STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525318	A. Building B. Wing	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Health and Rehabilitation Center	8400 Sheridan Rd Kenosha, WI 53143

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, document review, and review of facility policy, the facility failed to ensure an allegation of verbal abuse from 1 (R14) of 1 residents reviewed, that was documented by nursing staff, was reported State Survey Agency (SSA) within 2 hours of the allegation of abuse. Nursing staff documented Resident (R) 14 was yelling at and using racial slurs towards other residents. Findings include: Review of a document provided by the facility titled Policy & Procedure Abuse and Neglect Reporting and Investigating, dated 05/09/19 indicated . IDENTIFICATION, INVESTIGATING AND REPORTING OF ABUSE: Abuse is defined differently under both State and Federal law and Regulation. Please review the key definitions in this policy that should be considered when determining whether an event constitutes abuse. All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the administrator or designated representative . All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the state survey agency no later than two (2) hours after the allegation is made, if the events that caused the allegation involved abuse and result in serious bodily injury or not later than twenty-four (24) hours if the events that cause the allegation involve abuse but do not result in serious bodily injury. Review of R14's electronic medical record (EMR) titled Admission Record, indicated the resident was admitted to the facility on [DATE] with a diagnosis of alcohol dependence. Review of R14's EMR admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) located under the MDS tab dated 09/08/22 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident was able to ambulate with the use of a cane or a wheelchair. Review of R14's EMR nursing Progress Notes, located under the Prog [progress] Notes tab dated 10/10/22 documented R14 was intoxicated and was swearing and yelling at other residents, along with racial slurs and was disruptive of the residents' environment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The agency nurse who documented the 10/10/22 progress note was not available to be interviewed. During an interview on 11/22/22 at 9:44 AM, Director of Nursing (DON)-B stated he was not aware of the allegations of abuse towards other residents made by R14. DON-B stated the nurse who wrote the nursing progress notes did not inform him. DON-B stated he would have handled this by reporting the allegations of potential verbal abuse to the Administrator. During an interview on 11/22/22 at 1:08 PM, Administrator-A stated he was aware of the verbal abuse against staff but not towards other residents. Administrator-A stated he could hear R14 yelling and screaming clear down to his office. Administrator-A stated he attempted to calm the resident down but was not successful. Administrator-A stated he expected staff to report any allegation of verbal abuse to him immediately.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, and review of facility's policy, the facility failed to ensure a thorough investigation of an allegation of verbal abuse was completed from 1 (R14) of 1 residents reviewed, that was documented by nursing staff. Nursing staff documented Resident (R) 14 was yelling at and using racial slurs towards other residents this was not investigated by the facility as an allegation of abuse. Findings include: Review of a document provided by the facility titled Policy & Procedure Abuse and Neglect Reporting and Investigating, dated 05/09/19 indicated . IDENTIFICATION, INVESTIGATING AND REPORTING OF ABUSE: Abuse is defined differently under both State and Federal law and Regulation . Should an incident or suspected incident of Resident abuse (as defined above) be reported or observed, the administrator or his/her designee will designate a member of management to investigate the alleged incident. The facility will use the checklist for concerns and self-reports for guidance . Review the complete documentation of the allegation of Resident abuse . Review the Resident's medical record to determine events leading up to the incident . Documentation of any physical assessment conducted will be made in the Resident's chart and a copy of this documentation will be included in the abuse investigation file . The Director of Nursing or designated nurse will notify the Resident's attending . physician of the alleged incident. The responsible family member or responsible party, as documented on the Resident's chart, will be notified of the incident, and advised of the status of the investigation and the actions and reporting being taken . Interview the person(s) reporting the incident and the alleged perpetrator and document witness statements . Interview all witnesses to the incident and document all witness statements . Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident . Review of R14's electronic medical records (EMR) Admission Record, indicated the resident was admitted to the facility on [DATE]. Review of R14's EMR nursing Progress Notes, located under the Prog [progress] Notes tab dated 10/10/22 documented R14 was intoxicated and was swearing and yelling at other residents, along with racial slurs and was disruptive the residents' environment. The agency nurse who documented the 10/10/22 progress note was not available to be interviewed. During an interview on 11/22/22 at 1:08 PM, Administrator-A stated he was the abuse coordinator for the facility and did not complete an investigation of potential verbal abuse by R14 towards other residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on observations, interviews, record review, and policy review, the facility failed to ensure residents who were dependent on staff for shaving received services for one (Resident (R) 10) reviewed for Activities of Daily Living (ADL) assistance out of a survey sample of 16 residents. Findings include: Review of a document provided by the facility titled Activities of Daily Living (ADL's) Supporting, dated 03/18, indicated . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Review of R10's electronic medical records (EMR) Admission Record, located under the Profile tab indicated the resident was admitted to the facility on [DATE] with a diagnosis of spastic quadriplegic cerebral palsy. Review of R10's quarterly EMR titled Minimum Data Set (MDS) with an Assessment Reference Date (ARD) located under the MDS tab dated 08/16/22 indicated staff could not determine a Brief Interview for Mental Status (BIMS) score. The assessment indicated the resident was totally dependent on one staff for bed mobility and totally dependent on two staff for transfers. During an observation on 11/20/22 at 2:12 PM, R10 was observed in bed and facing the window. She was observed to have approximately one-half inch of upper lip and chin hair. R10 was unable to respond to questions. During an observation on 11/21/22 at 8:41 AM, R10 was again observed in bed. The resident was observed with upper lip and chin hair. During an interview/observation on 11/21/22 at 5:30 PM, Administrator-A confirmed R10 had upper lip and chin hair and it needed to be taken care of. During an interview on 11/22/22 at 9:44 AM, Director of Nursing-B stated R10 received bed baths, and it was his expectation staff should have paid attention to her facial hair and shave it off.

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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 0689 Level of Harm - 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** 12679 Based on observation, interview, record review, and facility policy review the facility failed to ensure the resident environment remained as free of accident hazards and possible for two of five residents (Resident (R) 12 and R8) reviewed for accidents. The facility failed to thoroughly investigate an incident when facility staff served R12 hot noodles and subsequently sustained 3rd degree burns from the noodles. Additionally, the facility did not ensure R12's interventions for accidents were consistently implemented. The facility failed to ensure R8 had an electric blanket assessed and monitored prior to use. R8 was at high risk for skin damage. Findings include: 1. Review of R12's Admission Record, undated, located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with medical diagnosis that included primary osteoarthritis, unspecified hand. a. Review of the facility policy titled Foods Brought by Family/Visitors, dated 10/2017, revealed Facility staff will assist the resident with accessing his or her food if unable to do so independently. Family/visitors are asked to prepare and transport food using safe food handling practices. including: Safe cooling and reheating processes . all personnel involved in preparing handling serving or assisting the resident with meals or snacks will be trained in safe food handling practices. The facility provided a copy of an incident report, for an incident on 09/27/22 with R12. The Description stated [R12] observed with burn injuries to right lower quadrant, mid-chest, and upper chest. The Immediate action revealed the area was cleaned, dried, and treated. The Nurse Practitioner and wound care doctor were notified. The report indicated R12 did not go to the hospital. Under pre-disposing environment factors other was checked but the form did not indicate what other factors were. Under pre-disposing psychological factors, weakness/fainting was checked. A note on the form documented Resident states she may have missed the edge of the overbed table and spilled on herself. A note on the report by the Director of Nursing (DON) documented . resident indicated she requested staff to make noodles for her . original container [Styrofoam cup] placed in second container so resident can handle independently. resident unaware of injury and did not experience pain . advised to screen for service needs . mild pain noted on assessment. [new interventions] apply clothing protector, encourage resident to allow foods to cool prior to handling. The report lacked documentation of the name of the staff who discovered the incident, circumstances around the situation at time of discovery, how long R12's call light had been on, vital signs, and if the staff member serving the noodles had heated them in accordance with facility polices. In response to a request for additional information regarding the investigation, the Administrator provided an in-service given to the staff after the incident on handling hot liquids. No additional investigation was provided. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/20/22 at 2:34 PM, R12 verbalized she needed assistance when eating because she had pain in her shoulders, her hands were numb and painful in September leading to her having carpel tunnel surgery in October. R12 stated a concern that it took a long time for the staff to answer the call light when she spilled hot noodles on herself causing a burn. R12 stated she could not feel the heat from the burn until staff moved her clothing to examine the area. Review of the R12's medical record lacked documentation of the incident resulting in injury from the hot noodle soup on 09/27/22. Review of R12's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 07/30/22 revealed facility staff coded R12 as having no upper extremity impairment and requiring only set up assistance with meals. During an interview on 11/21/22 at 4:47 PM, MDS Coordinator-E explained R12 had not been identified as having upper extremity impairment on the MDS due to having gross motor movement. Fine motor movement impairment was not identified on the MDS but R12 did have fine motor movement impairment. During an interview on 11/22/22 at 9:34 AM, Registered Nurse (RN)-N confirmed the dressing changes were still being done on the chest and abdomen for R12 since the incident with the hot soup on 09/27/22. RN-N confirmed the soup with noodles served was too hot and caused the burns on R12 and should have been documented in the progress notes. During an interview on 11/22/22 at 12:05 PM, DON-B confirmed that an agency staff prepared the ramen for R12 and served it to her, DON-B could not identify the name of the staff who served the resident. During an interview on 11/22/22 at 12:44 PM, Registered Nurse-Wound Nurse-S confirmed treating the wounds on R12 and confirmed the injuries to R12 were third degree burns on her right breast and two areas on her upper abdomen. Review of R12's medical record indicates R12's burns are being treated with Silvadene which is a topical treatment used for partial or full thickness burns to prevent infection. b. During an interview on 11/20/22 at 2:34 PM, R12 verbalized she needed assistance when eating because she had pain in her shoulders, her hands were numb, and her right dominate hand was in a splint following carpel tunnel surgery. R12 had carpel tunnel surgery on 10/12/22. Review of R12's quarterly MDS located in the EMR under the MDS tab with an ARD of 10/23/22, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R12 was cognitively intact. The MDS documented R12 had no upper body limitations and required set up assistance for meals. Review of the physician orders under the Orders tab in the EMR revealed an order dated 11/04/22 to ensure clothing protector is placed on resident with all meals and all hot snacks for protection every shift for prevention [of burns]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R12's EMR Care Plan, located under the Care Plan tab revealed a care plan that addressed accidents related to general weakness, on 09/27/22 interventions were added to have R12 wear a clothing protector and to encourage the resident to allow foods to cool. Interventions included to keep call light within reach. During an observation on 11/21/22 at 8:30 AM, R12 was in bed and the call light was out of reach for the resident, on the floor. During an observation on 11/21/22 at 9:07 AM, R12 was sitting in bed eating a banana with her left hand. The breakfast tray was on the overbed table in front of the resident and included a hot beverage. R12 did not have a clothing protector. During an interview on 11/21/22 at 9:07 AM, R12 verbalized sometimes staff placed a towel on her chest between her neck and the food tray. On 11/21/22 at 9:10AM, Assistant Director of Nursing (ADON)-C came into the room asking R12 do you need assistance today? and R12 replied I need it every day. During an observation on 11/21/22 at 10:39 AM, R12 was in bed and her call light was on the floor, not hooked to the bed to be within reach for the resident. During an interview on 11/21/22 at 4:47 PM, MDS Coordinator-E confirmed R12 was to have a clothing protector in place with meals. 2. Review of a document provided by the facility titled Electrical Appliances, dated January 2019, indicated . Only authorized electrical appliances will be permitted in resident living areas. Should electrical appliances be permitted, each must be in good working order, free of frayed cords, and UL (underwriter's laboratory) approved. The apparatus must be clearly labeled with UL certifications and./or standards confirming external and internal credibility. Facility must identify and evaluate hazards and risks and implement interventions and monitoring for safe use. Review of R8's EMR's titled Admission Record indicated R8 was admitted to the facility on [DATE] with diagnoses that included type II diabetes mellitus and neuropathy. Review of R8's EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/19/22 located under the (MDS) tab indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed the resident was cognitively intact. This assessment indicated the resident was extensive assistance of two staff for bed mobility and was totally dependent on two staff for transfers. This assessment revealed the resident had an ostomy. Review of R8's electronic medical record (EMR) Care Plan, located under the Care Plan tab failed to indicate the resident used an electric blanket. Review of R8's EMR, failed to indicate the resident was assessed for the use of an electric blanket nor did the clinical record indicate a discussion with the resident on the risks verses benefits of the use of an electric blanket. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 11/20/22 at 2:19 PM, R8 had a heating blanket on him. R8 stated staff have not done any assessment with him for the use of a heating blanket. During an observation on 11/21/22 at 8:25 AM, R8 still had a heating blanket on. During an interview on 11/21/22 at 5:05 PM, Administrator-A stated a heating blanket was a potential accident hazard. At 5:40 PM, Administrator-A and surveyor entered R8's room and Administrator-A stated he was not aware of R8's use of a heating blanket. Administrator-A stated there was no risk assessment done for the use of the heating blanket. R8 informed Administrator-A and surveyor that he had the blanket at the facility for several months and that facility staff had washed it several times for him. A request was made for the manufacturer's guidelines for the heating blanket and this document was not provided by the end of the survey. During an interview on 11/22/22 at 8:35 AM, Maintenance Director-T stated he was not aware of R8's use of a heating blanket. Maintenance Director-T stated the heating blanket was not monitored. Maintenance Director-T stated it was important to monitor a heating blanket for frayed wires. 39540

