STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 - 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** Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 3 residents (R1) reviewed for accidents. On 3/9/26, CNA C (Certified Nursing Assistant) was providing perineal care to R1. CNA C had R1 positioned on her left side which has paralysis from a stroke and toward the left side of the mattress versus the middle. Per NHA A (Nursing Home Administrator), CNA C turned to get more wipes and removed her hand from R1 for two (2) seconds. R1 fell from the bed onto the floor. R1's fall was unwitnessed as CNA C did not observe R1's fall from bed. R1 was not positioned toward CNA C for added stability nor did R1 have anything to hold onto with her right hand while positioned on her left side. On 3/10/26 an x-ray was obtained indicating No acute fracture or dislocation. On 3/11/26 R1 was sent to the emergency department. A computed tomography (CT) scan indicated a displaced fracture of greater trochanter of right femur (right hip).Evidenced by:The Facility's policy and procedure, Accidents and Supervision, reviewed 7/12/25, indicates, in part, as follows: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s) 2. Evaluating and analyzing hazard(s) and risk(s) 3. Implementing interventions to reduce hazard(s) and risk(s) 4. Monitoring for effectiveness and modifying interventions when necessary. Accident refers to any unexpected or unintentional incident, which results in injury or illness to a resident. Fall refers to unintentionally coming to rest on the ground, floor or other lower level. Risk refers to any external factor, facility characteristics (e.g. staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident. Supervision/Adequate Supervision refers to intervention and means of mitigating risk of an accident.A root cause analysis should be completed to determine: i. Specific interventions to keep the residents safe ii. Necessary supervision and monitoring of the resident Implementation of Interventions: .Providing training as needed.R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to the following: cerebrovascular disease (conditions affecting blood flow to the brain), hemiplegia and hemiparesis (a neurological condition causing paralysis or weakness on one side of the body) affecting the left side following cerebral infarction (stroke), vascular dementia (a decline in thinking skills resulting in memory loss, impaired decision making, and impaired safety awareness). cramp and spasm (muscle contraction commonly affecting calves, thighs or feet), muscle weakness, and contracture left hand,(a shortening of muscles causing rigid joint deformities and restricted movement. R1's Annual Minimum Data Set (MDS) dated [DATE] indicates R1 has a Brief Interview of Mental Status (BIMS) of a 7 out of 15, which indicates she is severely cognitively impaired. R1 has an Activated Power of Attorney for Health Care (APOAHC).R1's comprehensive Care Plan for Activities of Daily Living (ADLs): The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) activity intolerance, hemiplegia (left sided weakness), impaired balance, stroke, confusion. Goal: The resident will maintain current level of function through the review date. Interventions: May have side rails as an enabler, upper right (Date Initiated 12/11/25)Bed Mobility: R1 requires assistance by (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	1 staff to turn and reposition in bed and as necessary; (Revised 12/9/25)Contractures: R1 has contractures of the left hand. Apply carrot splint (used to treat hand contractures by separating fingers) as R1 allows. (Revised 12/9/25)Transfer: R1 requires assistance by 2 staff to move between surfaces via mechanical lift and as necessary. (Revised 12/9/25) R1's Fall report indicates the following: Fall Report: 3/9/25 5:30 AM Witnessed Fall without head injuryLevel of Consciousness: AlertMobility: Wheelchair boundMental Status: Baseline for individual; Oriented to placePredisposing environmental factors: OtherPredisposing physiological factors: Incontinent; Other; Weakness/FaintedOther information: was receiving care for large BM (bowel movement)On 3/9/26 at 5:53 AM, RN D (Registered Nurse) documented the following Progress Note: Resident (R1) was receiving incontinent cares from CNA C (Certified Nursing Assistant). R1 had a very large BM (bowel movement). CNA C was doing cares on R1 and reached back to get wipes and R1 slid out the left side of the bed. When writer (RN D) entered the room