STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525605	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health Services	3613 S 13th St 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 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 31 residents residing in the facility.The facility did not thaw frozen food via a safe thawing method.The facility did not consistently follow safe food cooling protocol.The facility did not consistently dispose of food items in a manner that ensured food safety.Findings include:During an initial kitchen tour that began at 8:17 AM on 12/16/25, Dietary Manager (DM)-D indicated the facility follows the Food and Drug Administration (FDA) Food Code.Thawing:The 2022 FDA Food Code documents at 3-501.13 Thawing: Except as specified in (D) of this section, time/temperature control for safety food shall be thawed: (A) Under refrigeration that maintains the food temperature at 5 degrees Celsius (C) (41 degrees Fahrenheit (F)) or less; or (B) Completely submerged under running water: (1) At a water temperature of 21 degrees C (70 degrees F) or below; (2) With sufficient water velocity to agitate and float off loose particles in an overflow; and (3) For a period of time that does not allow thawed portions of ready-to-eat food to rise above 5 degrees C (41 degrees F); or (4) For a period of time that does not allow thawed portions of a raw animal food requiring cooking as specified under 3-401.11(A) or (B) to be above 5 degrees C (41 degrees F), for more than 4 hours including: (a) The time the food is exposed to the running water and the time needed for preparation for cooking; or (b) The time it takes under refrigeration to lower the food temperature to 5 degrees C (41 degrees F) .During an initial kitchen tour that began at 8:17 AM on 12/16/25, Surveyor observed a plastic bag of ham soaking in water in the sink.During a continuous kitchen observation that began at 7:55 AM on 12/17/25, Surveyor interviewed DM-D who indicated the ham was being defrosted in the sink. DM-D indicated safe methods for defrosting meat are in the sink in water, in the sink under running water, and in the refrigerator. DM-D was not aware that thawing meat in water in the sink was not a safe defrosting method. Cooling:The 2022 FDA Food Code documents at 3-501.14 Cooling: (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 C (41 F) or less. If food is not cooled to 70 F within 2 hours, it must be either reheated to 165 F for 15 seconds and then re-cooled, or it must be discarded. This is because food that spends too long in the danger zone (between 41 F and 135 F) is at risk of rapid bacterial growth which can lead to foodborne illness. Proper cooling is essential to prevent the risk of foodborne illness, and failing to meet cooling time requirements can result in food safety violationsDuring an initial kitchen tour that began at 8:17 AM on 12/16/25, Surveyor observed the following pre-made and cooled food in the reach-in freezer:~ One bag labeled sausage links dated 12/1~ One bag labeled pumpkin dated 11/26~ One bag labeled BBQ dated 12/1~ One bag labeled beef tips dated 12/10~ One bag labeled pork dated 12/7Surveyor also observed one bag labeled grilled chicken dated 12/15 in the walk-in cooler.During a continuous kitchen observation that began at 7:55 AM on 12/17/25, Surveyor again observed the above items in the reach-in freezer and walk-in cooler and requested a copy of the facility's cooling logs from DM-D.On 12/17/25, Surveyor reviewed the facility's cooling logs and noted the following:~ The sausage links dated 12/1 and pumpkin dated (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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11/26 were not documented on the cooling log.