for the day, R8 was sleeping with R8's head against the wall. R8 had a reddened area on the top back of the head with a small abrasion. The physician was notified and directed staff to treat the area as a stage 1 pressure injury. (Of note: R8's alteration in skin integrity care plan was not updated following the discovery of the stage 1 pressure injury.) A physician order, dated 11/20/25 through 1/4/26, indicated to monitor the stage 1 pressure injury on top of R8's head related to leaning R8's head against the wall while sleeping. A progress note, dated 12/13/25 at 2:23 PM and written by Licensed Practical Nurse (LPN)-F, indicated Certified Nursing Assistant (CNA)-T informed LPN-F that R8's head was against wall when CNA-T got R8 up for the day. LPN-F indicated the area on top of R8's head was the same area that had previously healed. The area included a small bump that was approximately 0.5 inches (length) x 0.5 inches (width) with the top layer of skin peeled off. The area was cleaned and bandaged. LPN-F initiated an intervention to add padding between the wall and bed to prevent R8's head from rubbing the wall.A Therapy Screen, dated 12/16/25, contained a safety measure to place 2 foam wedges between the bed and the wall to prevent R8's head from rubbing against the wall.An admission Skin Assessment, dated 12/17/25, indicated R8 had a pressure wound on the top of the scalp that measured approximately 2.5 centimeters (cm) x 3.0 cm with a red abrased area, shallow. yellow crater areas, and dried red scabs. The area was open to air and covered with Aquaphor.R8's Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not include treatment orders for the stage 2 pressure injury.On 1/14/26 at 12:14 PM, Surveyor interviewed CNA-T who confirmed CNA-T got R8 up on 12/13/25. CNA-T stated R8's head was against the wall and skin from R8's head was on the wall when CNA-T repositioned R8. CNA-T notified LPN-F. CNA-T stated pillows and wedge cushions were put between the wall and bed to prevent R8 from rubbing R8's head. CNA-T was aware that R8 had a previous area on top of the head but was uncertain how the injury occurred or if there were any interventions in place.On 1/14/26 at 3:23 PM, Surveyor interviewed LPN-F who assessed R8's wound on 12/13/25. LPN-F verified CNA-T (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	01/20/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported that skin on the top of R8's head rubbed off on the wall. LPN-F stated the area had reopened and resulted from R8 resting R8's head against the wall. LPN-F completed the necessary treatment, entered a nursing order, and sent a fax to the physician. LPN-F stated the facility did not have a standardized wound assessment to complete and indicated nursing would monitor the area and document if it worsened. LPN-F stated LPN-F does not chart if the wound improves/heals and only documents if it worsens.On 1/15/26 at 8:19 AM, Surveyor interviewed Director of Nursing (DON)-B who was aware that wound care was an issue in the facility. DON-B stated the facility's previous wound nurse was no longer with the facility and a new wound provider was not scheduled to start rounds until 1/22/26. DON-B stated nurses only document wounds in progress notes. DON-B verified the facility did not have a standardized tool to assess wounds. DON-B stated Rehab Manager (RM)-I had more information related to R8's wound care.On 1/20/26 at 12:42 PM, Surveyor interviewed RM-I who stated RM-I became aware on 12/15/25 that R8 had an open area on top of the head from resting R8's head against the wall. RM-I was unsure why R8's head was against the wall and stated R8 had a severe left lean at times and head jerking movements related to RM-I's diagnosis. RM-I stated the facility's Interdisciplinary Team decided to place a mat next to the wall until therapy could screen R8. RM-I stated the open area was a new area on top of R8's head, but acknowledged R8 had a similar area prior. RM-I stated RM-I managed wounds on R8's unit only and did not know if an intervention was implemented following R8's first pressure injury on 11/20/25. RM-I stated if a safety measure was implemented on 11/20/25, it should have been on R8's care plan. RM-I confirmed R8's care plan did not include foam wedges or a wall mat.2. From 1/12/26 to 1/20/26, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had diagnoses including vascular dementia and cerebral infarction affecting the right dominant side. R36's MDS assessment, dated 1/2/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R36 had intact cognition. R36 was responsible for R36's healthcare decisions.A progress note, dated 12/26/25, indicated R36 was readmitted to the facility with a stage 2 pressure injury on the left buttock that was treated with barrier cream. (Of note: R36's medical record did not include a full nursing assessment or measurement of the area.) A progress note, dated 1/3/26, indicated R36 had a 1 cm x 0.7 cm x 0.1 cm open area on the right buttock. R36 had an order to clean the wound with normal saline and apply a Mepilex dressing. (Of note: R36's medical record did not contain ongoing assessments or monitoring of the area.)On 1/20/26 at 12:35 AM, Surveyor interviewed RM-I who stated when a new area is discovered, nurses should assess and measure the area and send a fax to the physician for orders. RM-I stated the facility did not have a specific procedure for ongoing wound assessments. RM-I stated some nurses document the status of the wound with each treatment or dressing change and others only document if the wound worsens. RM-I stated nurses should document an assessment of the wound every time they provide treatment to the area.On 1/20/26 at 10:48 AM, Surveyor interviewed DON-B who confirmed the only documentation of R36's wounds was in R36's progress notes. DON-B was aware of concerns regarding wound care and stated a new provider was starting on 1/22/26 and would complete weekly wound rounds. DON-B confirmed staff education was not completed regarding wound care concerns.

