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	02/11/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect more than 4 of the 30 residents residing in the facility.Staff did not complete proper hand hygiene prior to donning/doffing gloves, while preparing and serving food, and during dish washing.Findings include:On 2/10/26 at 1:09 PM, Culinary Manager (CM)-F stated the facility follows the Wisconsin Food Code.The Wisconsin Food Code documents at Chapter 2 Personal Cleanliness 2-301.14 titled When to Wash: Food employees shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms .(E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (H) Before putting on gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands.The facility's undated Hand Washing Policy & Procedure Manual indicates: .1. When to wash hands: a. When entering the kitchen at the start of a shift. b. After touching bare human body parts other than clean hands and wrists. c. After using the restroom. d. After caring for or handling service animals or aquatic animals. e. After coughing, sneezing, using a tissue, using tobacco, eating, or drinking. f. After handling soiled equipment or utensils. g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross-contamination when changing tasks. h. When switching between working with raw food and working with ready-to-eat food. i. Before donning disposable gloves for working with food and after gloves are removed. j. After engaging in other activities that contaminate the hands. 2. How to Wash Hands: a. Turn on the faucet using a paper towel to avoid contaminating the faucet. b. Wet hands and forearms with warm water and apply an antibacterial soap. c. Scrub well with soap and additional water as needed, scrubbing all areas thoroughly. Pay close attention to the fingernails using a brush as needed. Scrub for a minimum of 10 to 15 seconds within the 20-second hand washing procedure. Apply vigorous friction between fingers and fingertips. Rinse with clean, running warm water. d. Rinse thoroughly. e. Dry hands with paper towel or use a hand blow dryer .4. Each hand washing sink will post the hand washing procedure.During breakfast service on 2/10/26 at 7:56 AM, Surveyor observed [NAME] (CK)-G cook French toast on a grill with gloved hands. CK-G dipped bread in an egg mixture and put the bread on the grill. CK-G then removed and disposed of CK-G's gloves. Without completing hand hygiene, CK-G continued to prepare breakfast and continued to cook French toast and remove it from the grill.On 2/10/26 at 8:10 AM, Surveyor observed CK-G don a clean pair of gloves without completing hand hygiene. Surveyor observed CK-G prepare another batch of [NAME] toast by dipping bread into an egg mixture and placing the bread on the grill.On 2/10/26 at 8:13 AM, Surveyor observed CK-G remove gloves and obtain temperatures for two items on the steam table. CK-G did not wash hands after removing gloves and obtaining food temperatures. On 2/10/26 at 8:15 AM, Surveyor observed CK-G (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
	525607	A. Building B. Wing	02/11/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	walk to the handwashing sink near the dishwashing area and wash hands. Surveyor heard the water turn on and walked for appoximately four seconds toward the sink. When CK-G was in sight, Surveyor observed CK-G dry CK-G's hands with paper towel. CK-G continued to cook, prepare, and serve food from the steam table. Surveyor observed CK-G leave the serving line two more times and wash hands at the sink. Both times Surveyor walked to the service area, CK-G was drying hands within 4 seconds.On 2/10/26 at 9:17 AM Surveyor observed CK-G wash dishes and then wash hands at a nearby sink. Surveyor noted CK-G completed hand hygiene (including drying CK-G's hands) in 10 seconds.On 2/10/26 at 9:29 AM, Surveyor observed CK-G in the clean dish area. CK-G washed hands in the nearby sink and completed hand hygiene (including drying CK-G's hands) in 9 seconds.On 2/10/26, Surveyor requested certification for kitchen staff and the facility's Hand Washing policy.On 2/10/26 at 10:24 AM, Regional Dietary Manager (RDM)-E provided the facility's hand washing policy and signed education that was completed. RDM-E indicated RDM-E observed an issue during food service and provided education to CM-F and CK-G. RDM-E provided Surveyor with a form, dated 2/10/26 at 10:00 AM and signed by CM-F and CK-G, that indicated RDM-E reviewed the handwashing policy with CM-F and CK-G.On 2/10/26 at 1:04 PM, Surveyor interviewed CK-G who indicated CK-G received handwashing education earlier that day. When Surveyor asked when hand hygiene should be completed, CK-G provided appropriate instances for handwashing. When asked about missed hand hygiene opportunities and instances observed by Surveyor when CK-G did not meet the 20 second minimum for handwashing in accordance with the facility's policy, CK-G stated CK-G must have been having an off day.On 2/10/26 at 1:09 PM, Surveyor interviewed CM-F who stated all kitchen staff, including CM-F, were familiar with the facility's Hand Washing policy.On 2/11/26 at 2:01 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated kitchen staff should be aware of and follow the Wisconsin Food Code and the facility's Hand Washing policy.