~ The BBQ dated 12/1 did not reach 70 degrees F within the required two-hour time frame.Surveyor reviewed the facility's cooling logs for 10/27/25 to 12/16/25 and noted 50 documented foods were cooked, cooled, and saved for resident consumption but did not reach 70 degrees within the required two hours. On 12/17/25 at 12:30 PM, Surveyor interviewed DM-D who indicated staff should cool pre-cooked food to serve to residents at a future time to 70 degrees F within two hours. DM-D did not realize dietary staff were not safely cooling food and indicated staff are trained in food cooling methods. Storage/Disposal:The facility's contracted service's Receiving policy, revised 9/2017, indicates: All canned goods will be appropriately inspected for dents, rust, or bulges. Damaged cans will be segregated and clearly identified for return to vendor or disposal as appropriate.During an initial kitchen tour that began at 8:17 AM on 12/16/25 and a continuous kitchen observation that began at 7:55 AM on 12/17/25, Surveyor observed a can of pumpkin dated 11/13/25 with a dent on top of the rim, a can of chili sauce dated 6/19/25 with a dent on top of the rim, and a can of three bean salad dated 12/5/25 with a dent on top of the rim in the facility's dry storage.On 12/17/25 at 12:30 PM, Surveyor interviewed DM-D who verified the dented cans should not be on the shelf for resident consumption and indicated there is a place in DM-D's office for cans that need to be returned.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. Based on observation, staff interview, and record review, the facility did not ensure the provision of foot and nail care for 8 residents (R) (R21, R5, R9, R10, R6, R27, R29, and R30) of 8 sampled residents with diabetes.The facility did not provide daily diabetic foot checks for R21, R5, R9, R10, R6, R27, R29, and R30 in accordance with professional standards of practice, the residents' care plans, and the facility's policy. Findings include:The facility's Skin Integrity-Foot Care policy, dated 12/15/23, indicates: It is the policy of the facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot .The facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the resident's medical condition. The facility will utilize a systematic approach for the prevention and management of foot ulcers, including efforts to identify risk, stabilize, reduce, or remove underlying risk factors, monitor the impact of the interventions, and modify the interventions as appropriate .Interventions for prevention and to promote healing: Daily foot checks will be performed by the licensed nurse for all diabetic residents. Care should be used to check for excessive skin dryness, scaling, and cracking as these may be signs of potential problems. Other skin changes to look for include calluses, broken skin between the toes, and ulcers. Report abnormal finding to the resident's physician and responsible party .1.On 12/16/25, Surveyor reviewed R21's medical record. R21 had diagnoses including dementia, communication disorder, diabetes type 2, and chronic kidney disease. R29's Minimum Data Set (MDS) assessment, dated 10/14/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R21 had severe cognitive impairment. The MDS also indicated R21 required extensive assistance for activities of daily living (ADLs) and was dependent on staff for foot and nail care. R21's medical record contained a care plan that indicated R21 was diabetic and nail care should be completed by a nurse only. Non-licensed staff could file R21's nails if they were sharp or jagged. The care plan contained an intervention to inspect R21's feet daily for open areas, sores, pressure areas, blisters, edema, or redness.On 12/16/25 at 8:20 AM and on 12/17/25 at 9:58 AM, Surveyor observed R21 sitting on R21's bed and noted R21's feet were exposed. R21's feet appeared dry and had thick scaly and flaky areas. R21's toenails appeared long, jagged, and misshapen.2. On 12/18/25, Surveyor reviewed R5's medical record. R5 had diagnoses including type 2 diabetes, methicillin-resistant Staphylococcus aureus (MRSA) (a type of bacteria known as a superbug resistive to treatment with certain antibiotics), osteomyelitis of the right foot and ankle, bacteremia, partial amputation of the right heel, cellulitis, and right foot diabetic ulcer. R5's MDS assessment, dated 12/15/25, had a BIMS score of 15 out of 15 which indicated R5 had intact cognition. The MDS also indicated R5 was dependent on staff for foot and nail care. R5's medical record contained a care plan that indicated R5 was diabetic and nail care should be completed by a nurse only. Non-licensed staff could file R5's nails if they were sharp or jagged. The care plan contained an intervention to inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness.3. On 12/16/25, Surveyor reviewed R9's medical record. R9 had diagnoses including