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	03/21/2023

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45647 Based on observation, interview, and record review, the facility did not ensure 1 (R1) of 3 residents reviewed received adequate supervision and assessments to prevent accidents. *R1 had a Power of Attorney (POA) that was activated on 3/28/2022. R1 eloped from the facility on 2/7/2023 and was found by Emergency Medical Services (EMS) tipped over in their wheelchair on the sidewalk. EMS brought R1 back to the facility. R1 had an abrasion to the head but refused to be taken to the hospital and refused an assessment. On 2/28/2023, R1's POA was deactivated and R1 is now their own person. R1 was known by staff to request to leave the building in their wheelchair. There was no assessment completed to ensure R1 was able to safely maneuver their wheelchair across streets, avoid hazards, go in and out of doorways, and up and down ramps. There was no care plan initiated to notify staff that R1 can leave the building and the safety process/notification needed prior to R1 leaving the building and when to notify the administration if R1 is intoxicated and not safe to leave to building. Findings Include: Surveyor requested a policy and procedure from Nursing Home Administrator (NHA) A regarding safety for residents who desire to leave the building, however there was not a policy and procedure provided. R1 was admitted to the facility on [DATE] with diagnoses of alcohol dependence and alcohol abuse, muscle weakness, and abnormalities with gait and mobility. R1 was admitted to the facility with a POA that was activated on 3/28/2022. R1's Quarterly MDS (Minimum Data Set) dated, 12/20/22, documents a BIMS (Brief Interview for Mental Status) score of 13, indicating R1 is cognitively intact for daily decision making. Section G (Functional Status) documents R1 is independent with bed mobility, transfers, toilet use, and personal hygiene. On 2/7/2023, R1 eloped from the facility and was found by Emergency Medical Services (EMS) tipped over in their wheelchair on the sidewalk away from the facility. EMS brought R1 back to the facility and R1 had an abrasion to the head but refused to be taken to the hospital and refused an assessment. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/28/2023, R1's POA was deactivated and R1 is now their own person. On 3/1/2023 at 8:30 AM, Surveyor observed R1 sitting on the side of the bed eating breakfast. Surveyor did not observe R1 to have a wander guard on. On 3/1/2023 at 8:32 AM, Surveyor interviewed Registered Nurse (RN) C. RN C reported R1 should not have a wander guard on because R1's POA was deactivated so R1 could leave the facility if they wished. RN C and Surveyor went into R1's room together. RN C asked R1 if they had on a wander guard and R1 lifted their ankle and said No. RN C reminded R1 that if they wanted to leave the building, R1 needed to let RN C know and sign out. R1 stated that they knew that he had to sign out and that they needed to let the nurse know. RN C and R1 went to the nurse's station together and RN C showed R1 where to sign out and asked him to put his phone number down so the facility could contact R1 if needed. R1 informed RN C they understood. On 3/1/2023 at 2:49 PM, Surveyor interviewed RN D. RN D reported that R1 likes to leave the building. RN D reported that if R1 would leave the building, they would call NHA A and Director of Nursing (DON) B. On 3/2/2023 at 8:05 AM, Surveyor interviewed Licensed Practical Nurse (LPN) G. LPN G reported that they were familiar with R1 but is usually not assigned to R1. LPN G reported they are aware of R1 wanting to leave the building and thinks he would go get alcohol. On 3/2/2023 at 8:10 AM, Surveyor interviewed Business Office Manager H. Business Office Manager H reported that R1 liked to leave the building to go to the store. Business Office Manager H reported that R1 would use his wheelchair when leaving the building. On 3/2/2023 at 8:15 AM, Surveyor interviewed Certified Nursing Assistant (CNA) I. CNA I reported that R1 would want to go to the gas station. CNA I reported that R1 would ask staff and then would leave with their wheelchair. On 3/2/2023 at 8:20 AM, Surveyor reviewed R1's medical record and was unable to locate an assessment for R1 to ensure that R1 was safe to leave the building and was safely able to maneuver their wheelchair across streets, avoid hazards, go in and out of doorways, and up and down ramps that was completed after 2/28/23 when R1's POA was deactivated and R1 was their own person. On 3/2/2023 at 8:30 AM, Surveyor requested an assessment for R1 that showed R1 was assessed to be safe to leave the building from NHA A and DON B. On 3/2/2023 at 8:49 AM, NHA A and DON B reported that there is no formal safety assessment completed for R1. Surveyor asked NHA A and DON B how it was determined R1 was safe to leave the building, when on 2/7/23, R1 tipped their wheelchair over and fell on the sidewalk. NHA A reported they did have a meeting about it, but a formal assessment was not completed. DON B reported that if R1 wants to leave the building, DON B and R1 will discuss whether it is safe for R1 to leave the building at the time. DON B reported that if R1 is intoxicated and not safe to leave, then it will be an argument. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/2/2023 at 8:57 AM, Surveyor interviewed Social Service Coordinator E. Social Service Coordinator E reported that R1 does often want to leave the building. Surveyor asked if Social Service Coordinator E is aware if R1 is going to get alcohol. Social Service Coordinator E reported that they cannot prove that R1 is going to get alcohol. Social Service Coordinator E reported when R1's POA was activated, R1's POA gave R1 permission to leave the building. Social Service Coordinator E reported that R1's POA reported R1 has a long history of alcoholism. Social Service Coordinator E reported now R1 is their own person R1 can leave the building. On 3/6/2023 at 7:54 AM, Surveyor interviewed Therapy Director F. Therapy Director F reported that they complete safety assessments on residents who use electric wheelchairs, however if there is a safety concern, an assessment will be completed for a resident who uses a manual wheelchair. Therapy Director F reported most residents at the facility with manual wheelchairs are safe. Therapy Director F reported that the safety assessment includes moving in and out of doorways, going up and down ramps, locking the breaks of the wheelchair, and transferring from the wheelchair. Surveyor asked if they completed an assessment for R1 to be able to leave the building. Therapy Director F reported that R1 was in therapy when they were first admitted , and R1 was not leaving the building at that time, so they did not assess R1 for safety when leaving the building. Therapy Director F reported that R1 was independent in their wheelchair at that time. Therapy Director F reported if the nursing department had concerns regarding safety for R1, they would complete a safety assessment for R1. On 3/6/2023 at 10:41 AM Surveyor interviewed RN C. RN C reported that R1 is able the leave the building if they wish. Surveyor asked RN C how it was determined that R1 was safe to leave the building. RN C reported that she does not know how it was determined that R1 is safe to leave the building and is not really involved in that process. RN C reported that the process for when R1 requests to go on pass is that R1 needs to let a nurse know, R1 must tell them where R1 is going and when they are going to be back. RN C reported that R1 only goes a few blocks away to a gas station or the store and comes back in 20-30 minutes. RN C reported that they do not complete an assessment on R1 when they come back to facility, and this would be done if R1 would be gone for an extended period. Surveyor asked RN C what they would do if R1 was requesting to go on pass and was intoxicated. RN C reported that they are not sure what they are supposed to do, but they can't keep R1 from leaving the building. RN C reported they would explain to R1 that it is not safe for them to leave the building right now. RN C reported that if they had concerns for R1's safety, they would call the police, DON B, and NHA A. Surveyor reviewed R1's care plan. Surveyor noted R1's care plan did not include a care plan with interventions to ensure that R1 can safely leave the building and what facility staff should do if R1 is intoxicated and is requesting to leave the building. On 3/6/2023 at 9:27 AM Surveyor informed NHA A of the concerns that there was no assessment completed to ensure R1 was able to safely maneuver their wheelchair across streets, avoid hazards, go in and out of doorways, and up and down ramps after R1 tipped over in their wheelchair and fell on the sidewalk on 2/7/2023. Surveyor also shared that there was no care plan initiated to notify staff that R1 can leave the building and the process needed prior to R1 leaving the building and when to notify the administration if R1 is intoxicated and not safe to leave to building. NHA A reported that moving forward this information is going to be put in R1's special instructions in their medical record that way all staff have access to that information. NHA A reported they are planning a staff meeting for this week to address a lot of the concerns that Surveyors shared during survey. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no additional information provided by the facility.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on record review and interview, the facility did not maintain acceptable parameters of nutritional status, such as usual body weight, for 1 (R8) of 1 residents reviewed for weight maintenance. R8 received all nutrition through a gastrostomy tube and gained 27.5 pounds in four months, from 157 pounds on 9/13/2022 to 184.5 pounds on 1/11/2023, a significant weight gain of 17.5%. R8 was being monitored by a Registered Dietitian and the dietitian did not adjust the caloric needs to maintain usual body weight. Findings include: The facility policy and procedure entitled Weight Assessment and Intervention from MED-PASS (C)2001 revised 9/2008 states: Weight Assessment: 1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. 2. Weights will be recorded in each unit's Weight Record chart or notebook and in the individual's medical record. 3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. 4. The Dietitian will respond within 24 hours of receipt of written notification. 5. The dietitian will review the unit Weight Record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for 'significant' weight change has been met. 6. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight) / (usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. 7. If the weight change is desirable, this will be documented and no change in the care plan will be necessary. Analysis: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the: a. Resident's target weight range (including rationale if different from ideal body weight); b. Approximate calorie, protein, and other nutrient needs compared with the resident's current intake; c. The relationship between current medical condition or clinical situation and recent fluctuations in weight; and d. Whether and to what extent weight stabilization or improvement can be anticipated. Interventions: . 2. The Dietitian will discuss undesired weight gain with the resident and/or family. 3. Interventions for undesired weight gain should consider resident preferences and rights. A weight loss regimen should not be initiated for a cognitively capable resident without his/her approval and involvement. The facility policy and procedure entitled Enteral Nutrition from MED-PASS (C)2001 revised 11/2018 states: 3. The dietitian, with input from the provider and nurse: a. Estimates calorie, protein, nutrient and fluid needs; b. Determines whether the resident's current intake is adequate to meet his or her nutritional needs; c. Recommends special food formulations; and d. Calculates fluids to be provided (beyond free fluids in formula). 4. Enteral nutrition is ordered by the provider based on the recommendations of the dietitian. 6. If the resident has a feeding tube placed prior to admission or returning to the facility, the provider and the interdisciplinary team will review the rationale for the placement of the feeding tube, the resident's current clinical and nutritional status, and the treatment goals and wishes of the resident. 