STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525686	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muskego Health and Rehabilitation Center	S77 W18690 Janesville Rd Muskego, WI 53150

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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law through established procedures for 1 of 1 abuse investigation involving 1 of 1 Residents (R1). The facility became aware of an abuse allegation on the evening of 10/8/25 at approximately 9:00 PM and did not report to state agency until 10/9/25 at 8:09 PM. Evidenced by:The facility policy entitled Abuse, Neglect and Exploitation, dated 7/01/25, states, in part: . It is the guideline of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The facility has zero tolerance stance around founded abuse, neglect, exploitation and misappropriation of resident property. VII. Reporting/Response:A. The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. R1 admitted to the facility on [DATE] and has diagnoses that include chronic obstructive pulmonary disease (a chronic lung disease that causes ongoing inflammation and narrowing of the airways, making it difficult to breathe), hypertension (high blood pressure) and hypothyroidism (underactive thyroid, a condition that happens when your thyroid gland doesn't make or release enough hormone into your bloodstream). R1's Quarterly Minimum Data Set (MDS) Assessment, dated 9/9/25 shows that R1 has a Brief Interview of Mental Status (BIMS) score of 14 indicating R1 is cognitively intact. The facility Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, states, in part: . Summary of Incident: Allegation type Abuse: Hitting, slapping, threats of harm, assault, humiliation Name - Affected Person: R1. Is date and time when occurred known? YesDate occurred: 10/8/25Time Occurred: 9:00PMIs occurred date and time estimated? YesDate discovered? 10/09/25 Brief Summary of Incident:On 10/09/25 at approximately 6:45PM it was reported to the facility's social worker by R1 that last night, she believes, the night nurse came in her room and attempted to give her medication while she was on the toilet. Per R1 she voiced that she was not happy to the nurse and the nurse reportedly stated that, he would not come in and give her medication. R1 stated that she took the medication. R1 states that she feels safe in the facility but no longer wants to work with this nurse. The nurse was identified as LPN E (licensed practical nurse) who was immediately suspended pending investigation at approximately 7:00PM and his statement was received. Facility initiated the investigation.Report Submitted Date: 10/09/25 8:09:17 PM. The facility's Investigation regarding R1, dated 10/09/25, states, in part: . Action taken:*Statement was received from R1 -Statement indicated that LPN E attempted to give her medication while she was on the toilet, that he did not explain who he was. She indicated that she was scared and shaking. She also stated that LPN E would not tell her who he was and that he stated, I'll tell you, the next time I hand out pills I'm going to pass right over you. In other words, he's not going to give me my pills. Investigation conclusions:After conducting this investigation, the allegation of verbal abuse toward R1 was not witnessed by any other staff member. CNA F (certified nursing assistant) did state that the night she worked with R1, she did have to console R1, but she did not witness the interaction. CNA F's statement, undated, states: When I went to put R1 in bed R1 was shaking and nervous. She stated that earlier when she was in the bathroom LPN E walked in and was forcing her to take her pills. You know R1 likes to do her things her own way she can be slow, but that's okay. I did not witness the interaction. This was what R1 told me after it happened. On 10/27/25 at 12:45 PM, Surveyor interviewed SW G (social worker) who indicated she received a call from NHA A (Nursing Home Administrator) on 10/09/25 between 6:00 PM- 6:30 PM stating R1 wanted to talk to someone. NHA A did not say what R1 wanted to talk about but felt it was something that needed to be discussed. SW G indicated R1 told her LPN E came in her room the evening of 10/08/25 and while R1 was on the toilet she sees this big hand come at her with meds. R1 indicated she could not take those meds as she was about to wipe and did not have any water. R1 indicated she told LPN E she could not take the meds right then and LPN E took the med cup and put water in it and told R1 to take the pill. R1 indicated LPN E did not tell her who he was at that time or knock on her door. R1 asked LPN E who he was, and LPN E indicated I am the nurse. R1 indicated she took the pill and after CNA F came in her