diabetes type 2, dementia, and communication disorder. R9's MDS assessment, dated 10/3/25, had a BIMS score of 5 out of 15 which indicated R9 had severe cognitive impairment. The MDS also indicated R9 required extensive assistance for ADLs and was dependent on staff for foot and nail care. R9's medical record contained a care plan that indicated R9 was non-diabetic and all staff could assist with foot care and skin assessments. The care plan contained an intervention for foot care once weekly on shower days.On 12/17/25 at 10:18 AM, Surveyor interviewed Registered Nurse (RN)-C who indicated nurses should look at residents' feet and nails on shower days. After reviewing R21's Treatment Administration Record (TAR), RN-C indicated R21's feet were observed weekly on shower days. RN-C indicated there were no special instructions for residents with diabetes but confirmed R5 had special instructions for wound care and indicated R5's foot checks were (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed on shower days. RN-C indicated staff ask podiatry to see a resident if the resident's nails are thick or have other issues that require care. On 12/18/25 at 9:00 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated all residents have skin checks on shower days; however, diabetic residents should have daily foot checks by licensed nursing staff at bedtime. DON-B indicated the daily foot check task is in each diabetic resident's care plan and should be documented as completed on the resident's TAR. DON-B confirmed R21 and R5's care plans indicated to check feet daily. DON-B verified R21 and R5's TARs did not contain orders for daily foot checks to alert nurses that R21 and R5 were diabetic and foot checks were needed. DON-B also verified R9's care plan indicated R9 was not diabetic; however, R9 had a diagnosis of diabetes. DON-B confirmed R9's care plan should contain an intervention for daily foot checks. DON-B stated if daily foot checks are not on residents' TARS, nursing staff do not know to complete the task. DON-B verified R21, R5, and R9's medical records didn't indicate daily foot checks were being completed. On 12/18/25, Surveyor reviewed additional residents' medical records and noted the following residents were diabetic but did not have daily foot checks on their TARs:4. R10 had a diagnosis of type 2 diabetes mellitus. R10's MDS assessment, dated 12/5/25, had a BIMS score of 8 out of 10 which indicated R10 had moderate cognitive impairment. The MDS also indicated R10 required the assistance of one staff for foot care.R10's medical record contained a care plan that indicated R10 was diabetic and nail care should be completed by nurses only. Non-licensed staff could file R10's nails if they were sharp or jagged. The care plan contained an intervention to inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness.5. R6 had a diagnosis of type 2 diabetes mellitus. R6's MDS assessment, dated 9/7/25, indicated R6 had a BIMS score of 14 out of 15 which indicated R6 had intact cognition. The MDS also indicated R6 required the assistance of one staff for ADLs.R6's medical record contained a care plan that indicated was R6 was diabetic and nail care should be completed by nurses only. Non-licensed staff could file R6's nails if they were sharp or jagged. The care plan contained an intervention to inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness.6. R27 had diagnoses including type 2 diabetes mellitus and chronic kidney disease (CKD). R27's MDS assessment, dated 12/7/25, had a BIMS score of 14 out of 15 which indicated R27 had intact cognition. The MDS also indicated R27 required the assistance of one staff for ADLs.R27's medical record contained a care plan that indicated R27 was diabetic and nail care should be completed by nurses only. Non-licensed staff could file R27's nails if they were sharp or jagged. The care plan contained an intervention to inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness.7. R29 had diagnoses including type 2 diabetes mellitus and CKD. R29's MDS assessment, dated 11/15/25, had a BIMS score of 7 out of 15 which indicated R29 had severe cognitive impairment. The MDS also indicated R29 required extensive assistance for most ADLs.R29's medical record contained a care plan that indicated R29 was diabetic and nail