8. The dietitian monitors residents who are receiving enteral nutrition, and makes appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis, protein calorie malnutrition, quadriplegia, Stage 4 pressure ulcers to the sacrum and other site, depression, neoplasm of the colon, and dysphagia. R8 received all nutrition through a gastrostomy tube due to dysphagia (swallowing difficulties). No weight was obtained on admission, 7/25/2022. R8 was admitted with the following orders: -Osmolite 1.5 at 50 ml/hour continuous. -150 ml water flushes every four hours. -ProSource 30 ml daily (protein for wound healing). -Arginaid twice daily (to help with wound healing). On 7/27/2022 on the Nutritional Assessment form, Registered Dietician (RD)-X documented R8's most recent height was 66 inches and 159 pounds with a recommended weight range of 142 pounds. RD-X documented R8 had diagnoses of MS (Multiple Sclerosis), pressure areas, gastrostomy, protein calorie malnutrition, and dysphasia (difficulty speaking). Medications and laboratory values were reviewed. R8 had a Stage 4 pressure injury to the sacrum and a Stage 4 pressure injury to the right lower leg with no edema. Estimated nutritional needs were calculated. RD-X documented R8 was admitted for long term care from the hospital and due to advancing MS was bed bound. R8 had an activated Power of Attorney (POA) and palliative care was discussed in the hospital per the hospital discharge summary. RD-X recommended an increase of the Osmolite 1.5 from 50 ml/hour to 60 ml/hour with 175 ml water flushes every four hours. RD-X documented the tube feeding and flush would meet the estimated kcal, protein and water needs. RD-X documented R8's height and weight were obtained form the hospital record. RD-X documented the goal was to maintain tube feeding without signs or symptoms of intolerance or difficulty, prevent adverse significant weight loss, and maintain positive hydration status. On 7/28/2022, R8's Osmolite 1.5 was increased to 60 ml/hour. R8's Nutrition Care Plan was initiated on 7/31/2022 with the following focus: R8 requires tube feeding related to dysphagia secondary to MS; R8 takes nothing by mouth; R8 is at nutritional risk related to impaired skin. The goal was R8 would be free of aspiration through the review date and the insertion site would be free of signs or symptoms of infection. The interventions include: -Monitor weight per facility protocol; notify physician/RD of confirmed significant weight changes. -Monitor/document/report to physician as needed: aspiration, fever, shortness of breath, tube dislodged, infection at the tube site, self-extubation, tube dysfunction or malfunction, abnormal breath or lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, or dehydration. -Obtain and monitor lab/diagnostic work as ordered; report results to physician and follow up as indicated. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide local care to gastrostomy tube site as ordered and monitor for signs or symptoms of infection. -RD to evaluate quarterly and as needed; monitor caloric intake, estimate needs; make recommendations for changes to tube feeding as needed. On 8/5/2022, R8 weighed 158.6 pounds. On 8/10/2022, R8 weighed 157.9 pounds. On 8/17/2022, R8 weighed 155.0 pounds. On 8/27/2022 at 7:54 AM in the progress notes, RD-X charted R8's Stage 4 pressure injuries to the sacrum and right lower leg were noted to be improved in the last week. R8's weight was 155 pounds was a 2.2% loss in two weeks. R8's BMI (body mass index) was at the high end of normal at 25. R8's Osmolite 1.5 had been running at 60 ml/hour which met estimated nutritional needs with no intolerance noted. R8 also was receiving Arginaid twice daily and ProSource 30 ml daily for wound healing. RD-X charted a recommendation R8's Osmolite 1.5 be increased to 65 ml/hour and an increase to water flushes from 150 ml to 175 ml every four hours. RD-X charted with the increase in tube feeding and water flushes, R8 would meet the higher end of estimated kcal needs and exceed the estimated protein and fluid needs. RD-X also recommended weekly weights times four weeks. On 8/29/2022, R8's Osmolite 1.5 was increased to 65 ml/hour. On 8/29/2022 at 11:52 AM in the progress notes, Director of Nursing (DON)-B charted R8's POA was contacted and advised of RD-X's recommendations. R8's POA voiced no concerns. On 9/13/2022, R8 weighed 157.0 pounds. Surveyor noted weekly weights were not obtained as per RD-X recommendation. On 9/15/2022 at 2:14 PM in the progress notes, RD-T charted R8's weight was stable in the 150s since admission with a BMI at 25.3 which is within normal limits. RD-T charted weekly weights were in place, increased nutrition needs for wound healing were able to be met, mediations were reviewed, and RD-T recommended to continue the plan of care and monitor R8. R8's Nutrition Care Plan was revised on 9/15/2022 with the following interventions: -Provide supplements via gastrostomy tube as ordered. -Provide tube feeding and free water flushes as ordered via gastrostomy tube. On 9/21/2022, R8 weighed 170.0 pounds. That was an increase of 13 pounds in one week, an 8% weight gain. No re-weight was obtained. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/2022 at 5:35 PM in the progress notes, DON-B charted R8 had a significant weight gain. The Nurse Practitioner was advised, and the dietician reviewed R8's weight gain with no recommendations at that time. DON-B charted R8's POA was contacted and informed of the weight increase. The POA requested the dietician to re-evaluate R8 for a possible decrease in enteral feedings. DON-B charted DON-B would advise the dietician of the POA's request and update the POA of any planned changes to the regimen. On 10/20/2022, R8 weighed 198 pounds. That was an increase of 28 pounds in one month, a 16.4% weight gain. No re-weight was obtained. On 10/21/2022 at 11:51 AM in the progress notes, nursing charted R8 had a weight warning due to 198 pounds entered on 10/20/2022. Nursing charted the weight was reviewed and nursing was waiting for a re-weight to be completed. Nursing charted the weight will be addressed as indicated after the re-weight. No re-weight was obtained. On 10/21/2022 at 2:49 PM in the progress notes, RD-T charted a follow-up on weights, skin, and tube feeding. RD-T charted R8's weights were 198 pounds on 10/20/2022, 170 pounds on 9/21/2022, and 159 pounds on 8/5/2022 which showed a significant weight gain of 28 pounds or 16.4% in 30 days and a weight gain of 39 pounds in two months. RD-T charted RD-T questioned the accuracy of the weights and would request a re-weight. RD-T charted R8's BMI was 32.0 indicating obesity with no edema noted. RD-T charted the Osmolite 1.5 continued at 65 ml/hour along with free water flushes of 175 ml every four hours; Arginaid twice daily and ProSource 30 ml once daily to aid in skin healing. RD-T charted medications were reviewed and R8 had increased needs for skin healing and, with the tube feeding and supplements, nutritional needs were being met. RD-T recommended continuing the plan of care, reweighing R8, and monitoring. Surveyor noted no re-weight was obtained at that time. R8's Nutrition Care Plan focus was revised on 10/21/2022 to include R8 had significant weight gain for 30 days in October 2022. On 10/26/2022 on the Nutritional Assessment form, RD-U documented R8 currently weighed 198 pounds with a 16.4% weight gain in one month and a 27.74% weight gain in two months. RD-U documented a re-weight was requested for the 10/20/2022 weight. RD-U documented the tube feeding and supplements meet or exceed the estimated nutrition needs. RD-U documented increased nutrient needs were present related to increased demand in wound healing as evidenced by a Stage 4 pressure injury to the sacrum. (Surveyor noted the pressure injury to the sacrum had healed and R8 had a Stage 4 pressure injury to the right lower leg.) RD-U documented no new nutrition interventions were needed at that time. RD-U documented the goals were to maintain tube feeding without signs or symptoms of intolerance or difficulty, prevent adverse significant weight loss, maintain positive hydration status and wound healing as medically feasible. RD-U documented the plan was to continue the current regime and reweigh for accuracy. On 11/10/2022 at 4:13 PM in the progress notes, RD-U charted R8's Stage 4 pressure injury to the right lower leg was stable and Osmolite 1.5 continued at 65 ml/hour along with free water flushes of 175 ml every four hours; Arginaid twice daily and ProSource 30 ml once daily to aid in skin healing. RD-U charted medications were reviewed and R8 had increased needs for skin healing and, with the tube feeding and supplements, nutritional needs were being met. RD-U recommended continuing the plan of care and was waiting for a re-weight or the November weight. RD-U would follow as needed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/16/2022, R8 weighed 198 pounds. Surveyor noted this was the same weight as 10/20/2022. On 11/23/2022 at 8:45 AM in the progress notes, RD-V charted R8's current body weight was 198 pounds with a BMI of 32.0 indicating obesity. RD-V charted R8 had a significant weight gain of 39.4 pounds, or 24. 8% increase, in three months. RD-V charted Osmolite 1.5 continued at 65 ml/hour along with free water flushes of 175 ml every four hours; Arginaid twice daily and ProSource 30 ml once daily to assist with wound healing. RD-V charted R8 continued to tolerate the tube feeding well with no nausea, vomiting, coughing, or diarrhea. RD-V charted no edema was noted and R8 had a Stage 4 pressure injury to the right lower leg. RD-V charted the supplements of Arginaid and ProSource wound continue. RD-V charted R8 triggered for a significant weight gain times three months with the weight being stable in the last month. RD-V charted they were waiting for a re-weight to assure accuracy of the weights. RD-V recommended continuing the current plan of care with goals being no significant weight changes, maintaining tube feeding tolerance, and wound healing. On 11/29/2022, R8 weighed 178.5 pounds. Surveyor noted this was a 19.5 pound loss since 11/16/2022. On 11/30/2022 at 11:54 AM in the progress notes, RD-V charted R8's POA and family called RD-V regarding R8's tube feeding. RD-V charted R8's POA stated that R8 had gained a lot of weight and wanted the tube feeding to be cut in half or turned off for a couple of days. RD-V explained to R8's POA the importance of the tube feeding and the amount R8 was getting. RD-V charted R8's POA verbalized understanding but stated that the tube feeding rate per hour needed to be changed. RD-V informed R8's POA that RD-V would look more in depth into the matter. RD-V charted R8's weights had been fairly stable from high 150 pounds to 170 pounds. RD-V charted RD-V spoke with DON-B and the weights from 10/20/2022 and 11/16/2022 would be struck from the record due to suspected inaccuracy. RD-V charted DON-B stated they would do an updated BMP, CBC, and TSH. RD-V stated R8 would continue to be monitored. Surveyor noted the weights of 198 pounds on 10/20/2022 and 11/16/2022 were struck from R8's record. Surveyor noted R8, even with those weights removed, had gained 23.5 pounds, or 15%, in three months, from 8/17/2022 to 11/29/2022. On 12/7/2022 at 5:28 PM in the progress notes, nursing charted nursing called R8's POA regarding the POA's concerns with R8's tube feeding and question of the possible discontinuing of the tube feeding. A message was left on R8's POA's cellphone. On 12/8/2022 at 3:03 PM in the progress notes, RD-V charted a monthly tube feeding assessment. RD-V charted R8 had a Stage 4 pressure injury to the right lower leg. R8's current body weight was 178.5 pounds with BMI of 28.8 which was slightly overweight for age. RD-V charted R8 had a significant weight gain of 23. 5 pounds in the last three months. RD-V charted Osmolite 1.5 continued at 65 ml/hour along with free water flushes of 175 ml every four hours; Arginaid twice daily and ProSource 30 ml once daily to assist with wound healing. RD-V charted R8 continued to tolerate the tube feeding well with no nausea, vomiting, coughing, or diarrhea. RD-V charted no edema was noted and R8 had increased nutritional needs for skin healing. RD-V charted R8 was noted with a significant weight gain times three months. RD-V recommended decreasing the tube feeding to Osmolite 1.5 at 60 ml/hour continuously with free water flush of 175 ml every four hours. RD-V charted that would continue to meet the increased estimated kcal, protein, and water needs. RD-V recommended weekly weights for four weeks to monitor the change in rate of tube feeding. RD-V charted the goals were: no significant weight changes, no signs or symptoms of dehydration, maintain tube feeding tolerance, and wound healing. (continued on next page)