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review, and facility policy review the facility failed to ensure residents with colostomies (a surgical opening of the large intestine in which fecal material passes) were provided colostomy care consistent with standards of care for two of four residents (Resident (R) 9 and R8) reviewed for colostomy cares. Findings include: Review of the facility policy titled Colostomy/Ileostomy Care, dated October 2010, revealed .The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter. The following information should be recorded in the resident's medical record: l. The date and time the colostomy/Ileostomy care was provided. 2. The name and title of the individual(s) who provided the colostomy/Ileostomy care. 3. Any breaks in resident's skin signs of infection . or excoriation of skin. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data. 1. Review of R9's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with medical diagnoses that included unspecified intestinal obstruction, unspecified as to partial verses complete obstruction. Review of R9's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 10/21/22, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R9 was cognitively intact. During an interview on 11/22/22 at 10:16 AM, R9 verbalized several nights ago had told the Certified Nursing Assistant (CNA) to empty the [colostomy] bag and then they had to lay in bed for an hour and a half in feces because CNA did not know how to change the bag and had to wait for someone else to do it. Review of the physician orders under the Orders tab in the EMR lacked documentation of orders for the care of the colostomy for R9. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/22 at 12:05 PM, Director of Nursing (DON)-B explained the orders for R9 colostomy care should be imbedded in the standing orders (batch orders). Documentation of care should be found in the Treatment Administration Record (TAR) or the Medication Administration Record (MAR) in the EMR for colostomy care for any resident who had a colostomy. Review of the batch order set, provided by the facility, for R9 lacked orders for colostomy care. Review of the MAR and TAR, located in the EMR under the Orders tab, for R9 lacked documentation of colostomy care. During an interview on 11/22/22 at 2:10 PM, CNA-Q explained the CNAs empty the colostomy bags for residents with colostomies and do not change the bag. Nurses do that. During and interview on 11/22/22 at 2:19 PM, Licensed Practical Nurse (LPN)-M verbalized the CNA emptied the colostomy bags and the nurse changed the colostomy bag. LPN-M verified there was no documentation for R9 concerning colostomy care and if it was not marked on the MAR or TAR it should be in the progress notes. LPN-M reviewed the progress notes for R9 then verbalized there was no way to know when the last time the colostomy bag for R9 had been changed. 2. Review of R8's EMR Care Plan, located under the Care Plan tab dated 09/12/21 indicated the resident had an alteration in gastrointestinal status related to a colostomy. The intervention was to provide colostomy care per order and to update the physician with changes. Review of R8's EMR Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R8's EMR, failed to indicate the resident had physician orders for the care of his colostomy. Review of R8's EMR quarterly MDS with an ARD of 10/19/22 located under the MDS tab indicated the resident had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. This assessment indicated the resident required extensive assistance of two staff for bed mobility and was totally dependent on two staff for transfers. This assessment revealed the resident had an ostomy. Review of R8's EMR TAR located under the Orders tab dated from August 2022 through November 2022 indicated staff were to change the resident's colostomy wafer and pouch every three days and as needed for leakage. During an observation of R8's wound care 11/21/22 at 11:56 AM with Licensed Practical Nurse (LPN)-J, a large amount of tape was observed across R8's abdomen and colostomy site. R8 stated it was there to hold his colostomy bag in place. LPN-J stated she had not placed the tape. During an interview on 11/21/22 at 2:34 PM, Certified Nursing Assistant (CNA)-O stated she placed tape around the pouch to secure it better to R8 and this prevented leakage. CNA-O stated prior to placing paper tape on the pouch she applied skin prep. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/22 at 9:44 AM, Director of Nursing (DON)-B stated R8 was at risk for skin problems. DON-B stated the CNAs were not to use tape to secure the colostomy pouch and this placed R8 at risk for skin problems. DON-B stated his expectation was for the CNAs to empty the pouch frequently. 12679