resident was on floor on left side of room. She was laying supine on her back with a pillow under her head. Writer spoke with R1 and did quick assessment and then assisted CNA's with getting R1 up with hoyer lift (full body lift). Provider notified via hucu (communication application). DON B (Director of Nursing) made aware of incident. Admin (Administration) also aware. Vitals 98.2 sats 94% bp 132/59.On 3/9/26 at 6:05 AM, RN D documented the following Progress Note: Pain Score: 0 Pain Evaluation Summary; R1 does not appear to be in pain, is at baseline. At normal functional level. On 3/9/26 at 6:13 AM RN D documented the following: Change in Condition: Falls Blood Pressure (BP): 132/52; Pulse (P): 71; RR (Respiration Rate): 18; Temperature (T): 98.2 Pulse Oximetry: 95%; Blood Glucose: 172Of note, RN D did not specifically document range of motion (ROM). RN D stated to Surveyor that she assessed R1's ROM and R1 was at baseline with no concerns noted. On 3/9/26 at 6:13 AM, RN D documented the following Progress Note: Called (name) R1's APOAHC and informed her of fall. All questions answered.On 3/9/26 at 12:08 PM, DON B documented the following Progress Note: LATE ENTRY IDT (Interdisciplinary Team Review) R1 had witnessed fall off of bed while resident [sic] was changing resident's brief, staff turned to grab additional wipes and resident rolled off of edge of left side of bed. Resident did hit head, provider and POA (Power of Attorney) notified of fall, facility protocol followed and neuros initiated. Neuros WNL (within normal limits), no apparent injury at time of falls.Immediate Intervention: Staff to utilize 2 assist for bed mobility/cares.Immediate Intervention appropriate: YesIDT (Interdisciplinary Team Review) Intervention: R1 is on a low air loss mattress that is no longer needed due to previous PI (pressure injury) being resolved, R1 could benefit from having a pressure reducing mattress in place of low air loss mattress, as well as a left side rail to assist with bed mobility and promote independents [sic]. PT/OT (Physical Therapy/Occupational Therapy) will evaluate R1.Goal: Prevent serious injury r/t (related to) fall On 3/10/26 at 6:38 AM, LPN F (Licensed Practical Nurse) documented the following Progress Note: CNA E reported that while she was changing R1 she heard a loud cracking sound come from R1's R (right) leg. LPN F could not see any protruding bones, but R1 stated that she was having a lot of pain in her R hip. Vitals signs are stable. LPN F notified the provider. Order was given to get an x-ray of R1's R hip. X-ray company was called and set up appointment for today.LPN F completed a Change in condition: Pain (uncontrolled). Blood Pressure: 141/70; Pulse: 73; Respirations: 18; Pulse Oximetry: 94%; Blood Glucose: 172Primary Care Provider Feedback: Obtain R (right)-hip x-ray R1's Radiology Report (x-ray) documents the following:Date of Service: 3/10/26Report Date: 3/11/26 7:16 AMResults: Mild joint space loss with subchondral sclerosis of the femoral acetabular joint consistent with osteoarthritis. *No acute fracture or dislocation.Conclusion: No acute osseous (bone) abnormality. Consider cross-sectional imaging correlation if there is a concern for a radiologically occult fracture (a broken bone that does not appear on initial x-rays but causes pain, swelling, and tenderness, often following a fall, repetitive stress, or due to weak bones.) On 3/11/26 at 5:37 PM, R1's Progress Notes document as follows: R1 sent nonemergent stretcher to hospital ER (emergency room)ER report documents the following diagnoses: Fall, initial encounter, Displaced fracture of greater trochanter of right femur, initial (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	encounter for closed fractureCT Hip Right without Contrast: Result Date: 3/11/26Impression: 1. Mildly displaced (bone fragments have shifted) and slight comminuted fracture (broken bone with multiple pieces commonly caused by severe trauma) of the greater trochanter of the right femur.NHA A (Nursing Home Administrator) documented the following typed statement for CNA C. Writer, NHA A, met with DON B (Director of Nursing) and CNA C via phone to interview her related to a fall with fracture of a resident (R1's) right hip. CNA C stated that she came into the resident's room with incontinence supplies and placed them on the bedside table. CNA C said that she began to clean the resident. She (CNA C) stated that she placed her hand on the resident's hip and reached back to grab more products. While reaching for more product