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	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/2022, R8's Osmolite 1.5 was decreased to 60 ml/hour. Surveyor noted the decrease in tube feeding rate was three days after RD-V made the recommendation. On 12/14/2022, R8 weighed 179.8 pounds. On 12/17/2022, R8 weighed 179.2 pounds. On 12/18/2022, R8 weighed 179.4 pounds. On 12/29/2022 at 3:56 PM in the progress notes, RD-V charted R8 triggered for a significant weight gain over the last three months. RD-V charted R8's current body weight was 179.4 pounds with a BMI of 29 indicating overweight. RD-V charted R8 had a significant weight gain of 22.4 pounds, or 14.3%, in three months. RD-V charted R8 was receiving Osmolite 1.5 at 60 ml/hour continuous with free water flushes of 175 ml every four hours. RD-V charted R8 was receiving Arginaid twice daily and ProSource 30 ml daily to assist with wound healing. RD-V charted the tube feeding and flushes continue to meet increased estimated kcal, protein, and water needs. RD-V charted R8 was tolerating the current tube feeding and flushes well. RD-V charted R8 had a Stage 4 pressure injury to the right lower leg and noted R8 had a slightly decreased sodium lab from 12/2/2022. RD-V recommended discontinuing the ProSource and adding ProHeal 30 ml twice daily; the tube feeding and ProHeal would provide 2360 kcal and 120 grams of protein. RD-V charted R8 was noted to have a significant weight gain in three months likely related to increased nutrition needs related to wound healing. RD-V charted the tube feeding and water flushes would continue due to the tube feeding being adjusted on 12/8/2022. RD-V recommended to continue with weekly weights to monitor weights and the change in tube feeding on 12/8/2022. RD-V charted the goals were for no significant weight changes, no signs or symptoms of dehydration, maintain tube feeding tolerance, and wound healing. On 1/3/2023 at 2:45 PM in the progress notes, nursing charted R8 had abdominal swelling that appeared to be fluid build up from the tube feeding. R8's abdomen was warm and hard to the touch. DON-B suggested an abdominal x-ray and the nurse practitioner ordered R8 to be sent to the emergency room . At 10:40 PM in the progress notes, nursing charted the emergency room called and was sending R8 back to the facility due to the CT scan having the same results as in the past. Nursing charted R8's POA refused to have R8 be admitted to the hospital for a colonoscopy in the morning. On 1/4/2023 at 2:30 AM in the progress notes, nursing charted R8 returned to the facility with a new order for Keflex 500 mg twice daily for five days due to a urinary tract infection with hematuria. Nursing charted R8 had a diagnosis of a mass of the cecum. At 10:21 AM in the progress notes, nursing charted R8 was seen by the nurse practitioner and was given an order to send R8 to the emergency room due to a firm, round abdomen, and the absence of bowel sounds. R8 was admitted to the hospital. On 1/11/2023 at 9:43 PM in the progress notes, nursing charted R8 was readmitted to the facility at 5:30 PM with tube feeding running at 45 ml/hour with 100 ml water flush. On 1/11/2023 when R8 returned from the hospital, the tube feeding order was Osmolite 1.5 at 45 ml/hour. On 1/11/2023, R8 weighed 184.5 pounds. (continued on next page)

