STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525568	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNNY RIDGE NURSING AND REHABILITATION CENTER, LLC	3014 ERIE AVE SHEBOYGAN, WI 53081

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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** Based on observation, record review and staff interview, the facility did not ensure the resident environment remained as free of accident hazards as possible and did not ensure adequate supervision was provided for 5 Residents (R) (R2, R5, R7, R8 and R9) of 5 residents. R2's care plan contained an intervention for a motion sensor on R2's door to alert staff when R2 was out of the room. The motion sensor was implemented after R2 entered R1's room and attempted to assist R1 out of bed. As a result, R1 landed face down on the floor and incurred head injuries that resulted in death. The motion sensor was not consistently implemented. R5's plan of care contained an intervention for fifteen minute checks due to an expression of suicidal ideation. On the 6/17/20 AM shift and part of the PM shift, R5's fifteen minute checks were not completed. R7's plan of care contained an intervention for fifteen minute checks due to an incident of self harm. On the 6/17/20 AM shift and part of the PM shift, R7's fifteen minute checks were not completed. R8's plan of care contained an intervention for fifteen minute checks due to behavior, wandering and elopement attempts. On the 6/17/20 AM shift and part of the PM shift, R8's fifteen minute checks were not completed. R9's plan of care contained an intervention for fifteen minute checks due to a fall. On the 6/17/20 AM shift and part of the PM shift, R9's fifteen minute checks were not completed. Findings include: On 5/26/20, the Surveyor reviewed a complaint and self report filed with the State Agency. The complaint stated R1 was found face down on the floor in a pool of blood on 5/12/20. R1 was sent to the ER (emergency room), diagnosed with [REDACTED]. R1 passed away on 5/19/20. The complaint expressed concern with how R1 fell out of bed as R1 had not moved in years. The self report stated R2 and R3 assisted R1 out of bed and, in the process, R1 was left bleeding on the floor. The investigation stated R1 was administered PM medication at approximately 6:10 PM and was resting comfortably in bed. Staff observed R2 and R3 exit R1's room at approximately 6:35 PM. The investigation indicated R2 attempted to assist R1 out of bed. When R1 rolled onto the floor, R2 left R1's room and asked R3 for help. When staff noticed R2 and R3 exit R1's room, staff entered R1's room and observed R1 face down on the floor in a pool of blood. Staff noted blood on the bottom of R2's socks an smears of blood on the floor leading out of R1's room. R2, who had no memory of the incident, was placed on 30 minute checks during the evening and night shifts. On 5/13/20, a motion sensor was placed on R2's door to alert staff when R2 left the room. The Surveyor reviewed R1's medical record. R1 was admitted to the facility with [DIAGNOSES REDACTED]. R1's most recent Significant Change MDS (Minimum Data Set), dated 4/08/20, indicated R1 was severely cognitively impaired and required extensive to full assistance of staff for transfers, bed mobility and ADLs (activities of daily living). R1's plan of care stated R1 required a mechanical lift and the assistance of two staff for transfers and movement in and out of bed. A progress note, written by MD (Medical Doctor)-C and dated 5/08/20, stated R1 could not follow simple commands and was dependent on staff for cares. The Surveyor reviewed R2's medical record. R2 was admitted to the facility with [DIAGNOSES REDACTED]. R2's most recent Quarterly MDS, dated [DATE], indicated R2 was severely cognitively impaired. R2 was independently ambulatory and was noted to frequently visit with residents in the unit's common area. R2's plan of care contained an order, dated 5/19/20, to check the function of R2's door alarm every shift. R2's MAR (medication administration record) indicated the function of the