STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525607	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningside Health Services	3431 N 13th St 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51044 Based on staff interview and record review, the facility did not ensure a Power of Attorney for Healthcare (POAHC) was notified regarding an allegation of abuse for 1 resident (R) (R2) of 3 sampled residents. On 11/23/24, Certified Nursing Assistant (CNA)-D reported that CNA-D witnessed CNA-C be aggressive and use vulgar language during cares for R2 on 11/19/24. The facility did not notify R2's POAHC of the alleged abuse. Findings include: The facility's Change in Condition of the Resident policy, dated 9/20/22, indicates: A facility should immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident's representative when there is an accident involving the resident which results in an injury and has a potential for requiring physician intervention, a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status and either life-threatening conditions or clinical complications), or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .4. Notify the resident and/or family/responsible party as applicable and in accordance with the resident's wishes .Documentation needs to include but is not limited to the following .4. Notification of responsible party - include date, time, what was conveyed, any comments (each time notified). On 1/27/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Huntington's disease, depression, dysphagia, and weakness. R2's Minimum Data Set (MDS) assessment, dated 12/18/24, had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R2 had impaired cognition. R2 had an activated POAHC who was responsible for R2's medical decisions. On 1/27/25, Surveyor reviewed a facility-reported incident (FRI) that indicated on 11/19/24, CNA-D witnessed CNA-C use excessive force while changing R2's brief and witnessed CNA-C grab and yank R2 aggressively toward CNA-C. CNA-D also reported that CNA-C used vulgar language while completing cares. CNA-D did not report the allegation of abuse to administration until 11/23/24. The investigation did not indicate R2's POAHC was notified of the alleged abuse. (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

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2025
NAME OF PROVIDER OR SUPPLIER Morningside Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 N 13th St 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 11:37 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified R2's medical record did not contain documentation that R2's POAHC was notified of the allegation of abuse. NHA-A stated NHA-A would expect NHA-A or a staff delegated by NHA-A to contact R2's POAHC within hours of the reported incident on 11/23/24.