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	525318	A. Building B. Wing	03/21/2023

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/2023 on the Nutritional Evaluation form, RD-V documented R8 weighed 184.5 pound with a recommended weight range of 130 pounds plus or minus 10 pounds. RD-V documented R8 was overweight and had a pressure injury to the sacrum. RD-V documented the re-entry assessment showed R8 was tolerating the tube feeding well with no nausea, vomiting, coughing or diarrhea. RD-V documented R8 did not have any edema. RD-V recommended adjusting the tube feeding to meet the increased needs to assist with wound healing and would also adjust the time of the tube feeding to allow time for bowel rest. RD-V recommended Osmolite 1.5 at 75 ml/hour for 18 hours a day with 175 ml of free water flushes every four hours. RD-V also recommended ProHeal 30 ml twice daily to assist with wound healing. RD-V would continue to monitor. RD-V documented the goals were no significant weight changes, wound healing, and tube feeding tolerance. On 1/20/2023, R8 weighed 180 pounds. On 1/21/2023, R8's Osmolite 1.5 was increased to 75 ml/hour for 18 hours per day. Surveyor noted the increase in tube feeding rate was eight days after RD-V made the recommendation. No weights were documented in R8's record after 1/20/2023. On 2/9/2023, R8 was sent to the hospital for a change in condition and altered mental status. R8 did not return to the facility. In an interview on 3/21/2023 at 8:46 AM, Surveyor reviewed with RD-W R8's weight gain and asked RD-W why so many different dietitians, RD-X, RD-T, RD-U, and RD-V, were involved in R8's care while at the facility. RD-W stated RD-W did not work as the dietitian at the facility until after R8 was already discharged but stated the dietitians all work for the same company and RD-V was the assigned dietitian, but the other dietitians would help with resident assessments when the census was high. RD-V could not answer to R8's weight gain while on tube feeding. In an interview on 3/21/2023 at 8:50 AM, Surveyor asked Director of Maintenance-Y how often the scales in the facility were calibrated, how many scales were in the facility, and if there had been any issues with scales not staying calibrated. Director of Maintenance-Y stated the scales are calibrated monthly using a 10-pounds weight. Director of Maintenance-Y stated since Director of Maintenance-Y started working at the facility in 5/2022, there have been no problems with the scales. Director of Maintenance-Y stated the facility has two standing scales and four Hoyer lift scales, two of which are brand new. (continued on next page)

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	525318	A. Building B. Wing	03/21/2023