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	02/11/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on staff and resident representative interview and record review, the facility did not maintain privacy of medication and healthcare information for 1 resident (R) (R41) of 15 sampled residents. R39 was discharged home with a blister pack of R41's medication.Findings include:The facility's Discharge Medication Policy indicates: Medications are sent with the resident upon discharge on ly under conditions that protect the resident and assure compliance with applicable state laws .2. The labels of discharge medications are verified for completeness and accuracy by checking them against the most recent prescriber's orders. 3. Directions for use are reviewed with the resident or responsible party. If current directions for use are not the same as those on a prescription label, the medication name, strength, and correct directions for use are written on a separate piece of paper. The correct directions are given to the resident or responsible party, not affixed to the container .6. Discharge medication information is entered on the discharge instruction form, continuity form, or facility designated form. From 2/9/26 to 2/11/26, Surveyor reviewed R39's medical record. R39 was admitted to facility on 11/21/25 and had diagnoses including diabetes, transient ischemic attack, dysphagia, cognitive communication deficit, congestive heart failure, chronic kidney disease, anxiety disorder, and hallucinations. R39's Minimum Data Set (MDS) assessment, dated 11/25/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R39 had intact cognition. R39 had an activated Power of Attorney (POA). On 2/10/26 at 12:16 PM, Surveyor interviewed Family Member (FM)-L who stated when R39 was discharged on 12/4/25, another resident's medications were sent home with R39 and FM-L's sibling accidentally administered the medication to R39. FM-L stated FM-L called the facility on 12/5/25 to report the error and was told by an unknown staff to send the medication back. When FM-L stated the facility was incompetent, the staff member hung up on FM-L. FM-L stated one medication was in a blister pack and provided the name of the resident (R41) and the dosage. Surveyor verified that R41 discharged from the facility on 12/31/25 and was prescribed the medication that FM-L described.On 2/10/26 at 2:36 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware that R39 received R41's medication upon discharge. NHA-A indicated R39 and R41 were discharged on different dates in December (2025). NHA-A stated it is the responsibility of the discharge nurse to reconcile discharge medications with the resident or the resident's resposible party.

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	02/11/2026

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 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 and resident representative interview and record review, the facility did not ensure a bed-hold and transfer/discharge notice and/or a discharge summary was provided for 3 residents (R) (R24, R1, and R39) of 4 sampled residents. R24 was transferred to the Emergency Department (ED) on 1/18/26 and 2/6/26. Neither R24 or 24's representative were provided with a bed-hold or transfer/discharge notice. R1 was transferred to the hospital on [DATE]. Neither R1 or R1's representative were provided with a bed-hold or transfer/discharge notice.R39 was not provided with an accurate discharge summary. R39 discharged home on [DATE] with a blister pack of R41's medication which was accidentally administered to R39. Findings include: The facility's Transfer and Discharge policy, dated 7/15/22, indicates: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except as initiated by the resident, as necessary for the health and safety of residents or other individuals are endangered, or as otherwise permitted by applicable law .7. Emergency Transfers/Discharges - initiated by the facility for medical reasons .I. Provide a notice of the facility's bed-hold policy to the resident and representative at the time of transfer, as soon as possible but no later than 24 hours after the transfer. J. Provide a transfer notice as soon as practicable to the resident and the resident's representative .9. Anticipated Transfers or Discharges .b. A member of the Interdisciplinary Team completes relevant sections of the discharge summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the discharge summary is complete and includes .iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). iv. A post-discharge plan of care that is developed with the participation of the resident and the resident's representative(s) which will assist the resident to adjust to a new living environment. The facility's Discharge Medication Policy indicates: Medications are sent with the resident upon discharge on ly under conditions that protect the resident and assure compliance with applicable state laws .2. The labels of discharge medications are verified for completeness and accuracy by checking them against the most recent prescriber's orders. 