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	01/20/2026

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 0689 Level of Harm - Minimal harm or potential for 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 staff interview and record review, the facility did not complete a fall report to determine the root cause of a fall, update a care plan, or implement post-fall monitoring for 1 resident (R) (R8) of 1 sampled resident. R8 had an unwitnessed fall on 1/8/26. The facility did not complete a fall incident report or post-fall neurological checks. In addition, the facility did not update R8's care plan with a preventative safety intervention.Findings include:The facility's undated Assessing Falls policy indicates: .6. Observe for delayed complications of a fall for approximately seventy-two hours after a fall and document findings in the medical record .8. Complete an incident report for a resident fall no later than 24 hours after the fall occurs. The incident report should be completed by the nursing supervisor on duty and submitted to the Director of Nursing (DON) .When a resident falls, the following information should be recorded in the resident's medical record . 2. Assessment data, including vital signs and injuries. 3. Interventions, first aid, or treatment administration.The facility's undated Neurological Assessment procedure indicates routine neurological assessments are conducted to evaluate the resident for small changes over time or from a fall that may be indicative of neurological injury.The facility's undated Neurological Flow Sheet indicates staff should complete vital signs and neurological checks as follows: Every 15 minutes x 1 hour; Every 30 minutes x 1 hour; Every 1 hour x 4 hours; Every 4 hours x 24 hours.From 1/12/26 to 1/20/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including dementia, Parkinson's disease, abnormal involuntary movements, and history of repeated falls. R8's Minimum Data Set (MDS) assessment, dated 11/1/25, indicated R8 was rarely to never understood/understands. A staff interview for mental status indicated R8 had severe cognitive impairment. R8 had an activated Power of Attorney for HealthCare (POAHC) to assist with healthcare decisions.A progress note, dated 1/8/26 at 3:38 PM, indicated staff discovered R8 on the floor lying on the left side. R8's medical record did not include a fall report, a preventative safety intervention implemented post-fall, or neurological checks completed post-fall.On 1/20/26 at 12:44 PM, Surveyor interviewed Rehab Manager (RM)-I who confirmed R8's care plan was not updated with a safety intervention following the fall. RM-I confirmed R8's care plan should have been updated.On 1/20/26 at 11:47 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who stated if a resident has an unwitnessed fall, neurological checks should be completed using a paper flowsheet. The checks should be documented in the resident's medical record.On 1/20/26 at 10:47 AM, Surveyor interviewed Director of Nursing (DON)-B who verified an incident report, care plan revision, and neurological checks were not completed for R8 following R8's fall on 1/8/26. DON-B verified an incident report should have been completed to determine the root cause of the fall and appropriate safety interventions should have been implemented. DON-B also confirmed neurological checks should have been completed.

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	01/20/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not provide the necessary respiratory care and services for 3 residents (R) (R10, R15, and R62) of 3 sampled residents.R10, R15, and R62 did not have orders or care plans for nebulizer (a medical device that turns liquid medicine into a fine mist allowing it to be inhaled directly into the lungs to treat respiratory conditions) cleaning.Findings include:The facility's undated Administering Medications Through a Small Volume Nebulizer policy indicates: .Steps in the Procedure: .26. Rinse and disinfect the nebulizer equipment according to facility protocol, or: a. Wash pieces with warm, soapy water; b. Rinse with hot water; c. Place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes; d. Rinse all pieces with sterile water (not tap, bottled, or distilled); and e. Allow to air dry on a paper towel .28. When equipment is completely dry, store in a plastic bag with the resident's name and date. 29. Change equipment and tubing every seven days, or according to facility protocol .1.From 1/12/26 to 1/15/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes mellitus and chronic obstructive pulmonary disease (COPD). R10's Minimum Data Set (MDS) assessment, dated 1/5/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R10 had intact cognition.R10 had the following physician orders:~ Budesonide (used to treat respiratory conditions) suspension for nebulization; 0.5 milligrams (mg)/2 milliliters (ml); 1 vial via inhalation once daily.