R1 slid to the other side of the bed and to the floor. CNA C stated that it happened very fast and that she did not have time to react. (It is important to note, CNA C did not sign this statement. In addition, the facility did not obtain a written statement from CNA C following R1's fall from bed. CNA C was the only staff member in the room when the fall occurred.)On 4/7/26 at 3:00 PM, Surveyor attempted to speak with R1. R1 declined to speak with Surveyor. On 4/7/26 at 3:15 PM and 4/8/26 at 4:00 PM, Surveyor spoke with CNA C. Surveyor asked CNA C to describe what occurred while assisting R1 with perineal care and the fall on 3/9/26. CNA C stated she was working the NOC (night) shift and doing her regular rounds. CNA C stated R1 was soiled and needed to be changed. CNA C stated she brought the needed supplies to R1's room with her. CNA C stated R1 had an XXL (extra extra large) bowel movement and it took longer to clean than normal. CNA C stated, R1 was positioned on her left side in bed and facing the wall with the window. CNA C stated she was standing behind R1. CNA C stated she had one (1) hand on R1 and was using her other hand to pull wipes out of the package. CNA C stated she did not see R1 fall as she was turned to grab more wipes and suddenly R1 rolled off the bed onto the floor (Note: Surveyor asked CNA C, which side of the bed did R1 roll off. CNA C stated the left side of the bed nearest the window. Surveyor asked CNA C, did R1 complain of any pain after the fall. CNA C stated, no, she did not. CNA C stated she immediately notified RN D (Registered Nurse). CNA C stated, RN D assessed R1, took vital signs, and asked her questions. CNA C stated, R1 was a 1 assist with perineal care and bed mobility. CNA C stated, my hand was never off her (R1) (prior to the fall). Surveyor asked CNA C, how was R1 positioned in the bed. CNA C stated, when she first walked in the room R1 was positioned in the middle of her bed. CNA C stated, R1 could have been closer to me and not on the edge of the bed. Surveyor asked CNA C, did the facility provide education to her as well as other staff following this incident. CNA C stated, yes. CNA C stated the facility provided education regarding making sure R1 (and all residents) are in the middle of the bed before starting cares, turning and repositioning residents, they did an evaluation for 2 assist, added 1 extra enabler bar (to the left side of R1's bed), and educated if staff notice that a resident is not able to stay positioned safely during cares to report this to the nurse. CNA C stated this has never happened with R1 prior to this. CNA E's typed statement documents as follows: I, CNA E, was repositioning R1 in her bed. I was turning R1 on to her left side with her help. I heard a cracking noise, R1 asked if I heard that and stated that her hip was in pain. I notified the nurse (LPN E) (Licensed Practical Nurse). CNA E signed the statement.On 4/7/26 at 4:00 PM, Surveyor spoke with CNA E. CNA E stated she was unable to talk at this time and would return Surveyor's call. CNA E has not returned Surveyor's call.LPN F's (Licensed Practical Nurse-Agency) typed statement documents as follows: NHA A interviewed LPN F about the nurses' note on the 10th that indicated CNA E heard a pop while providing incontinent care. LPN F stated that she conducted ROM (range of motion) and R1 had complaints of pain to her right hip area. MD (Medical Doctor) and POA (Power of Attorney) notified and initial x-ray was negative. CT (computed tomography) scan indicated a fracture to the right trochanter. LPN F signed the statement.On 4/7/26 at 4:02 PM, Surveyor spoke with LPN F (Agency). LPN F stated, CNA E notified her when CNA E was providing perineal care to R1 that she heard a crack or a pop. LPN F notified the provider who ordered an x-ray. The x-ray was completed that day. LPN F stated, R1 was in pain. R1 was provided with pain medication and monitored.On 4/8/26 at 2:45 PM, Surveyor spoke with CNA G. CNA G stated, she has (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	worked at the facility for 31 years. CNA G is a consistent caregiver for R1. Surveyor asked CNA G, what R1's ability was with rolling and assisting during perineal care prior to her hip fracture. CNA G stated, R1 would just roll when you ask her to roll. CNA G stated, however, R1's level of cooperation depends on her mood. CNA G stated, if R1 is in a good mood she will help staff roll her with 1 hand using the enabler bar on R1's right side. CNA G stated, if R1 is in a bad mood she will