3. Directions for use are reviewed with the resident or responsible party. If current directions for use are not the same as those on a prescription label, the medication name, strength, and correct directions for use are written on a separate piece of paper. The correct directions are given to the resident or responsible party, not affixed to the container .6. Discharge medication information is entered on the discharge instruction form, continuity form, or facility designated form. 1. From 2/9/26 to 2/11/26, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] and had a diagnosis of left above-the-knee amputation. R24's Minimum Data Set (MDS) assessment, dated 2/3/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R24 had intact cognition. R24 was responsible for R24's healthcare decisions. R24's medical record indicated R24 was transferred to the ED on 1/18/26 and on 2/6/26. R1's medical record did not include documentation that R24 or R24's representative received a bed-hold or transfer/discharge notice. On 2/11/26 at 2:42 PM, Surveyor interviewed Senior [NAME] President of Success (SVPS)-C who confirmed the facility did not complete bed-hold or transfer/discharge notices for R24's hospital (continued on next page)

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	02/11/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfers. 2. From 2/9/26 to 2/11/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had a diagnosis of personal history of urinary tract infections. R1's MDS assessment, dated 12/14/25, had a BIMS score of 15 out of 15 which indicated R1 had intact cognition. R1 was responsible for R1's healthcare decisions. R1's medical record indicated R1 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. R1's medical record did not include documentation that R1 or R1's representative received a written bed-hold or transfer/discharge notice. On 2/11/26 at 2:42 PM, Surveyor interviewed SVPS-C who confirmed the facility did not complete a bed-hold or transfer/discharge notice for R1's 12/7/25 hospital transfer. 3. From 2/9/26 to 2/11/26, Surveyor reviewed R39's medical record. R39 was admitted to the facility on [DATE] and had diagnoses including diabetes, transient ischemic attack, dysphagia, cognitive communication deficit, congestive heart failure, anxiety disorder, and hallucinations. R39's MDS assessment, dated 11/25/25, had a BIMS score of 15 out of 15 which indicated R39 had intact cognition. R39 had an activated Power of Attorney (POA) and was discharged home on [DATE]. Surveyor reviewed R39's discharge medications which did not include a medication of R41's that was sent with R39 upon discharge. A discharge nursing note, dated 12/4/25, indicated R39 was discharged home with belongings and all medications. The note indicated Family Member (FM)-L signed the discharge paperwork and took R39 home. On 2/10/26 at 12:16 PM, Surveyor interviewed FM-L who stated (R41's) medication was sent home with R39 when R39 discharged on 12/4/25 and was accidentally administered to R39 by FM-L's sibling. FM-L called the facility on 12/5/25 to report the error and an unknown staff told FM-L to send the medication back. When FM-L stated the facility was incompetent, the staff member hung up on FM-L. FM-L stated one medication was in a blister pack that contained R41's name and the dosage. Surveyor verified that R41 discharged from the facility on 12/31/25 and was prescribed the medication that FM-L described. On 2/10/26 at 2:36 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware that R39 was discharged with R41's medication. NHA-A indicated R39 and R41 were discharged on different dates in December (2025). NHA-A stated it is the discharge nurse's responsibility to reconcile discharge medications with the resident or the resident's resposible party. On 2/10/26 and 2/11/26, Surveyor left messages for FM-L's sibling but did not receive a return call.