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/21/2023 at 10:00 AM, Surveyor shared with DON-B the concern of R8's significant weight gain with 100% of the nutrition coming from tube feeding. DON-B stated R8's POA had expressed concern with R8's weight gain, but R8 had a wound so extra calories were warranted. DON-B stated R8's POA told the dietitian they wanted less tube feeding but the dietitian did not agree. DON-B stated DON-B knew R8 had picked up a little weight and suggested to R8's POA they could maybe do a bolus feeding instead of the continuous feeding. DON-B stated the dietitian reached out to R8's POA as well. Surveyor shared with DON-B the concern R8's weights were not being monitored and re-weights were not done timely if at all. Surveyor agreed with DON-B that extra calories are needed to aid in wound healing, but when R8 had significant weight gains, the dietitian did not re-evaluate or address the excess calories to maintain an ideal weight. Surveyor shared with DON-B the concern that R8's weights on 10/20/2022 and 11/16/2022 were struck from R8's record with no investigation to determine the validity of the weights. Surveyor shared with DON-B that R8, even with those two weights removed, still had a significant weight gain. Surveyor shared with DON-B that the hospital determined on admission the rate of the tube feeding to be at 50 ml/hour which the dietitian increased to 65 ml/hour and on readmission on 1/11/2023, the hospital determined the rate of the tube feeding to be at 45 ml/hour. DON-B stated R8 did not have any difficulty breathing and DON-B was aware hospice was talked about when R8 was in the hospital. In an interview on 3/21/2023 at 10:26 AM, Surveyor shared with Nursing Home Administrator-A and Registered Nurse (RN) Regional Educator-L the concern R8 received 100% of their nutrition through a gastrostomy tube where the facility has complete control over the amount of calories and nutrients provided and R8 had a significant weight gain while at the facility that was not addressed. RN Regional Educator-L stated the dietitian wanted increased calories for wound healing. RN Regional Educator-L stated R8 had a Stage 4 pressure injury to the sacrum and a Stage 4 pressure injury to the right leg of which one had healed and the other was almost healed when R8 discharged . Surveyor agreed with RN Regional Educator-L that increased calories are needed for wound healing, but Surveyor shared with RN Regional Educator-L the concern the dietitian did not adjust the caloric intake when R8's weight increased significantly, and re-weights were not done to verify those weights. R8 did not have weekly weights when recommended by the dietitian and R8's POA contacted the facility more than once to address their concern with R8's increase in weight. No further information was provided at that time.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the facility did not ensure 1 of 3 residents (R2) reviewed who displayed or had diagnoses of a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain their highest practicable mental and psychosocial well-being. R2 has self-injurious behavior, hallucinations, delusions, and suicidal and homicidal ideations including threats to staff and R3 (a peer.) There are multiple notes, including from [DATE], [DATE], [DATE], [DATE], & [DATE] from Psychologist-J documenting the facility is not an appropriate placement for R2. There is no evidence the facility addressed alternative placement except to refer to other nursing homes in the Milwaukee area. Progress notes in August document R2 engaging in self-injurious behavior to include chewing on and eating his fingers including removing bandages to further injure himself. A nurse's note dated [DATE] documents: Resident came back from [Name of] Hospital with orders to start Amoxicillin ,d+[DATE] mg 1 tablet PO (by mouth) 2 x (two times) day for 14 days for eating his own finger. Psychologist-J's progress notes dated [DATE] document: R2 has significant delusions which are violent in nature. Psychologist-J's progress note dated [DATE] documents: R2's mind is racing and he's broken. There was no assessment for R2 and no revisions in R2's care plan. On [DATE], the psych PA (physician assistant) recommended adding melatonin 3 mg (milligrams) at hour of sleep and increasing R2's Buspirone to 20 mg three times daily. This recommendation was not implemented. This was reordered on [DATE]. This recommendation was still not implemented until [DATE]. On [DATE], R2 called 911. EMTs determined R2 was having a mental health issue, he was hearing voices and the voices were taunting him. R2's physician was not notified, there was no assessment, and R2's care plan was not revised. On [DATE], R2 indicated to LPN/UM-N he calls 911 due to panic attacks and the voices being too loud in his head. LPN/UM-N discussed non medication interventions with R2. These interventions were not incorporated into R2's plan of care and R2's physician was not notified regarding the voices in his head being too loud. On [DATE], R2 was involved in a resident-to-resident altercation with R3. R2 made homicidal statements after this altercation. There is no evidence crisis was called and no revisions in R2's plan of care. (continued on next page)

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	525318	A. Building B. Wing	03/21/2023

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], Psychologist-J saw R2. During this session R2 made homicidal ideations toward a staff member he had a verbal argument with and toward R3. Psychologist-J indicated the staff would call the police regarding these statements. The police were not contacted after, there was no plan implemented to protect staff, & resident's and R2's plans of care were not revised. Psychologist-J's note dated [DATE] documents: R2 needs an activated power of attorney as well as long term commitment. The facility did not start the process for activating R2's power of attorney. On [DATE], R2 called 911 stating his head hurts, he was having chest pain, and no one is taking care of him. In the hospital R2 voiced suicidal and homicidal ideations and was transferred to a mental health institute. Upon return the facility did not implement a plan of what staff should be aware of with regard to R2's prior suicidal and homicidal ideations. The failure of staff to provide services to R2 for his mental health issues including assessments and revisions in his care plan after R2 made suicidal statements and homicidal statements regarding staff and R3, not implementing recommendations regarding R2's severe eating disorder, R2 not being appropriately placed, and activating a power of attorney created a finding of immediate jeopardy that began on [DATE]. Administrator-A, DON (Director of Nursing)-B, RN (Registered Nurse) Regional Educator-L, & Sr. (Senior) Dir. (Director) of Clinical Services-M were notified of the immediate jeopardy on [DATE] at 11:03 a.m. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as the facility continues to implement and monitor their action plan. Findings include: The Behavioral Assessment, Intervention, and Monitoring policy 2001 Med Pass inc (Revised [DATE]) under Management documents: 1. The interdisciplinary team will evaluate behavioral symptoms in resident to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. a. Atypical behavior will be differentiated from behavior that is dangerous or problematic for the resident(s) or staff, or behavior that signals underlying distress. b. If the behavior is atypical but not problematic or dangerous and the resident does not appear to be in distress, then the IDT (interdisciplinary team) will monitor for changes but not necessarily intervene to normalize the behavior. 7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. (continued on next page)

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	525318	A. Building B. Wing	03/21/2023

