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	08/26/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect 72 of 72 residents. Surveyor observed left over food items not properly covered, labeled, or dated. Surveyor observed cleanliness concerns in main kitchen. Surveyor observed staff in kitchen not wearing beard restraints. Surveyor observed food being stored on the floor in the dry storage, walk in refrigerator, and walk in freezer. Surveyor observed staff touching the inside surface of a container used to hold food with their bare hands. Surveyor observed staff prepare food without using a recipe. This is evidenced by: The facility's policy Food Preparation Guidelines, dated 12/17/24, includes: The cook, or designee, shall prepare menu items following the facility's written menus and standardized recipes. The facility's policy Date Marking for Food Safety, dated 5/26/24, includes: The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. The marking system shall consist of the day/date of opening, and the day/date the item must be consumed or discarded. The facility's policy Food Safety Requirements dated 5/26/24, includes: .keep foods/beverages in a clean, dry area off the floor. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its us-by date. Staff shall wash hands prior to handling clean dishes, and shall handle them by outside surfaces or touch only the handles of utensils. Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food. On 8/20/25 at 8:50 AM, Surveyor completed an initial tour of the kitchen with DM C (Dietary Manager). Surveyor observed the following: In the walk-in refrigerator: There were small bowls of prepared salad on a baking sheet on a storage rack. The lettuce was brown, and the salads were partially covered with parchment paper. The salads were not dated with a preparation date or use by date. There were 8 pitches of varying amounts of purple and pink liquid that were not dated with a preparation date or use by date. There was a crumpled up individual chocolate milk carton on the floor under the storage rack. There was food debris scattered on the floor. In the dry storage room: There were personal belongings on the floor and a box of personal belongings on the floor left from the previous dietary manager. There were boxes of snacks on the floor that included bags of chips and protein bars. There were pieces of paper and cardboard debris on the floor. In the walk-in freezer: There were empty boxes on the floor. There was packaging debris on the floor. There was food wrapped in plastic on the floor. Surveyor questioned DM C about the package of food on the floor. DM C picked up the package of food from the floor, stated the food inside was breadsticks and placed the package of breadsticks on the shelf, walked out of the freezer and shut the door. Surveyor asked DM C if he picked up the package of breadsticks and placed them on the shelf to later serve to the resident, DM C discarded the package of breadsticks. The main kitchen had food debris on the floor along with food wrappers. There were tops to individual butter packets on the floor. There were plastic bread ties on the floor. There was food spatter on the front surface of the stove and tray line. Broken eggshells were sitting on top of the flat top stove. During the initial tour of the kitchen, Surveyor interviewed DM C. DM C indicated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the prepared salads should be properly covered and dated. DM C indicated the pitchers of fluids should be dated. DM C indicated food should not be stored on the floor and there should not be debris on the floor. DM C indicated the kitchen was not clean. On 8/20/25 at 11:36 AM, Surveyor observed the kitchen staff. Surveyor observed DM C, DA D (Dietary Aide), and DA F in the kitchen preparing the lunch meal. DM C, DA D, and DA F were not wearing beard restraints. On 8/20/25 at 12:12 PM, Surveyor interviewed DA D regarding his facial hair. DA D indicated he does have facial hair and should have been wearing a beard restraint and was not. DA D indicated he would put on a mask to cover his facial hair. On 8/21/25 at 8:16 AM, Surveyor observed DA D walk out of the kitchen, carrying a plate of food, without a beard restraint on. DA D walked back into the kitchen without donning a beard restraint. DA D walked back out of the kitchen wearing a mask. On 8/21/25 at 9:15 AM, Surveyor interviewed DM C regarding beard restraints. DM C indicated they started wearing masks after DA D was interviewed on 8/20/25 by the surveyor. DM C indicated the facility did not have beard restraints available