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	02/11/2026

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 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 staff interview and record review, the facility did not ensure Minimum Data Set (MDS) assessments were accurate for 2 residents (R) (R8 and R6) of 15 sampled residents. R8 had diagnoses including anxiety disorder and delusional disorder. R8's MDS assessment, dated 1/21/26, indicated R8 did not have a mental illness. R6 had diagnoses including post-traumatic stress disorder (PTSD), bipolar disorder, major depressive disorder, and schizoaffective disorder. R6's MDS assessment, dated 11/20/25, indicated R6 did not have a mental illness. Findings include: The facility's Conducting an Accurate Resident Assessment policy, dated 4/28/25, indicates: The purpose of the policy is to assure all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas .3. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identify residents' strengths to maintain or improve medical status, functional abilities, and psychosocial status. 1. From 2/9/26 to 2/11/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including anxiety disorder and delusional disorder. R8's MDS assessment, dated 1/21/26, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R8 had severely impaired cognition. R8 had an activated Power of Attorney for Healthcare (POAHC) who assisted R8 with healthcare decisions. R8's medical record included a Pre-admission Screening and Resident Review (PASRR) Level II Screen, dated 1/17/24, that indicated R8 had a serious mental illness. R8's MDS assessment, dated 1/21/26, indicated R8 was not considered by the PASRR Level II process to have a serious mental illness (Section A1500). On 2/11/26 at 2:42 PM, Surveyor interviewed Social Services Designee (SSD)-M. After reviewing R8's Level II PASRR Screen, SSD-M indicated Section A1500 of the assessment should have indicated a PASRR Level II Screen confirmed the presence of a mental illness. 2. From 2/9/26 to 2/11/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including post-traumatic stress disorder (PTSD), bipolar disorder, major depressive disorder, and schizoaffective disorder. R6's MDS assessment, dated 11/20/25, had a BIMS score of 15 out of 15 which indicated R6 had intact cognition. R6 was responsible for R6's healthcare decisions. R6's medical record included a PASRR Level II Screen, dated 4/10/23, that indicated R6 had a serious mental illness. R6's MDS assessment, dated 11/20/25, indicated R6 was not considered by the PASRR Level II process to have a serious mental illness (Section A1500). On 2/11/26 at 2:42 PM, Surveyor interviewed SSD-M. After reviewing R6's Level II Screen, SSD-M indicated Section A1500 of the assessment should have indicated a PASRR Level II Screen confirmed the presence of a mental illness.

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	02/11/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure Pre-admission Screening and Resident Review (PASRR) requirements were met for 1 resident (R) (R24) of 5 sampled residents. R24 had diagnoses including anxiety disorder and major depressive disorder. The facility did not ensure R24's PASRR Level I Screen was completed timely or accurately. Findings include: The facility's admission of a Resident policy, dated 2/2/26, indicates: As part of the pre-admission preparation .c. Facility designated staff member(s) may be needed to assist in the admission process in gathering of information such as mental retardation (MR) and mental illness (MI) screening forms, mental health diagnoses, and background information, etc. From 2/9/26 to 2/11/26, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] and had diagnoses including anxiety disorder and major depressive disorder. R24's Minimum Data Set (MDS) assessment, dated 2/3/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R24 had intact cognition. R24 was responsible for R24's healthcare decisions. R24's medical record did not include a PASRR Level I Screen following R24's 11/21/25 admission. R24's medical record indicated R24 was transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. R24's PASRR Level I Screen, dated 12/31/25, did not indicate R24 had a serious mental illness. R24's medical record did not include a PASRR Level II Screen. On 2/11/26 at 1:59 PM, Surveyor interviewed Social Services Designee (SSD)-M who was responsible for PASRR completion. SSD-M stated a PASRR Level I Screen is completed any time a resident admits to the facility. SSD-M indicated SSD-M was not aware of the requirements for when to send a referral for a PASRR Level II Screen and only sent them in when the state mental health authority sent SSD-M an email that a Level II Screen was due. SSD-M confirmed a PASRR Level I Screen was not completed for R24's 11/21/25 admission. On 2/11/26 at 2:42 PM, Surveyor interviewed Senior [NAME] President of Success (SVPS)-C who confirmed PASRR Level I and Level II Screens should have been completed timely and accurately for R24.