not help staff roll her. CNA G stated, R1 has a short temper and gets upset easily. CNA G stated it is important to have everything ready (clarified supplies) before providing care to R1. CNA G stated, if staff are taking too long R1 gets upset. CNA G stated, it is not safe to walk away or turn away from R1 while providing perineal care. CNA G stated a left enabler was added to R1's bed following R1's fall out of bed. Surveyor asked CNA G, when providing perineal care to which side do you roll R1. CNA G stated, most of the time she will roll R1 on her left side so she is facing the window. CNA G stated, R1 can use her arm (right) to hold on if she has something to grab. CNA G stated, if R1 gets upset CNA G will tell her it is CNA G's fault and that will calm R1.On 4/8/26 at 3:20 PM, Surveyor spoke with DON B. Surveyor asked DON B to walk to R1's room with Surveyor. Surveyor asked DON B, which enabler bar did R1 have in place at the time of her fall from bed. DON B stated, R1 had a right enabler bar (clarify-R1's right side while she is lying in bed on her back) at the time of her fall. DON B stated, R1 would use the enabler bar to push herself up in bed. DON B stated a second enabler bar was added to the left side of R1's bed following R1's fall from bed. DON B stated the second grab bar was added so when R1 turns toward the left she has something to reach/grab onto with her right hand. DON B stated, prior to the fall with fracture R1 could use her right arm with the right enabler bar to turn on her side. DON B stated, R1 (and all residents) should be positioned in the middle of the bed. DON B added, staff should always be with that resident. DON B stated the facility educated staff regarding having supplies at bedside in reach. DON B stated, We determined that R1 was toward the left side of the bed not the center. Surveyor asked DON B, should CNA C (Certified Nursing Assistant) have positioned R1 in the center of the bed prior to starting perineal care. DON B stated, yes. DON B stated, we immediately did education with CNA C. Surveyor asked DON B, why is it important for R1 and other residents to be positioned in the center of the bed prior to starting perineal care. DON B stated, for safety it's important there's equal distance on either side of the bed. On 4/8/26 at 3:40 PM, Surveyors spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A to describe R1's fall from bed and actions taken by the facility. NHA A stated, RN D assessed R1's range of motion, R1's ROM was at baseline with no concerns noted. NHA A stated, the facility investigated how R1 fell. NHA A stated that the facility reviewed R1's care plan. NHA A stated, she interviewed CNA C about how R1 slid out of bed. NHA A stated, R1 had a low air loss mattress. NHA A stated, she has seen other residents (not at this facility) fall from a low air loss mattress and break both legs. NHA A stated, CNA C had had her hand on R1 and when CNA C turned to get more wipes her hand must have come off. NHA A stated, if R1 had something to hold she could have told CNA C she was slipping. NHA A stated, therapy worked with R1 regarding turning and repositioning following the fall from bed. NHA A added, the facility removed R1's low air loss mattress, notified R1's APOAHC (Activated Power of Attorney for Health Care), educated CNA C immediately and all staff. NHA A stated, she gave R1's APOAHC her personal phone number and had an in-person discussion with R1's APOAHC and another family member. NHA A stated, R1 knows about the fall but cannot elaborate. NHA A stated R1 had no complaints of pain after the fall and then started to have pain about 24 hours later. Surveyor asked NHA A, what is the root cause of R1's fall with fracture. NHA A stated, R1 was rolled to her weakened side (her left side with no movement following stroke), did not have anything to hold onto (no grab bar on left side of bed at the time of the fall), and CNA C was reaching behind her instead of having a hand on R1. Surveyor asked NHA A, if a resident is being repositioned in bed prior to perineal care where they should be positioned in the bed. NHA A stated, the middle of the bed and be secure - able to hold onto something. NHA A stated, if staff need to leave they should lower the bed to the lowest position and cover the resident for dignity. NHA A stated, R1 and CNA C needed education on securing R1's body. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked NHA A, where was R1 positioned in the bed prior to CNA C providing perineal care. NHA A stated, she is not sure. NHA A stated, she is not aware R1 was positioned to the left side of the bed versus middle. NHA A stated, she thinks what occurred is when R1 was turned to her left side her legs may have gone off the bed and her body then follows. NHA A stated, I can't answer to that because I don't think that occurred. NHA A stated, she believes R1's weight was shifted and R1 fell off the low air loss mattress. NHA A stated, CNA C said she had her hand off R1 for two (2) seconds and it happened so fast. Surveyor asked NHA A, do you expect staff to be holding onto the resident at all times (secured). NHA A stated, yes. Surveyor asked NHA A, would you have expected staff to roll R1 toward them versus away to provide stability to R1 while in bed on her side. NHA A stated, yes.On 3/13/26 the facility educated twelve (12) staff members regarding Turning and RepositioningOn 4/3/26 the facility educated eighteen (18) staff members regarding the following:Preventing FallsMake sure you have products in front of youMake sure the resident is in the middle of the bedDo not turn away from residentHave the resident help and communicate with the resident to ensure they are comfortable Maintaining residents and staff's safety is a priority:Only leave the room when the bed is in the lowest position and your resident is safe from fallingUse the call light to ask for assistance if you need more products or forgot itemsNever leave resident in an unsafe positionIf the resident seems like they have had a physical decline complete a Stop and Watch The facility has 74 staff members and 58 agency staff that have worked over the past 30 days.As of 4/7/26 the facility has educated a total of 30 staff / agency staff with an education rate of approximately 22.7%. The facility failed to educate staff regarding positioning residents towards them while providing perineal care.CNA C rolled R1 away from CNA C, R1 was lying on her affected side, while cares were being provided resulting in R1 sustaining a fall due to sliding off the bed. R1 was noted to have increased pain and a fractured right femur on 3/11/26. On 4/9/26 The facility provided additional information for review.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, staff interview, and record review the facility did not provide special assistive eating equipment for 1 of 3 sampled residents (R6) reviewed for assistive devices. The facility did not provide R6 with a built-up utensil (adaptive eating tools with thickened handles, designed for residents with limited gripping strength or hand tremors) as indicated per plan of care. Evidenced by: R6 was admitted with diagnoses of cerebral palsy (a neurological disorder affecting movement and muscle tone) and epilepsy (a chronic neurological disorder characterized by seizures causes by abnormal electrical activity in the brain). R6's meal ticket on 4/7/26 (breakfast) states in part, as follows: Built up utensils R6's comprehensive care plan documents as follows: Focus: R6 has nutritional problem or potential nutritional problem r/t (related to) multiple medical diagnoses including epilepsy (a chronic neurological disorder characterized by seizures causes by abnormal electrical activity in the brain).DM (diabetes mellitus), anxiety; need for therapeutic diet, and need for skilled nursing care, wt (weight) loss x 180 days at risk of malnutrition (Date Initiated: 3/18/26) Goal: R6 will maintain adequate nutritional status as evidenced by maintain weight. Interventions: Adaptive equipment: lipped plate, heavy weight built up silverware (Date Added: 4/6/26) On 4/7/26 at 8:30 AM, Surveyor observed R6 eating her breakfast. Surveyor observed regular silverware on R6's breakfast tray. R6 stated, she is supposed to receive built up utensils and when she asks staff for them, they do not listen to her. Surveyor observed R6's meal ticket on her tray indicated Built up utensils. Surveyor observed R6 eating Fruit Loops with a regular spoon. R6 stated that it is difficult for her to hold regular silverware. Surveyor observed R6 having difficulty eating with a regular spoon. On 4/7/26 at 8:48 AM, Surveyor spoke with CNA M (Certified Nursing Assistant). Surveyor asked CNA M if R6 should have built up utensils on her meal tray per her care plan. CNA M stated, yes. On 4/8/26 at 11:40 AM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B if R6 is to have built up utensils during meals. DON B stated, yes. Surveyor asked DON B, do you expect staff to provide R6 with built up utensils per her meal card. DON B stated, yes.