and that is why the kitchen staff were wearing masks. On 8/21/25 at 2:30 PM, Surveyor went to the kitchen to observe the walk-in freezer. DA F answered the door, not wearing a beard restraint. DA F was observed walking across the kitchen and back again without a beard restraint. DA F indicated to surveyor he was not wearing a mask but should be. On 8/20/25 at 11:44 AM, Surveyor observed kitchen staff during the tray line process. DM C was obtaining the temperature of the foods on the tray line. DM C indicated the mashed potatoes were not at the right temperature and was going to correct them. DM C handed the metal container of mashed potatoes to DA U. DA U walked over to the coffee maker and dispensed an unmeasured amount of hot water into the mashed potatoes container. DA U carried the container to the prepping table and poured an unmeasured amount of potato flakes into the metal container of mashed potatoes. DA U whisked the potatoes and returned them to DM C. DM C rechecked the temperature of the mashed potatoes and the temperature still needed to be corrected. The kitchen staff placed the mashed potatoes into a pot on the stove to heat the mashed potatoes up. DM C went to get a new metal container and carried the new container to the tray line with his ungloved hand and was holding the container with his thumb on the inside of the container. On 8/25/25 at 2:10 PM, Surveyor interviewed DM C regarding recipe usage and safe handling of containers. DM C indicated DA U should have measured the water and potato flakes prior to adding them to the already prepared mashed potatoes. DM C indicated staff should only touch the outside of the containers or handles. DM C indicated he should not have placed his thumb inside the container for the mashed potatoes. On 8/21/25 at 3:11 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding the observations made by surveyor in the kitchen. NHA A indicated the kitchen should be clean, food should not be stored on the floor, food should be covered and dated, staff should wear the appropriate facial hair restraints, recipes should be followed, and proper handling should be done of dishes. NHA A indicated the above observations were unacceptable and should not have happened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 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. This has the potential to affect 3 of 6 hallways. Surveyor observed 2 staff members incorrectly wearing PPE (Personal Protective Equipment) on the Covid-19 positive hallway. RN V (Registered Nurse) did not perform hand hygiene between glove changes. This is evidenced by: The facility's policy Personal Protective Equipment, dated 6/11/25, includes: This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. Personal protective equipment, or PPE, refers to a variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infections agents. It includes gloves, gowns, face protection (facemasks, goggles, and face shields), and respiratory protection (respirators). All staff who have contact with residents and/or their environment must ear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. PPE will be utilized as part of standard precautions regardless of a resident's suspected or confirmed infection status. Respiratory protection: Select the size according to fit testing. Put on PPE in this order: gown, mask or respirator, goggle or face shield, then gloves. On 8/20/25, 8/21/25, 8/25/25, and 8/26/25, Surveyor observed the 100 hallway fire doors were closed and a sign was posted on both doors stating staff must wear a mask. On 8/20/25 at 9:00 AM, NHA A (Nursing Home Administrator) informed the surveyors the 100 hallway has Covid-19 positive residents. On 8/20/25 at 10:25 AM, Surveyor was on the 100 hallway and observed CNA I (Certified Nursing Assistant) entering a room. Surveyor observed CNA I wearing an N95 mask (a respirator) over a surgical mask. At 10:33 AM, Surveyor interviewed CNA I regarding PPE. CNA I indicated it was ok to wear an N95 mask over a surgical mask since he removed both masks upon exiting the room. On 8/20/25 at 2:17 PM, Surveyor was on the 100 hallway and observed CNA J in the hallway. CNA J was wearing an N95 mask over a surgical mask. Surveyor interviewed CNA J regarding PPE. CNA J indicated wearing an N95 mask over a surgical mask not correct and was not appropriate. On 8/25/25 at 10:36 AM, Surveyor interviewed DON B (Director of Nursing) regarding appropriate use of PPE. DON B indicated it is not the policy of the facility to wear an N95 mask over a surgical mask. DON B indicated wearing both masks at the same time is not a