motion sensor was checked every shift. A progress note, dated 3/18/20, stated R2 was mostly independent with ADLs and was able to ambulate without aid. A progress note, dated 5/15/20, stated R2 was increasingly confused and started to become aggressive at times. A progress note, dated 5/18/20, stated hourly door alarm checks and thirty minute checks were initiated to provide for the safety of (R2) and other residents. A progress note, dated 5/27/20, stated R2's motion sensor was still missing. A progress note, dated 6/01/20, stated R2 continued to remove the motion sensor from the wall and place it in R2's dresser. Progress notes, dated 6/03/20 and 6/05/20, stated R2's motion sensor was either missing or hidden. On 6/17/20 at 1:10 PM, the Surveyor observed R2's room. When the Surveyor entered the room, R2's motion sensor did not sound. The Surveyor noted a plastic bracket on the wall inside of R2's door. The Surveyor noted the bracket, which was meant to hold a motion sensor, was empty. The Surveyor located CNA (Certified Nursing Assistant)-D in the hallway and reentered R2's room. CNA-D verified R2's motion sensor wasn't in place when the Surveyor and CNA-D entered the room. CNA-D stated, I was just talking to the nurse .(R2) has a habit of hiding (the motion sensor) because (R2) doesn't like the noise it makes. CNA-D opened R2's top dresser drawer and located the motion sensor on top of R2's clothing. On 6/17/20 at 1:15 PM, the Surveyor interviewed LPN (Licensed Practical Nurse)-E regarding R2's motion sensor. LPN-E stated R2's motion sensor was in place and alarming earlier in the shift. LPN-E stated, (R2) likes to (take the motion sensor) off. It's so loud . We've had to search for it multiple times. Last time (R2) hid (the sensor) in a closet . LPN-E stated R2 was able to remove and/or deactivate the motion sensor within two days of its installation. LPN-E stated LPN-E wasn't aware of any other interventions were tried aside from thirty minute checks and stated, We always see (R2) .We always know where (R2) is at. We always look for (R2). On 6/17/20 at 2:52 PM, the Surveyor observed R2 sitting in the common area with two residents. The Surveyor again interviewed LPN-E regarding safety and supervision interventions for R2. LPN-E stated R2 was placed on thirty minute checks after R1's fall out of bed. LPN-E verified R2's current care plan did not contain an intervention for thirty minute checks. LPN-E said LPN-E was unsure when R2's thirty minute checks were discontinued and stated, I assumed (the thirty minutes checks) were continued because nobody told me otherwise. On 6/17/20 at 2:55 PM, the Surveyor interviewed LPN-F regarding R2's thirty minute checks. LPN-F stated LPN-F thought R2 was on thirty minute checks; however, LPN-F was unable to locate R2's check sheet in either the nursing station or R2's chart. LPN-F stated, I don't remember when (R2) was removed (from checks) or if (R2) was removed. On 6/17/20 at 3:00 PM, the Surveyor interviewed CNA-G and CNA-H regarding R2's safety interventions. CNA-G and CNA-H stated their check list and the white board in the nursing station did not indicate R2 was on thirty minute checks. CNA-G said R2 had a motion sensor in R2's doorway and stated, I've seen (R2) reset it and walk out of the room. CNA-G and CNA-H stated they hadn't done checks yet on their shift for the four residents on the unit who required them because they were unable to locate the check sheets at the start of the shift. During the course of the interview, CNA-H went to the nurses' station and located the check sheets on a side desk. The Surveyor, CNA-G and CNA-H noted the check sheets were not filled out for the 6/17/20 AM shift. CNA-G and CNA-H stated four residents (R5, R7, R8 and R9) required fifteen minute checks. On 6/17/20 at 3:15 PM, the Surveyor observed R2 exit R2's room. The Surveyor noted R2's motion sensor did not sound. The Surveyor noted the motion sensor was in place; however, the sensor did not sound when the Surveyor entered or exited R2's room. The alarm also did not sound when the Surveyor entered and exited the room a second time; however, the motion sensor emitted one beep when the Surveyor closed R2's door. On 6/17/20 at 3:20 PM, the Surveyor again interviewed LPN-E regarding R2's safety interventions. LPN-E stated R2's thirty minute checks were discontinued on 5/13/20 when the motion sensor was added. LPN-E stated the checks were discontinued because the alarm alerted staff if R2 exited the room. LPN-E verified R2 was out of the room for lengthy periods of time and stated, We don't do thirty minute checks when (R2's) out of (R2's) room because (R2) is in the