care should be completed by nurses only. Non-licensed staff could file R29's nails if they were sharp or jagged. The care plan contained an intervention to inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness.8. R30 had a diagnosis of type 2 diabetes mellitus and was a suspected carrier of MRSA. R30's MDS assessment, dated 10/2/25, had a BIMS score of 5 out of 15 which indicated R30 had severe cognitive impairment. The MDS also indicated R30 required extensive assistance for most ADLs.R30's medical record contained a care plan that indicated R30 was diabetic and nail care should be completed by nurses only. Non-licensed staff could file R30's nails if they were sharp or jagged. The care plan contained an intervention to inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness.On 12/18/25 at 11:45 AM, DON-B approached Surveyor and verified R10, R6, R27, R29, and R30's care plans contained interventions for daily foot checks due to diabetes; however, R10, R6, R27, R29, and R30's TARs did not contain instructions for nurses to complete daily foot checks. DON-B verified R10, R6, R27, R29, and R30 did not receive foot care per professional standards of practice and the facility's policy.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure weights were monitored for 4 residents (R) (R27, R30, R36, and R37) of 12 sampled residents.The facility did not obtain weights or re-weights for R27, R30, R36, and R37 in accordance with physician orders and the facility's policy. In addition, the facility did not update the physician regarding R27, R30, R36, R37's weight loss/gain of more than 5 pounds. Findings include:The facility's Weight Monitoring policy, revised 12/21/22, indicates: The Interdisciplinary Team (IDT) will strive to prevent, monitor, and intervene for undesirable weight change for our residents .6. Any weight change of 5 pounds or more since the last weight assessment will be retaken for confirmation .8. The threshold for significant weight change will be based on the following criteria: a. one month - 5% weight change is significant; Greater than 5% is severe. b. 3 months - 7.5% weight change is significant; Greater than 7.5% is severe. c. 6 months - 10% weight change is significant; Greater than 10% is severe .10. The nursing staff will notify the individual or responsible party, physician, and registered dietary nutritionist or designee of any individual with an unintended significant weight change.1.From 12/16/25 through 12/18/25, Surveyor reviewed R27's medical record. R27 was admitted to the facility on [DATE] and had diagnoses including surgical aftercare following surgery of digestive system, chronic systolic (congestive) heart failure, sarcopenia, and localized edema. R27's Minimum Data Set (MDS) assessment, dated 12/7/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R27 had intact cognition. R27's order for furosemide (prescribed for congestive heart failure) was increased from 20 milligrams (mg) daily to 40 mg daily on 12/6/25.R27's medical record contained the following orders:~ Daily weights (order date: 12/6/25).~ Weight on admit, daily x 2, weekly x 3, then monthly. Obtain re-weight if change of 5 pounds since last weight (order date: 12/3/25).Surveyor reviewed R27's weights and noted the following:~ 12/16/25 at 11:41 AM: 140.0 pounds (lbs) on wheelchair scale (manual) ~ 12/15/25 at 7:24 AM: 142.5 lbs on wheelchair scale (manual) ~ 12/14/25 at 7:08 AM: 146.5 lbs on wheelchair scale (manual) ~ 12/13/25 at 9:59 AM: 147.0 lbs on wheelchair scale (manual) ~ 12/12/25 at 11:29 AM: 146.0 lbs on wheelchair scale (manual) ~ 12/11/25 at 7:50 AM: 146.5 lbs on wheelchair scale (manual) ~ 12/10/25 at 7:52 AM: 147.0 lbs on wheelchair scale (manual) ~ 12/9/25 at 7:19 AM: 152.0 lbs on wheelchair scale (manual) ~ 12/8/25 at 11:49 AM: 154.5 lbs on wheelchair scale (manual) ~ 12/6/25 at 8:03 AM: 156.0 lbs on wheelchair scale (manual) ~ 12/5/25 at 11:05 AM: 164.0 lbs on wheelchair scale (manual) ~ 12/4/25 at 9:19 AM: 163.5 lbs on wheelchair scale (manual)R27 did not have a documented weight on 12/7/25 or re-weights on 12/6/25 and 12/10/25. R27's medical record did not contain progress notes regarding the missing weights/re-weights or indicate R27's provider was updated.