standard of practice. DON B indicated staff should not be wearing an N95 mask over a surgical mask. Example 2: Facility policy entitled ' Hand Hygiene,' states in part: all staff will perform proper hand hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Definitions: Hand Hygiene is a general term for cleaning your hands by handwashing with soap and water or use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR).additional considerations: a. the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (putting on) gloves, and immediately after removing gloves. On 8/25/2025 at 12:25 PM Surveyor observed RN V (Registered Nurse) apply gloves, take out an insulin pen from the cart along with a new insulin cap needle. RN V then proceeded to go to R15's room with the insulin pen. RN V voiced to R15 that he's getting 2 units. RN V put the needle on R15's insulin pen, then removed her gloves. RN V did not use hand gel or wash her hands before putting on a new pair of gloves. RN V was observed dialing up 2 units and injecting the 2 units into R15's right arm. On 8/25/2025 at 12:33 PM Surveyor interviewed RN V (Registered Nurse) regarding Hand hygiene. RN V indicated she used gloves to prep her medications. Surveyor asked about Hand hygiene in between removing gloves, RN V indicated every time you remove your gloves. Surveyor asked RN V if she did hand hygiene between changing her gloves, RN V indicated I didn't touch anything. On 8/25/2025 at 3:02 PM Surveyor interviewed LPN T (Licensed Practical Nurse) regarding insulin pens and hand hygiene. Surveyor asked LPN T when it's appropriate to perform hand hygiene. LPN T indicated before you eat/drink, use the restroom, going from dirty to clean. Surveyor asked about hand hygiene with med pass. LPN T indicated before/after entering a room, after giving insulin, before/after using gloves, and before you leave a room and when you have visible soiled hands. Surveyor asked about gloves at med cart. LPN T indicated you shouldn't be wearing gloves at the med cart. Surveyor shared observation with LPN T and asked about Hand hygiene. LPN T indicated before discarding gloves and putting a new pair on. LPN T indicated anytime you discard gloves, you do hand hygiene. On 8/26/2025 at 1:49 PM, Surveyor interviewed DON B (Director of Nursing) regarding Hand hygiene. DON B indicated hand hygiene is to be performed after removing gloves and before doing anything else, staff should perform hand hygiene.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Number of residents sampled: 2Number of residents cited: 1Based on observation, interview, and record review, the facility did not ensure that all residents are clinically appropriate to self-administer medications for 1 of 2 residents (R48) reviewed for self-administration of medications. Surveyor observed R48 to have a cup of medications left on her bedside table on her meal tray for her to take independently. R48 did not have an assessment for self-administration of medications and did not have an active physician's order. R48's care plan does not indicate R48 can self-administer medications. This is evidenced by: The facility's policy Resident Self-Administration of Medication dated 4/17/25, includes it is the guideline of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. Each resident is offered the opportunity to self-administer medications during the routine assessment by licensed nurse and/or the facility's interdisciplinary team. The results of the licensed nurse and/or interdisciplinary team assessment are recorded using a Self-Administration of Medication Evaluation, which is placed in the resident's medical record. The care plan must reflect resident self-administration and storage arrangements for such medications. On 8/20/25, NHA A (Nursing Home Administrator) provided surveyors with a piece of paper indicating medication administration times. The facility's medication administration times were listed as:AM medication administration 7 AM - 10 AMNoon medication administration 11 AM - 1 PMPM medication administration 4 PM - 6 PMHS (Hours of Sleep) medication administration 7 PM - 10 PMEarly AM medication administration 4 AM - 6 AM R48's physician orders printed on 8/26/25 include:Acetaminophen 500 MG give 2 tables by mouth three times a day for pain.Protonix 40 MG give 1 tablet by mouth one time a day for heartburn.Sertraline 100 MG give 2 tablets by mouth one time a day for mood. R48 does not have an active order for self-administration of medication in her physician orders. R48's comprehensive care plan, printed on 8/26/25, does not include self-administration of