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. If the resident requires inpatient psychiatric services, State specific guidelines and requirements will be followed. Law enforcement to be notified if warranted. R2 was admitted to the facility on [DATE]. Diagnoses includes major depressive disorder, anxiety disorder, bipolar disorder, attention deficit hyperactivity disorder, and personality disorder. R2's psychotropic medications include Abilify 25 mg (milligrams) administered at hour of sleep with an order date of [DATE], Buspirone 20 mg three times a day with an order date of [DATE], Lamotrigine 25 mg one time a day for 14 days, 50 mg one time a day for next 14 days and then 100 mg one time a day with an order date of [DATE]. R2's care plan includes: Resident has a behavior problem r/t (related to) attention seeking [DATE] noted to be intoxicated, declined AA (alcoholics anonymous) states incident was isolated. Altercation with another resident. Initiated [DATE] & revised [DATE]. Interventions documented are: * Explain all procedures to the resident, before starting and allow me, the resident, to adjust to changes. Initiated [DATE]. Revised [DATE] without any change to verbiage of intervention. * If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Initiated [DATE]. Revised [DATE] without any change to verbiage of intervention. * Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Initiated [DATE]. Revised [DATE] without any change to verbiage of intervention. The Resident is/has potential to demonstrate physical behaviors biting fingers and finger nails r/t poor impulse control and attention seeking behavior [DATE] declining medication care plan initiated [DATE] and revised [DATE]. Interventions documented are: * Redirect resident from concentrating on fingers to another activity. Initiated [DATE]. * Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Initiated [DATE]. * Give the resident as many choices as possible about care and activities. Initiated [DATE]. Revised [DATE] without any change to verbiage of intervention. * Monitor resident's fingers for biting/chewing. Redirect when visualized to be chewing/biting on fingers. Initiated [DATE]. * Psych services consult as needed. Initiated [DATE]. * When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Initiated [DATE]. Revised [DATE] without any change to verbiage of intervention. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The E-MAR (electronic medication administration record) dated [DATE] documents: Biting fingers and taking off treatment to effected areas intentionally. The nurses note dated [DATE] includes documentation of Very agitated, wanting staff to call 911 said he was bleeding. It was where he chewed on his fingers Crawled out of bed and crawled around his room, refusing to be assisted back to bed for 30 minutes. The nurses note dated [DATE] documents: Resident came back from [Name of] Hospital with orders to start Amoxicillin ,d+[DATE] mg 1 tablet PO (by mouth) 2 x (two times) day for 14 days for eating his own finger. The nurses note dated [DATE] indicates, Resident approached the nurses station and states he had a dream that their fingers tasted like chicken so the resident stated they wanted a bandage to cover their finger. The resident then showed this nurse their middle finger where the resident chewed their finger. This nurse cleansed the finger with normal saline and applied a bandage. Will monitor. The nurses note dated [DATE] documents, Psych services notified of residents behavior of biting finger(s). Request sent for resident to be seen next time provider is in. The nurses note dated [DATE] includes documentation of, Resident came out to nurses station. Needed R (right) middle finger cleaned, and bandage applied to tip. Resident stated was hungry and started to chew on finger, slight bleeding noted gave snacks now. Surveyor noted R2's care plan was not revised until [DATE] regarding R2 chewing on his finger although there is a nurses note dated [DATE] regarding biting off the nail and skin of the right middle finger. The nurses note dated [DATE] documents, Seen by in house wound MD (medical doctor). Wound improved, treatment changed, resident aware of treatment change and encouraged not to bite on finger. Psychologist-J note dated [DATE] documents [R2's first name] continues to self-abuse by eating his fingers and excessive caloric intake. He complains continually about being hungry and feels that he has no option other than to eat his fingers or food. He is unable to attempt learned stress reducing techniques. He presents with significant delusions, which, at times are violent in nature. [R2's first name] is not appropriately placed in his current facility, and in my professional opinion, would be better served at a state agency. The nurses note dated [DATE] documents, Pt (patient) constantly asked to call 911 because he was having pain. Upon assessment pt did not appear to be distressed and started laughing when asked about pain and reason he felt the need to be sent out. He stated that he needed to get to Milwaukee by his mother that was in the hospital and ambulance on the way. Pain medication offered but refused and 911 was not called. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Psychologist-J note dated [DATE] documents, [R2's first name] presented as angry. He stated that his roommate kicked me out of the room. I asked him why the roommate would attempt to kick him out of his room, to which he stated that he was not sure. (Note: The roommate is hospitalized at this time). He continues fearing that his cousin is attempting to kill him. He complains of possible auditory hallucinations; however, the authenticity of his complaints have not been determined. He has been systematically destroying the blinds on his windows. He states for no reason for this behavior. [R2's first name] is not appropriately placed in his current placement. He would be better served in a long-term mental health facility. Psychologist-J note dated [DATE] documents, [R2's first name] was eating his hospital gown when I entered his room. He was waiting for breakfast and stated that he was hungry and could not wait. Significant delusions were noted, as were hallucinations. [R2's first name] refuses to discuss the future and appears to have no plans or goals for himself, other than to remain in his current placement and talk with his family. His attention, concentration and judgement are severely impaired. On [DATE], R2 was involved in a resident-to-resident altercation with R1. The facility's investigation revealed both residents were intoxicated. Psychologist-J note dated [DATE] documents, [R2's first name] has been, by self-reporting, sleeping excessively. He states he has no interest in getting up or socially interacting with others. He did not eat breakfast, and stated that he was not hungry, which is unusual for [R2's first name]. He denied SI (suicidal ideations) or intent. The nurses note dated [DATE] at 12:20 a.m. documents, Resident presented with c/o (complaint of) anxiety. Resident stated, I was watching television and I saw something walk pass him out the corner of my eye. Writer assured Resident that no one was in his room. Resident stated to writer that whatever walked pass him had wings. Resident stated that he was scared, his body was shaking, his body was vibrating within, and that he felt like someone was sitting on his chest. Writer assessed resident's vitals BP (blood pressure) , d+[DATE], P (pulse)-96 (right), ,d+[DATE] (left), P-82, T (temperature) 98.6, R (respirations)-20 POX (pulse oximetry)- 97% room air. Resident did not appear to be in any physical distress. Writer contacted [name] NP (nurse practitioner) and received one time order for Hydroxyzine 25 mg. Writer administered to resident as indicated. Resident was noted speaking to mother on the phone for a while but is now in bed sleeping. The NP (Nurse Practitioner) note dated [DATE] under history of present illness documents, [AGE] year old male seen today for reports of increased anxiety last night with reports of hallucinations from patient. Patient also reports increased alcohol use. Patient is stable in no acute distress. Under assessment/plan documents 1. anxiety, stable on meds reports symptoms to psych. 2. bipolar disorder, stable reports increased symptoms to psych. 3. hallucinations. stable alcohol use discouraged. Surveyor noted R2's care plan was not revised to include interventions regarding alcohol use after R2 reported increase in alcohol use to the NP on [DATE]. The nurses note dated [DATE] at 12:51 a.m. documents, Resident reportedly called 911 and was transported to hospital. Writer called to get report from ER (emergency room) nurse but was placed on hold and left. Resident to return to facility per ambulance service. (continued on next page)

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	525318	A. Building B. Wing	03/21/2023

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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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated [DATE] at 2:16 a.m. documents, Resident returned from [hospital name] ER with NNOs (no new orders). Labs were drawn and per ambulance service creatinine and WBC (white blood count) slightly elevated. No results sent with resident discharge. Psych PA (Physician Assistant)-K note dated [DATE] under history of present illness documents, [AGE] year old male Patient seen at [Facility's name] for increase in anxiety. He has been calling 911 multiple times without an emergency. This is per the Director of Nursing. Patient states he gets irritated with other residents, and he has had a room change. He states he likes to chew on his fingers and eat junk food. He states his mood has been down. He talks about a new girlfriend. He states he is having some family difficulty and usually talks on the phone with them regularly. He continues on BuSpar on 15 mg (milligrams) three times a day and Abilify 25 mg a day. He denies any suicidal or homicidal ideation. Vital signs are blood pressure ,d+[DATE], temperature 96.9, weight is 312 pounds. Nursing documentation states that he did go out of the facility on pass recently. Under Review of System for Psychiatric: + (positive) anxiety; +depression; denies suicidal ideation; +insomnia; +hallucinations; +paranoia; +delusions; Under Assessment & Plan includes Other insomnia [G47.09] (unchanged) Plan: Consider adding melatonin 3 mg QHS (every hour sleep), work on good sleep hygiene. He should try listening to calm music or trying noise canceling headphones. For Disposition: documents For increase in anxiety recommend increase buspirone to 20 mg TID (three times daily) (max 60 mg/day) continue to maintain good support and CBT (cognitive behavioral therapy). Would consider next to increase Abilify to 15 mg BID (twice daily) (max 30 mg/day). Goal to use lowest effective dose for managing his symptoms, feel he is manic/anxious at today's visit. Surveyor noted Psych PA-K's recommendation to add Melatonin 3 mg QHS and increase Buspirone to 20 mg TID was not implemented until [DATE]. The nurses note dated [DATE] at 1:12 a.m. documents, Resident called 911 for nausea. When the EMTs (emergency medical technicians) arrived, it was determined that resident is having mental health issues. He was hearing voices and he reported that the voices were taunting him. Resident agreed to stay at the facility. His mom spoke to him on the phone and is going to try to get the names of his psych doctors he has seen in the past. Will monitor resident. The nurses note dated [DATE] at 6:17 a.m. documents, Resident has been asleep since shortly after the EMTs left. No further reports of hallucinations. Will monitor. The IDT (interdisciplinary team) note dated [DATE] at 1:40 p.m. documents, IDT meeting with resident to review 911 calls and request to go to ED without symptoms. Resident stated the food was better and my mom will have to pay the bill, she owes me. Review with resident that he is self-responsible and when bills are issues, he would be responsible. Resident verbalized understanding of education regarding alerting staff to needs. Resident pleasant and verbalizing willingness to communicate with staff for any needs. The nurses note dated [DATE] at 4:15 a.m. documents, Resident displayed signs of anxiety at beginning of shift, resident went into room and stated that they were sleepy. Resident currently sleeping in bed with call light within reach. (continued on next page)