(See interviews under example #4.)2. From 12/16/25 to 12/18/25, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] and had diagnoses including osteomyelitis of vertebra, sacral and sacrococcygeal region, type 2 diabetes mellitus, and stage 4 pressure ulcer of sacral region. R30's MDS assessment, dated 12/13/25, had a BIMS score of 5 out of 15 which indicated R30 had severely impaired cognition. R30's medical record contained the following orders:~ Weight on admit, daily x 2, weekly x 3, then monthly. Obtain re-weight if change of 5 pounds since last weight. One time per day every Monday, Saturday for admission for 3 weeks and one time per day every 1 month starting on the 1st for 3 days (order date: 10/27/25).~ Weight on admit, daily x 2, weekly x 3, then monthly. Obtain re-weight if change of 5 pounds since last weight (order date: 7/4/25 through 10/24/25). A dietician progress note, dated 12/9/25 at 6:53 PM, indicated: Weight Warning: 12/4/25 current weight 247 pounds +3.0% change from last weight. (R30) follows a carb-controlled diet with variable intake 51-100%. Liquid protein twice daily (BID) for wound healing. Pressure injury stage 4 sacrum. Weight gain likely related to weight measure discrepancy on 11/15 and 11/17. Recommendations: Re-weigh for 3 consecutive days. Registered Dietitian (RD) available as needed (PRN).Surveyor reviewed R30's weights and noted the following:~ 12/4/25 at (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12:06 PM: 247.0 lbs on mechanical lift scale (manual) ~ 11/17/25 at 11:09 AM: 239.1 lbs on mechanical lift scale (manual) ~ 11/15/25 at 10:23 AM: 237.6 lbs on mechanical lift scale (manual) ~ 11/10/25 at 12:12 PM: 243.2 lbs on mechanical lift scale (manual) ~ 11/3/25 at 10:01 AM: 242.0 lbs on mechanical lift scale (manual) ~ 11/1/25 at 10:34 AM: 235.0 lbs on mechanical lift scale (manual) ~ 10/29/25 at 9:41 AM: 250.6 lbs on mechanical lift scale (manual) ~ 10/28/25 at 11:23 AM: 242.6 lbs on mechanical lift scale (manual) ~ 10/27/25 at 1:25 PM: 251.6 lbs on mechanical lift scale (manual) ~ 10/18/25 at 12:42 PM: 249.0 lbs on mechanical lift scale (manual)R30's medical record did not contain documented weights on 12/9/25, 12/10/25, or 12/11/25 per the dietitian's recommendation. R30's medical record also did not contain re-weights on 10/28/25, 10/29/25, 11/1/25, 11/3/25, 11/15/25, and 12/4/25, progress notes regarding the missing re-weights, or indicate R30's provider was updated.(See interviews under example #4.)3. From 12/16/25 to 12/18/25, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had diagnoses including unspecified facture of sacrum, unspecified atrial fibrillation, heart failure, and atherosclerotic heart disease. R36's MDS assessment, dated 12/13/25, had a BIMS score of 13 out of 15 which indicated R36 had intact cognition. Hospital documentation, dated 12/9/25, indicated R36's weight was 115.13 pounds via hospital bed.R36's medical record contained the following order:~ Weight on admit, daily x 2, weekly x 3, then monthly. Obtain re-weight if change of 5 pounds since last weight (order date: 12/9/25).R36's medical record contained the following weights:~ 12/11/25 at 8:01 AM: 105.5 lbs on wheelchair scale (manual) ~ 12/10/25 at 10:59 AM: 107.0 lbs on wheelchair scale (manual) ~ 12/9/25 at 9:50 PM: 115.1 lbs on mechanical lift scale (manual)R36's medical record did not contain a documented re-weight on 12/10/25, a progress notes regarding the missing re-weight, or indicate R36's provider was updated. (See interviews under example #4.)4. From 12/16/25 to 12/18/25, Surveyor reviewed R37's medical record. R37 was admitted to the facility on [DATE] and had diagnoses including fracture of unspecified part of neck of left femur, fracture of unspecified part of neck of right femur, pneumonia, and acute respiratory failure with hypoxia. R37's MDS assessment, dated 12/13/25, had a BIMS score of 14 out of 15 which indicated R37 had intact cognition. R37's medical record contained the following order:~ Weight on admit, daily x 2, weekly x 3, then monthly. Obtain re-weight if change of 5 pounds since last weight (order date: 12/9/25).R37's medical record contained the following weights:~ 12/16/25 at 11:33 AM: 86.5 lbs on wheelchair scale (manual) ~ 12/15/25 at 9:51 AM: 85.0 lbs on wheelchair scale (manual) ~ 12/11/25 at 11:50 AM: 98.0 lbs on mechanical lift scale (manual) ~ 12/9/25 at 