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	02/11/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, staff and resident interview, and record review, the facility did not ensure nail care was provided for 1 resident (R) (R23) of 15 sampled residents.R23 was not provided nail care on a regular basis.Findings include:The facility's Nail Care policy, revised 4/20/23, indicates: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health .3. Routine cleaning and inspection of nails will be provided during activities of daily living (ADL) care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift or shower day). Nail care will be provided between scheduled occasions as the need arises.From 2/9/26 to 2/11/26, Surveyor reviewed R23's medical record. R23 had diagnoses including dementia, depression, and anxiety. R23's Minimum Data Set (MDS) assessment, dated 12/22/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R23 had moderate cognitive impairment. R23 had an activated Power of Attorney (POA) who assisted with healthcare decisions.A care plan indicated R23 had an ADL self-care deficit related to weakness and Huntington's disease and was non-diabetic. The care plan contained an intervention (initiated 6/16/25) for Certified Nursing Assistants (CNAs) to provide nail care.On 2/9/26 at 10:48 AM, Surveyor observed R23 in a wheelchair near the nurses' station. R23's fingernails were yellow and curved around the fingertip, longer than a 1/4 inch, and contained dark colored debris underneath them. On 2/10/26 at 3:25 PM, Surveyor noted R23's nails were in the same condition. Surveyor interviewed R23 who acknowledged R23's nails were long.On 2/10/26 at 3:29 PM, Surveyor interviewed Director of Nursing (DON)-B who reviewed R23's electronic medical record and did not see any refusals for nail care. DON-B stated R23 should receive nail care weekly on Friday which was R23's shower day and staff should clean under R23's nails more frequently if needed. Surveyor requested R23's past four months of nail care documentation, including whether nail care was offered and completed.On 2/10/26 at 3:33 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who attempted to review R23's shower sheets to see if nail care was documented. ADON-D indicated there were no shower sheets entered into R23's medical record after 2024.On 2/10/26 at 3:49 PM, Surveyor interviewed Senior [NAME] President of Success (SVPS)-C who indicated the facility did not have shower sheets for R23 because they do not keep them. SVPS-C was unsure when R23's nails were last cut or cared for. SVPS-C indicated R23's nails were long and were being cleaned and cut that day. On 2/11/26 at 9:47 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-I who stated CNAs should complete nail care for residents on shower days or whenever they need care. CNA-I stated nail care should be documented in task charting in the resident's medical record and shower sheets should indicate if nail care was provided or refused. When asked what staff should do if they notice nail care was not completed, CNA-I stated CNA-I would provide nail care and notify a nurse of any issues. CNA-I stated nurses do weekly skin checks on shower days and should also note if there is an issue with nail care.On 2/11/26 at 9:59 AM, Surveyor noted R23's nails were trimmed and cleaned. R23 indicated R23 was happy that nail care was provided and stated R23 felt better.On 2/11/26 at 10:56 AM, Surveyor interviewed Registered Nurse (RN)-H who indicated nail care should be documented in the Treatment Administration Record (TAR) and is also documented on shower sheets. RN-H stated refusals should be documented in the TAR or a progress note. RN-H stated CNAs and nurses should notice if nail care is not being done with weekly showers.On 2/11/26, Surveyor reviewed R23's TAR which indicated R23 was scheduled for a weekly shower on Fridays. The TAR did not indicate whether R23's shower on 2/6/26 was completed or refused.On 2/11/26 at 11:14 AM, Surveyor interviewed ADON-D who indicated nail care does not need to be documented and is part of weekly shower care. When Surveyor asked ADON-D why some residents had nail care documented on their TARs but R23 did not, ADON-D stated Surveyor should ask SVPS-C.On 2/11/26 at 2:05 PM, Surveyor interviewed SVPS-C who indicated staff do not typically document nail care for non-diabetic residents; however, nail care should be consistent for non-diabetic residents and should be completed weekly with showers.