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 -** Some	(continued... from page 1) common area. LPN-I, CNA-G and CNA-H were outside R2's room during the interview and verified R2's motion sensor did not function properly. On 6/17/20 at 3:30 PM, the Surveyor interviewed DON (Director of Nursing)-B regarding R2's safety interventions. DON-B verified R2's thirty minute checks were discontinued when R2's motion sensor was initiated. DON-B also verified R2 knew how to deactivate the motion sensor. DON-B stated an intervention was added to R2's MAR indicated [REDACTED]. DON-B stated, (R2) is usually in the hallway. (Staff) are watching (R2). DON-B verified DON-B could not ensure staff monitored R2 closely when R2's motion sensor wasn't effective and R2 was not on visual checks. DON-B stated additional interventions were not put in place when staff learned the motion sensor was ineffective. 2. On 6/17/20, the Surveyor reviewed R5's medical record. R5 was admitted to the facility with [DIAGNOSES REDACTED]. R5's plan of care indicated R5 was at risk for falls due to dementia. A progress note, dated 6/09/20, stated R5 expressed suicidal ideation. Upon further discussion, R5 stated R5 was upset and mad and had no plans to self harm. An intervention for fifteen minute checks was initiated on 6/09/20. On 6/17/20 at 3:00 PM, the Surveyor observed R5's fifteen minute check sheet. The Surveyor noted R5's check sheet was last initialed at 6:00 AM on 6/17/20. 3. On 6/17/20, the Surveyor reviewed R7's medical record. R7 was admitted to the facility with [DIAGNOSES REDACTED]. R7's plan of care stated R7 was at risk for elopement and wandered on the unit. A progress note, dated 4/17/20, stated R7 was sent to theER on [DATE] after attempting to self harm by wrapping a call cord around R7's neck. Upon R7's return, R7 was placed on fifteen minute checks. On 6/17/20 at 3:00 PM, the Surveyor observed R7's fifteen minute check sheet. The Surveyor noted R7's check sheet was last initialed at 6:00 AM on 6/17/20. 4. On 6/17/20, the Surveyor reviewed R8's medical record. R8 was admitted to the facility with [DIAGNOSES REDACTED]. R8's plan of care indicated R8 was at risk for wandering and at high risk for elopement. R8's medical record indicated [REDACTED]. R8's medical record contained detailed documentation of R8's elopement attempts. R8 had an intervention for fifteen minute checks. On 6/17/20 at 3:00 PM, the Surveyor observed R8's fifteen minute check sheet. The Surveyor noted R8's check sheet was last initialed at 6:00 AM on 6/17/20. 5. On 6/17/20, the Surveyor reviewed R9's medical record. R9 was admitted to the facility with [DIAGNOSES REDACTED]. R9's plan of care indicated R9 wandered on the unit and was at high risk for falls. R9 was placed on fifteen minute checks following a fall on 5/08/20. On 6/17/20 at 3:00 PM, the Surveyor observed R9's fifteen minute check sheet. The Surveyor noted R9's check sheet was last initialed at 6:00 AM on 6/17/20. On 6/17/20 at 3:05 PM, the Surveyor interviewed CNA-G and CNA-H regarding R5, R7, R8 and R9's fifteen minute checks. CNA-G and CNA-H verified the check sheets were not filled out for the 6/17/20 AM shift and part of the 6/17/20 PM shift. On 6/17/20 at 3:30 PM, the Surveyor interviewed DON-B regarding R5, R7, R8 and R9's fifteen minute checks. DON-B verified the fifteen minute checks were not completed on the entire AM shift as well as part of the PM shift on 6/17/20. DON-B stated the check sheets should have been completed and was unsure why they were not.