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not implement professional standards of practice to prevent pressure injuries (PIs) from developing and/or worsening or to promote healing of PIs for 1 of 1 residents (R2) reviewed for PIs out of a sample of 5 residents.R2's treatment orders were not followed and hand hygiene was not performed during wound care for R2's pressure injury.This is evidenced by:The facility's policy Clean Dressing Change, dated 2/14/23, includes: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes. 7. Wash hands and put on clean gloves. 9. Loosen the tape and remove the existing dressing. 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse the wound as ordered. Pat dry with gauze. 14. Wash hands and put on clean gloves. 15. Apply topical ointments or creams and dress the wound as ordered. 17. Discard disposable items and gloves into appropriate trash receptacle and wash hands.R2 admitted to the facility on [DATE] with a pressure ulcer of left hip, stage 4.R2's physician orders, printed on 10/27/25, include: Left hip: Clean with wound cleanser, apply Hydrofera blue into wound, cover with bordered gauze. Change three times weekly and as needed.R2's NP D (Nurse Practitioner) note, dated 10/23/25, includes: Pressure injury of left hip.Continue to pack wound with Hydrofera blue soaked with wound wash and cover with bordered gauze.On 10/27/25 at 12:57 PM, Surveyor observed LPN C (Licensed Practical Nurse) complete R2's left hip dressing change. Surveyor observed the following: LPN C donned gloves, removed the old dressing, clean the wound with wound cleanser and gauze, removed dirty gloves, and don clean gloves. LPN C packed R2's left hip wound with Theraform blue soaked in Dakin's solution, apply bordered gauze, remove dirty gloves, grab the trash bag and exit the room. LPN C walked down the hallway and outside to throw the trash bag in the dumpster. LPN C reentered the building and used hand sanitizer for hand hygiene. Of note, LPN C missed hand hygiene opportunities after removing the old dressing, after cleaning the wound, after applying the packing to the wound, and after completing the dressing change.On 10/27/25 at 1:15 PM, Surveyor interviewed LPN C regarding the dressing change observation. LPN C indicated she did not perform hand hygiene appropriately. LPN C indicated R2's orders were to pack the left hip wound with Dakin's soaked Theraform blue. Surveyor asked LPN C if wound cleanser should have been used to soak the Theraform blue instead of Dakin's solution. LPN C insisted R2's orders were for Dakin's solution.On 10/27/25 at 3:14 PM, Surveyor interviewed NP D (Nurse Practitioner) regarding R2's wound care. NP D indicated she had previously ordered Dakin's solution but R2's wound had improved and no longer needed the Dakin's solution. NP D indicated LPN C should have used wound cleanser and not Dakin's solution. NP D indicated she expected the facility staff to follow the orders she writes.On 10/27/25 at 2:46 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding wound care. NHA A indicated she expects the facility staff to follow the order that the provider has given for wound care. NHA A indicated the facility staff should follow standards of practice in regards to hand hygiene and would expect the staff to follow the facility's policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility did not ensure the provision of pharmaceutical services (including procedures that assure that accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 sampled resident (R1) reviewed for medications. R1 did not receive medications that included, a blood pressure medication, a thyroid medication and a pain medication 5 days during the months of September and October. Evidenced by: The facility policy entitled Medication Error Reporting and Counseling Procedure, dated 4/09/25, states, in part: . Guideline: It is the expectation of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Explanation and Compliance Guidelines:1. The facility shall ensure medications will be administered as follows:a. According to physician's orders. 4. The facility will consider factors indicating errors in medication administration, including, but not limited to: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: . ii. Medication omission. 7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right medication, dose, route, and time of administration; b. Right resident and right documentation. R1 was admitted to the facility on [DATE] and has diagnoses that include gastro-esophageal reflux disease (happens when stomach acid flows back up the esophagus and causes heartburn), hypertension (high blood pressure) and hypothyroidism (underactive thyroid, a condition that happens when your thyroid gland doesn't make or release enough hormone into your bloodstream).R1's Quarterly Minimum Data Set (MDS) Assessment, dated 9/9/25 shows that R1 has a Brief Interview of Mental Status (BIMS) score of 14 indicating R1 is cognitively intact. R1's Care Plan dated 8/21/22 states, in part: . Focus: R1 has hypothyroidism. Date Initiated: 8/21/22.Interventions: *Give thyroid replacement therapy as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 8/21/22.Focus: R1 has GERD &Chronic gastric ulcer. Date Initiated: 5/07/23.Interventions: .