7:01 AM: 100.0 lbs on mechanical lift scale (manual) R37's medical record did not contain a documented weight on 12/10/25 or a re-weight on 12/15/25, progress notes regarding the missing weights, or indicate R37's provider was updated.On 12/17/25 at 11:09 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated nursing staff re-weigh a resident if there is a weight gain or loss of greater than 5 lbs. LPN-E indicated nursing staff contact the provider regarding the resident's weight and enter a progress note in the resident's medical record regarding the weight and provider notification. LPN-E stated if the provider is contacted, there should be a progress note in the resident's medical record.On 12/18/25 at 12:11 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated it is the facility's policy to weigh residents on admission, the first 2 days after day of admission, once weekly for 3 weeks, and then monthly if there are no significant weight changes. DON-B indicated nursing staff should re-weigh a resident if there is a 3 pound weight difference from the resident's last weight and/or a 5 pound weight change in the last week. DON-B indicated nursing staff are responsible for contacting the provider regarding the weight gain/loss and should enter a progress note for the weight gain/loss and provider contact in the resident's medical record. DON-B verified R27 should have been re-weighed on 12/6/25 and 12/10/25 and confirmed R27 had an order for daily weights on 12/6/25 and should have been weighed on 12/7/25. DON-B verified R30 should have been re-weighed on 10/28/25, 10/29/25, 11/1/25, 11/3/25, 11/15/25, and 12/4/25 and should have been weighed on 12/9/25, 12/10/25, and 12/11/25. DON-B verified R36 should have been re-weighed on 12/10/25 due to an 8 pound weight loss and verified R37 should have been weighed on 12/10/25 and re-weighed on 12/15/25 due to a 13 pound weight loss.

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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. Based on staff and resident interview and record review, the facility did not ensure an allegation of misappropriation was thoroughly investigated for 1 resident (R) (R38) of 1 sampled resident.R38 reported that $42 was taken from R38's room. The facility did not thoroughly investigate the allegation of misappropriation.Findings include:The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, indicates: It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .Investigation of Alleged Abuse, Neglect, and Exploitation: .Written procedures for investigations include: Providing complete and thorough documentation of the investigation .On 12/16/25, Surveyor reviewed R38's medical record. R38 had diagnoses including Prader-Willi syndrome, anxiety, and major depressive disorder. R38's Minimum Data Set (MDS) assessment, dated 9/10/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R38 had intact cognition. R38 was R38's own decision maker.On 12/16/25, Surveyor reviewed a facility-reported incident regarding an allegation of misappropriation for R38. The investigation indicated the facility was informed on 9/29/25 that R38 alleged $42 was stolen from R38's room. The investigation indicated R38 was interviewed and R38's room and personal belongings were searched. R38 was offered a safe or for the facility to store R38's money in the business office which R38 declined. The police and Ombudsman were notified. Staff education on misappropriation was completed. The investigation did not contain staff or resident interviews about the missing money.On 12/16/25 at 3:08 PM, Surveyor interviewed R38 who did not know what happened to the money and thought it was taken from R38's room. R38 did not think the money was misplaced but indicated R38 had no proof that another resident or staff took the money. R38 stated R38 did not want a safe or to keep money in the business office because R38 did not have any more money and was there for short-term rehab.On 12/16/25 at 2:43 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A interviewed staff but did not document the interviews. NHA-A wrote down the names of the staff who were interviewed, but did not recall interviewing other residents. NHA-A verified the investigation was not conducted or documented in accordance with the facility's policy.