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	02/11/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure the accurate and safe administration of medication for 1 resident (R) (R13) of 15 sampled residents.Containers of Mentholatum Original Ointment (decongestant, analgesic ointment), Biofreeze (pain relieving gel), and Equate Vaporizing Rub (cough suppressant, topical analgesic) were observed on R13's bedside table. The medications did not contain pharmacy labels and only one of the medications had a physician's order. In addition, R13 did not have a self-administration of medication assessment that indicated R13 could safely and accurately self-administer medication and/or store medication at the bedside.Findings include: The facility's Self-Administration of Medication policy, dated 5/19/25, indicates: The Center will ensure that a resident can self-administer medication if the resident wants to do so and is determined to be able to do so safely. 1. The Executive Director/designee will inform residents on admission that they have the right to self-administer medication unless the resident has been found incompetent or does not have the physical or mental capacity to self-administer as determined by the resident's physician. 2. The Executive Director/designee will complete a medication self-administration evaluation on admission, annually, and with any significant change of condition for all residents who desire to self-administer medication and do not meet the exemption criteria listed in #1 .5. Staff will assume responsibility for administering medication for residents who are not capable of self-administering medication or who choose to have their medication managed and administered by staff. 6. The Executive Director/designee will ensure written orders are in the resident's record for all medication that the resident self-administers. 7. The Executive Director/designee will incorporate the plan for a resident to self-administer medication on the ISP. 8. The Executive Director/designee will ensure there is a secure location in the resident's room for storing medication, including a locked refrigerator if needed .On 2/9/26, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including alcoholic polyneuropathy, chronic pulmonary disease with acute exacerbation, solitary pulmonary nodule, and edema. R13's Minimum Data Set (MDS) assessment, dated 2/5/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R13 had intact cognition. R13 was R13's own decision maker.On 2/9/26 at 2:09 PM, Surveyor interviewed R13 and observed three containers of medication on R13's bedside table, including Mentholatum Original Ointment, Biofreeze, and Equate Vaporizing Rub. None of the medications contained a pharmacy label or indicated they were prescribed to R13. R13 stated R13 applied the medications when R13 needed them. R13 stated R13 brought the medications from home when R13 was admitted to the facility approximately a year ago and the medications have been in R13's room ever since.Surveyor reviewed R13's physician orders and noted R13 did not have orders for Mentholatum Original Ointment and Equate Vaporizing Rub. R13 had a physician's order, dated 8/11/25, for Biofreeze External Cream 10% (menthol topical analgesic). Apply a thin layer to both knees topically every 8 hours as needed for pain control. R13 did not have an order to keep Biofreeze at the bedside.R13's care plan did not indicate R13 could store medication at the bedside or self-administer medication.R13's medical record did not contain a self-administration of medication assessment.On 2/10/26 at 2:19 PM, Surveyor observed the same medications in R13's room.On 2/11/26 at 9:47 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-I who stated residents should not have medication in their rooms and indicated residents cannot bring medication from home to keep in their rooms.On 2/11/26 at 10:03 AM, Surveyor interviewed R13 who stated R13 was not told that R13 cannot apply medication or store medication in R13's room. Surveyor noted the three medications were still on R13's bedside table.On 2/11/26 at 10:56 AM, Surveyor interviewed Registered Nurse (RN)-H who indicated a resident can have medication in their room if they have an approved self-administration of medication assessment 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
	525607	A. Building B. Wing	02/11/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	can safely self-administer medication. RN-H stated if there is medication in a resident's room, the resident should have an order for bedside storage and it should be reflected in the resident's care plan.On 2/11/26 at 11:14 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who indicated a resident can have medication at the bedside if they have a self-administration of medication assessment, a risk versus benefits form, and a physician's order to keep medication at the bedside. ADON-D indicated bedside medication storage should be included in a resident's care plan and the medication should be locked up. ADON-D also indicated medication stored in a resident's room should contain a pharmacy label. ADON-D indicated the facility does not allow residents to bring medication from home and stated if a resident brings medication from home, the medication is locked up until they can be taken back home. On 2/11/26, Surveyor requested a bedside medication storage order for R13 and R13's most recent self-administration of medication assessment.On 2/11/26, Senior [NAME] President of Success (SVPS)-C approached Surveyor and indicated R13 did not have an order to store medication at the bedside or a self-administration of medication assessment. On 2/11/26 at 2:01 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated there should be an order for all medication in a resident's room and a bedside storage order. NHA-A indicated the resident should also have a self-administration of medication assessment that indicates the resident can safely and accurately administer medication.