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	525318	A. Building B. Wing	03/21/2023

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated [DATE] at 4:22 a.m. documents, Writer received report that resident called 911 with c/o lung pain and anxiety and that resident was transported to [hospital name] ER. Resident returned to facility per Ambulance service at 0300 (3:00 a.m.) Resident currently sitting up in w/c (wheelchair) watching movie on his phone. VSS (vital signs stable) ,d+[DATE], 95, 97.9, 95% room air. Offer no c/o anxiety, of lung pain. The nurses note dated [DATE] at 11:29 a.m. documents, Discussion with resident regarding his frequent calls to 911. He indicates he called because he was having a panic attack, and the voices were too loud in his head. Writer educated resident of some non-medication interventions to try when he has these issues as an alternative to calling emergent services such as notifying the nurse on duty first, then trying ice (applying to back of neck, wrists, or drinking something cold or chewing ice), moving to a quiet room where he can decompress and lay down. Education regarding breathing techniques to help him relax (breathe in through nose for 4 counts, hold for 4 counts and breathe out of mouth for 4 counts). After much discussion, resident then indicated that the reasons he calls 911 is because he wants to go to Milwaukee to be closer to his family (grandfather?) and he is hoping one of the hospitals will transfer him closer to the family. Educated resident to indicate this is not the appropriate channel or path to take if he wants to be moved closer to his family and is tying up emergent services in the community. This note was written by LPN/UM (Licensed Practical Nurse/Unit Manager)-N. There is no evidence R2's physician was notified regarding the voices being loud in his head and R2's care plan was not revised to include non-medication interventions. Surveyor was unable to interview LPN/UM-N as she is no longer employed at the facility. The nurses note dated [DATE] at 11:58 a.m. documents, Message to Social Services to discuss potential DC (discharge) options for resident to be nearer to family. The social service note dated [DATE] at 1:23 p.m. documents, SSC (social service coordinator) met with resident to go over risk vs benefit of calling 911 when not appropriate. If resident feels he is having a health issue or a change of condition to notify his nurse for assessment and treatment and the nurse will determine if emergency services are necessary. Resident verbalized understanding. Psychologist-J note dated [DATE] documents, [R2's first name] states that people are talking about his brother. He is using his phone to make calls to threaten the individuals that are responsible. [R2's first name] used significant profanity throughout the session, and described himself as a [NAME], racist and having a big mouth. He further states, My mind is racing, and I'm broken, and I want to go for a 72 hour hold. After our session, I determined that he is not suicidal, and not a danger to others in the facility. Later in the same day, he was observed repeatedly singing 18 Men On a Dead Man's Chest, Away we Go. [R2's first name] is not appropriately placed at this facility. The social service note dated [DATE] at 12:45 p.m. documents, SSC sent referrals per resident and family to facilities in Milwaukee area, [nursing home name] and [nursing home name]. (continued on next page)

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	525318	A. Building B. Wing	03/21/2023

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Psychologist-J note dated [DATE] documents, [R2's first name] would like to relocate to be closer to family in Milwaukee. He states that if he is not relocated by next week, he will leave the facility go to my grandpa's in Milwaukee, stand on his doorstep, and he'll have to let me in. We reviewed the pros and cons of this plan, focusing on the negative consequences and the lack of planning. He has not slept for at least 48 hours. He was escorted to his room this morning, and told to go to bed; however, he continued to roam the hallways. He is frustrated that he does not like the food in the facility, and no one will give him money to purchase take-out food. Delusions were noted. Psychologist-J note dated [DATE] documents, [R2's first name] was talking with his family when I entered his room. His phone was on his bed, and his family could be heard screaming and swearing from his phone. [R2's first name] insisted that this type of interaction was normal when he spoke with his family, and that at this point in time, They were trying to kill my sister. I asked [R2's first name] to end the phone conversation so that we could talk, and he did so without delay. He expressed his anger towards several staff members, as he feels that they are not helpful to him. He states that he requires extra assistance, because my hands don't work. It should be noted that he spends most of his day typing on his phone. He informed me that he planned to call 911 regarding the staff, (Note: He has called 911 on several occasions). I suggested that he speak with the DON prior to making any further 911 calls. He agreed to consider my suggestion. The nurses note dated [DATE] at 1:20 a.m. documents, Resident had an altercation with another resident [R3's initials]. Resident alleged physical assault by [R3's initials]. Resident called [initials of police department]. [Initials of police department] arrived and took a statement from resident. Resident made homicidal statements. Resident was educated of outcome by [initials of police department] when making homicidal statements. Resident now in room, sitting in wheelchair eating pizza. Resident shows no signs of injury. The nurses note dated [DATE] at 8:49 a.m. documents, Res (Resident) propelling self in wheelchair using profanity. Res states, I'm just pissed off at my ex-girlfriend. Resident was redirected. Psychologist-J note dated [DATE] documents [R2's first name] was engaged in a physical altercation last night with an elderly resident. He stated that the man attacked him for no reason. [R2's first name] called 911, and after investigating, the police sent him to their respective rooms. This morning [R2's first name] engaged in a verbal altercation with a staff member, which I witnessed. [R2's first name] made threats, stating that he was going to kill both the worker and the man he had the physical altercation with. He has gone so far as to make a plan for the attack. The staff will contact the police with this information today. [R2's first name] does not like the food provided by the facility, and often begs staff for money needed to order food. Unfortunately, the staff often will give him the money he requests. [R2's first name] has a severe eating disorder, and he should not be verbally or financially encouraged to purchase outside of the meals provided. [R2's first name] is not appropriately placed. The social service note dated [DATE] at 11:35 a.m. documents, SSC resident met with psych services today to follow up after reported incident. The behavior evaluation dated [DATE] is check for history of behavior, behavior occurs less than daily. Verbal, repetitive & other is checked. Under other information documents Resident repetitive & food seeking constantly. Resistive to long term care, attention seeking. (continued on next page)

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	525318	A. Building B. Wing	03/21/2023