*Give medications as ordered. Monitor/document side effects and effectiveness. Date Initiated: 5/07/23.Focus: Pain.Interventions: . Administer pain medications as ordered and monitor for effectiveness/side effects. Date Initiated: 8/21/22. R1's Physician Orders dated 10/27/25, states, in part: . Amlodipine besylate oral tablet 10 mg (milligrams): Give 10 mg by mouth one time a day for hypertension related to Essential Hypertension. start date: 11/21/23. Gabapentin Oral Capsule 100 mg. Give 100 mg by mouth two times a day for pain. start date: 6/30/23. Levothyroxine Sodium Oral Tablet 75 mcg (micrograms). Give 1 tablet by mouth in the morning every Mon, Tue, Wed, Thu, Fri, Sat related to Hypothyroidism. Start Date: 8/08/25. Pantoprazole Sodium Oral Tablet Delayed Release 40 mg. Give 1 tablet by mouth two times a day related to Gastro-Esophageal Reflux Disease. Start Date: 5/17/23 Potassium Chloride ER (extended release) Oral Tablet. Give 10 mEq (milliequivalents) by mouth in the morning related to Hypokalemia (low potassium levels in the blood which is essential for proper nerve, muscle, and heart function) . R1's MAR for September 2025 shows R1 did not receive the following medications on these days by showing blanks where the medications should be signed off: -Amlodipine 10 mg on September 9th and 13th -Levothyroxine 75 mg on September 9th 13th and 19th -Potassium Chloride 10 mEq on September 9th 13th and 19th -Gabapentin 100 mg 0n September 9th 13th and 19th -Pantoprazole 40 mg on September 9th 13th and 19th R1's MAR for October 2025 shows R1 did not receive the following medications on these days by showing blanks where the medications should be signed off: - Amlodipine 10 mg on October 7th - Levothyroxine 75 mg on October 1st and 7th - Potassium Chloride 10 mEq on October 1st and 7th - Gabapentin 100 mg on October 1st and 7th - Pantoprazole 40 mg on October 1st and 7th On 10/27/25, at 3:40 PM, Surveyor interviewed LPN C (Licensed Practical Nurse) and asked what blanks on the MAR mean. LPN C indicated if it was not charted it was not administered. On 10/27/25, at 3:45 PM, Surveyor asked NHA A (Nursing Home Administrator) what blanks on the MAR indicated, and NHA A indicated the medication was not administered. NHA A indicated it would be a medication error.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility has not established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 residents (R2) observed for wound care.The facility staff did not wear proper PPE (Personal Protective Equipment) when providing wound care to R2.This is evidenced by:The facility's policy Enhanced Barrier Precautions, dated 9/9/25, includes: It is the guideline of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. 4. High-contact resident care activities include: h. Wound care: any skin opening requiring a dressing.R2 admitted to the facility on [DATE] with a pressure ulcer of left hip, stage 4.R2's physician orders, printed on 10/27/25, include: Left hip: Clean with wound cleanser, apply Hydrofera blue into wound, cover with bordered gauze. Change three times weekly and as needed.Enhanced barrier precautions r/t (Related To) woundsOn 10/27/25 at 12:57 PM, Surveyor observed LPN C (Licensed Practical Nurse) complete R2's left hip dressing change. Surveyor observed the following: LPN C brought gathered supplies to R2's room. LPN C donned gloves and proceeded with changing R2's left hip dressing. When LPN C completed the dressing change, she removed the dirty gloves, grabbed the trash bag and exited the room. LPN C walked down the hallway and outside to throw the trash bag in the dumpster. LPN C reentered the building and used hand sanitizer for hand hygiene. Of note, LPN C did not wear a gown for the dressing change procedure.On 10/27/25 at 1:15 PM, Surveyor interviewed LPN C regarding the dressing change observation. Surveyor asked LPN C about the signage regarding enhance barrier precautions hanging on the door frame of R2's door. LPN C indicated R2 was on EBP for her wound. LPN C indicated she followed the EBP by wearing gloves. Surveyor and LPN C reviewed the signage together where the sign stated a gown should be worn during high contact activities. LPN C indicated she did not wear a gown for the dressing change.On 10/27/25 at 2:46 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding wound care. NHA A indicated the facility staff should follow standards of practice in regard to infection control and enhanced barrier precautions during wound care. NHA A indicated she would expect the staff to follow the facility's policy.