~ Ipratropium-albuterol (used to treat respiratory conditions) solution for nebulization; 0.5 mg-3 mg (2.5 mg base)/3 ml; 1 ampule via inhalation four times daily.On 1/12/26 at 7:30 PM, Surveyor interviewed R10 and observed a nebulizer on the nightstand with a mouthpiece stained with what appeared to be red lipstick. R10 thought staff cleaned the nebulizer and stated R10 used the nebulizer a couple days ago. Surveyor also interviewed Registered Nurse (RN)-C who entered R10's room during the interview. RN-C confirmed the mouthpiece contained red lipstick and indicated it was from that day because R10 had nebulizer treatments scheduled four times daily. RN-E stated nursing staff usually rinse the nebulizer.On 1/12/26 at 8:56 PM, Surveyor interviewed RN-C regarding nebulizer cleaning. RN-C stated nebulizers should be rinsed after each use, placed in the bathroom to dry, and should be dated and changed every 3 days.2. From 1/12/26 to 1/15/26, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including shortness or breath, chronic cough, and other COPD. R15's MDS assessment, dated 10/30/25, had a BIMS score of 12 out of 15 which indicated R15 had moderate cognitive impairment. R15 had an activated Power of Attorney for Healthcare (POAHC).R15 had the following physician order:~ Budesonide suspension for nebulization 0.5 mg/2 ml; 1 dose via inhalation twice daily.On 1/12/26 at 7:44 PM, Surveyor interviewed R15 and observed a nebulizer on the nightstand. The tubing was not dated and the nebulizer chamber contained liquid. R15 stated the nebulizer was not cleaned that day after use.3. From 1/12/26 to 1/15/26, Surveyor reviewed R62's medical record. R62 was admitted to the facility on [DATE] and had diagnoses including acute bronchospasm (sudden tightening of airway muscles) and influenza. R62's MDS assessment, dated 1/13/26, had a BIMS score of 13 out of 15 which indicated R62 had intact cognition.R62 had the following physician order:~ Albuterol sulfate (used to treat respiratory conditions) solution for nebulization 2.5 mg/3 ml; 1 vial via inhalation.On 1/12/26 at 7:20 PM, Surveyor interviewed R62 and observed a nebulizer on the nightstand. The nebulizer tubing and equipment were not dated and the nebulizer chamber contained drops of liquid. R62 stated R62 had not seen anybody rinse the nebulizer chamber. R62 used the nebulizer twice daily.On 1/13/26 at 2:38 PM, Surveyor interviewed RN-C and Licensed Practical Nurse (LPN)-E who both indicated nebulizer equipment should be taken apart and rinsed under tap water then dried on a paper towel after each use. RN-C and LPN-E confirmed R10, R15, and R62's medical records did not contain orders for nebulizer cleaning. RN-C and LPN-E also indicated nurses clean nebulizers after nebulizer treatments (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	01/20/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but there was no documentation for cleaning.On 1/13/26 at 3:05 PM, Surveyor interviewed Director of Nursing (DON)-B regarding nebulizer cleaning. DON-B indicated nebulizer chambers/parts should be rinsed with sterile water after each use and cleaning should be documented in the resident's Medication Administration Record (MAR) or Treatment Administration Record (TAR).

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	01/20/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure vital signs, weight, and monitoring of the fistula site were completed before and after dialysis for 1 resident (R) (R28) of 1 sampled resident.R28's medical record did not contain orders to obtain vital signs or weight or monitor the fistula site pre- or post-dialysis. Findings include: The facility's Dialysis policy, dated October 2025, indicates: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan .to meet the medical needs of the resident receiving hemodialysis .Compliance Guidelines: .4. The licensed nurse will communicate to the dialysis facility via .dialysis communication form or other form, that will include but not limit itself to: .b. Vital signs .d. Nutritional/fluid management including documentation of weights .7. The nurse will monitor and document the status of the resident's access site upon return from the dialysis treatment to observe for bleeding or other complications .11. The nurse will ensure the dialysis access site is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility, and/or nephrologist. From 1/12/26 to 1/15/26, Surveyor reviewed R28's medical record. R28 was admitted to the facility on [DATE] and had diagnoses including end stage renal disease and dependence on renal dialysis. R28 received hemodialysis related to renal failure at an outside dialysis center 3 times weekly (Monday, Wednesday, and Friday). R28's Minimum Data Set (MDS) assessment, dated 8/20/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R28 had intact cognition. R28's medical record did not contain documentation of fistula site assessment for bleeding, thrills, or bruits or documentations of vital signs obtained by facility staff. Vital signs recorded in R28's medical record were vital signs obtained by dialysis staff. On 1/12/26 at 7:59 PM, Surveyor interviewed R28 regarding assessments done before and after dialysis. R28 indicated staff do not obtain R28's vital signs or weight prior to or after dialysis treatments. R28 stated the dialysis center obtains R28's vital signs and weight when R28 arrives. R28 stated facility staff check R28's fistula for bleeding. On 1/13/26 at 2:41 PM, Surveyor interviewed Registered Nurse (RN)-C and Licensed Practical Nurse (LPN)-E regarding assessments completed for R28 pre- and post-dialysis. RN-C stated RN-C ensures R28's fistula is assessed and not bleeding. When Surveyor asked if RN-C documents the assessment, RN-C could not provide documentation and stated RN-C might have missed some assessments. LPN-E confirmed R28 did not have an order to check for bruit and thrill. LPN-E verified vital signs are not obtained by facility staff pre- or post-dialysis but stated they are obtained at the dialysis center. On 1/13/26 at 2:55 PM, Surveyor interviewed Director of Nursing (DON)-B who stated nurses should check a resident's fistula for bruit and thrill and confirmed R28 did not have an order to do so. DON-B also stated nurses should obtain a resident's vital signs pre- and post-dialysis and check the fistula site for bleeding. DON-B verified monitoring and assessments should be documented in R28's medical record.