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated [DATE] at 1:21 p.m. documents, Res agitated this morning. Upset his room is being deep cleaned and floors waxed. Worried his belongings will be misplaced. Res redirected. In activity at this time. The nurses note dated [DATE] at 11:22 p.m. documents, Resident very agitated that a DVD, cords, CD's clothing and condiments are missing after his room was cleaned. The admin (Administrator), DON (Director of Nursing) and Business Office Mgr (Manager) are aware. Resident called and spoke with [initials of police department]. Resident has been loud all shift complaining about his missing items. He has been complaining to fell ow residents, staff, and people on the phone. When asked to lower his voice because people are sleeping, he continued to speak loudly. Unable to redirect resident to wait until the morning about his missing items. Staff has searched his room already. Psych PA-K's note dated [DATE] under history of present illness documents, [AGE] year old male seen for f/u (follow up) at [Facility's name]. He is alert, self-propelling in the hallway, asks to see writer. He asks for food; states he is hungry. He then asks another resident for food. He is smiling, in a good mood. He then beginning sic (began) to swear/use profanity in the hallway. Nursing staff asks him to stop using profanity and he says excuse me, I will stop. He tells provider have a good day and self-propels down the hallway. States mood and sleep are down/difficult. Speech is quick, jumps from topic to topic. Does fabricate per staff. No SI/HI (suicidal ideations/homicidal ideations). VS (vital signs) BP ,d+[DATE] T (temperature) 97.9 W (weight) 311.6 lb (pounds). Under Review of System for Psychiatric documents +anxiety; +depression; denies suicidal ideation; +insomnia; +hallucinations; +paranoia; +delusions; Under Assessment & Plan includes Other insomnia [G47.09] (unchanged) Plan: Consider adding melatonin 3 mg QHS (every hour sleep), work on good sleep hygiene. He should try listening to calm music or trying noise canceling headphones. For Disposition: documents For increase in anxiety recommend increase buspirone to 20 mg TID (max 60 mg/day) continue to maintain good support and CBT. Would consider next to increase Abilify to 15 mg BID (max 30 mg/day). Goal to use lowest effective dose for managing his symptoms, feel he is manic/anxious at today's visit. Surveyor noted Psych PA-K's recommendation to add Melatonin 3 mg QHS and increase Buspirone to 20 mg TID was not implemented until [DATE]. The APNP (Advanced Practice Nurse Prescriber) note dated [DATE] under history of present illness documents, [AGE] year old male seen today for recent ER visit for anxiety symptoms of chest pain, coping skills discussed with patient at length. Patient is stable in no acute distress but is asking for more food and staff said he does this often. He is also asking for a prescription for Xanax and I explained that his psych doctor would need to address this issue. Under assessment/plan documents 1. anxiety, stable on meds coping technique to reduce anxiety discussed. 2. bipolar disorder, stable reports increased symptoms to psych. 3. hallucinations. stable alcohol use discouraged. (continued on next page)

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	525318	A. Building B. Wing	03/21/2023

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Psychologist-J note dated [DATE] documents [R2's first name] brother and uncle died within the past week. He states that he has only met his brother a few times, but he is grieving the loss of his uncle. He has not been sleeping well, and states that he has flashbacks and nightmares at night. He told me that he was depressed and tired. He denied SI or intent. He wanted to be placed in a 72 hour hold at a mental health unit. He was only interested in being placed at a facility where he had previously been a patient. I told him there were several hospitals that had mental health units, and that he would mostly likely be placed closer to this facility. He rejected that idea, stating that he didn't want to go anywhere but Milwaukee. He stated that he needed something, but he could not articulate what it was. [R2's first name] needs an active POA (power of attorney), as well as a long-term psychiatric commitment. The social service note dated [DATE] at 10:59 a.m. documents, Resident verbalizing that his little brother on his dad's side passed away that he never met. Resident has a history of attention seeking behaviors and telling unsubstantiated stories. SSC unable to verify but placed a call to resident's mother to confirm SSC awaiting call back. Resident was seen by psych services today and resident verbalized no concerns or trauma or ill effects. The social services note dated [DATE] at 4:00 p.m. documents, Resident PHQ9 today of 20 and psych services updated, and resident seen today. A PHQ9 score of 20 indicates severe depression. The [R2's first name] has a potential to have a psychosocial well-being problem as it relates to his PHQ-9 of score of 20 and dx (diagnosis) of anxiety, bipolar, MDD (major depressive disorder) care plan initiated & revised [DATE] has the following intervention [TRUNCATED]

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not provide behavioral health training to staff who care for Residents who were diagnosed with a mental, psychosocial, or substance use disorder consistent with the Facility assessment. This has the potential to affect R2 and 47 of 66 Residents identified by the Facility as having behavioral and/or substance use disorder. Findings include: The Facility's Assessment Tool last updated 3/6/23 indicates in section 1.3, residents the Facility may accept under the Category section includes Psychiatric/Mood Disorders. Common diagnoses documents Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (i.e., Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, ETOH (alcohol) Abuse, Anxiety Disorder, & Behavior that needs attention. Under section 1.5 for mental health the number/average or range of residents with behavioral health needs is 15 and active or current substance use disorders is 9 residents. Under section 3.4 documents [Name of Facility] strives to provide the highest quality care to the residents it serves through regular and thorough training, education, and competencies of all licensed and unlicensed staff. The list below is a representation, but not all inclusive: includes Caring for persons with Behavioral Disturbances: Alzheimer's or other dementia, AODA (alcohol and other drugs of abuse), Substance Abuse. R2 was admitted to the facility on [DATE]. Diagnoses includes major depressive disorder, anxiety disorder, bipolar disorder, attention deficit hyperactivity disorder, and personality disorder. The nurses note dated 2/28/23 at 12:11 p.m. documents Called [hospital name] campus and checked on status of resident, he is still in the ER, diagnosis is unstable psychotic episode, plan of care is to chapter into a psychiatric facility, [name] RN has mad sic (made) all the necessary calls to facilities and is awaiting cal back for admission information into a facility. She will call with update of which facility resident is admitted to when information becomes available. Contact information provided. The nurses note dated 3/1/23 at 7:08 a.m. documents Writer called [hospital name] ER to determine placement facility for psychiatric services. Resident was transferred to [name]. Updated NP (Nurse Practitioner). The nurses note dated 3/2/23 at 2:27 p.m. documents Resident arrived at facility via [name of] Transportation, no report obtained from sending facility, unsure of any medication changes or circumstances surrounding readmission. On 3/6/23 at 10:35 a.m. Surveyor asked SSC (Social Service Coordinator)-E after R2 returned from the mental health institute if she provided any behavioral training to staff. SSC-E informed Surveyor staff are to call the crisis center if R2 verbalizes any suicidal or homicidal ideation's and didn't know if DON (Director of Nursing)-B or Administrator-A in-serviced staff. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/23 at 10:43 a.m. Surveyor asked LPN (Licensed Practical Nurse)-G after R2 returned from the mental health institute if she was provided with any training. LPN-G informed Surveyor R2 is on one to one, closely monitor and if verbalizes any suicidal or homicidal ideation's to call the crisis center but hasn't been provided with any behavioral training. On 3/6/23 at 10:50 a.m. Surveyor asked CNA (Certified Nursing Assistant)-I since R2 has returned form the mental health institute if she has been provided with any behavioral training. CNA-C informed Surveyor since R2 has come back he's on a one to one, so no. On 3/6/23 at 11:08 a.m. Surveyor asked DON-B after R2 returned from the mental health institute if there was any training provided to staff. DON-B informed Surveyor if R2 had any behavior, suicidal or homicidal ideation's or aggression staff was to contact the crisis center. DON-B informed Surveyor he put the crisis center information under the special instructions in the medical record and the evening shift was verbally educated in regards to the process. Surveyor inquired what the process is. DON-B informed Surveyor to maintain safety, contact crisis, take directions from them, and tell the DON & Administrator. DON-B informed Surveyor this information was be relayed shift to shift. Surveyor inquired if there was any behavioral training provided to staff. DON-B informed Surveyor he could not say and would have to speak to Administrator-A. On 3/6/23 at approximately 11:30 a.m. Surveyor asked Administrator-A for any behavioral & substance use training provided to staff. On 3/6/23 at 1:00 p.m. Administrator-A informed Surveyor she is not able to locate any behavioral & substance use training. Surveyor inquired what their training process is. Administrator-A explained corporate sends monthly which topics are to be covered and there there is a post test for competency. Surveyor inquired if the training is on a computer program. Administrator-A replied no and explained there is a paper sign in sheet with the education provided attached. Administrator-A informed Surveyor in March they are going to start education on dementia and dementia with behaviors.