medications. R48 does not have an evaluation for self-administration of medication in her electronic health record. On 8/20/25 at 11:30 AM, Surveyor entered R48's room. R48 was sitting in her chair with her bedside table in front of her. On her bedside table, R48 had her breakfast tray and a medication cup with 4 pills inside. R48 indicated these medications were from the morning medication pass. R48 stated she is slow at taking her medications and staff leave the cup of medications for her to take at her own pace. On 8/20/25 at 11:31 AM, Surveyor interviewed LPN H (Licensed Practical Nurse) regarding R48's medications. LPN H verified R48 had 1 Acetaminophen, 1 Protonix and 2 Sertraline pills in her medication cup on her bedside table. LPN H indicated these medications were scheduled for the AM medication administration time which is between 7 AM and 10 AM. LPN H reviewed R48's physician orders and indicated R48 does not have an active order for self-administration of medications. LPN H indicated R48 should have an active physician's order and an assessment to determine if R48 can safely self-administer medications. LPN H indicated R48 should not have her medications left at bedside to self-administer. On 8/25/25 at 2:11 PM, Surveyor interviewed DON B (Director of Nursing) regarding self-administration of medications. DON B indicated the following steps should be completed for a resident who wants to self-administer medications; a licensed nurse will evaluate the resident for safe self-administration of medication, document the evaluation in the resident's electronic health record, obtain a physician's order for the resident to self-administer medications, enter the order into the resident's medical record, and update the care plan. DON B indicated R48 does not have a self-administration of medication evaluation. DON B indicated R48 does not have an active physician's order for self-administration of medications. DON B indicated R48 should not have had medications left at bedside since she does not have an evaluation indicating R48 is safe to self-administer medications nor does R48 have an active physician order.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that every resident had an Advance Directive, including Code Status (Do Not Resuscitate or Full Code (resuscitate)), this affected 1 of 21 residents (R58).R58 did not have a code status determination in her medical record.This is evidenced by:The Facilities Policy and Procedure entitled Resident's Rights Regarding Treatment and Advance Directives dated [DATE], documents in part: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive .9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care .R58 admitted to the facility [DATE], went out to the hospital [DATE] and re-admitted to the facility [DATE]. R58 has the following diagnoses: acute and chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), heart failure, morbid (severe) obesity with alveolar hypoventilation (lungs are not adequately ventilating, leading to a buildup of carbon dioxide in the blood), obstructive sleep apnea (condition where sleep is interrupted by abnormal breathing), and dilated cardiomyopathy (heart becomes enlarged and can't pump blood effectively).Review of R58's EHR (Electronic Health Record) in banner on top of record, in the orders section, and in the miscellaneous section did not contain R58's code status.R58's Hospital Discharge summary dated [DATE] documents R58 is a full code.R58's Hospital Discharge summary dated [DATE] documents R58 is a full code.On [DATE] at 10:20 AM, Surveyor interviewed LPN P (Licensed Practical Nurse). Surveyor asked LPN P where you would look for a resident's code status, LPN P stated on their banner in EHR. Surveyor asked LPN P what would you do if you had a resident who was pulseless and nonbreathing and you could not see their code status, LPN P stated, That should not be a thing, but we would code them if we didn't know code status. Surveyor asked LPN P who does the code status paperwork with residents when they admit, LPN P said it should be the admitting RN (Registered Nurse) or whoever is doing their admission, could be the floor nurse. Surveyor asked LPN P should each resident have a code status on file in their record, LPN P replied yes.On [DATE] at 10:22 AM, Surveyor interviewed RN Q. Surveyor asked RN Q where would you look for a resident's code status, RN Q said in EHR (pointed to banner) or on the crash cart in binder. Surveyor asked RN Q what would you do if you had a resident who was pulseless and nonbreathing and you could not see their code status, RN Q said check for DNR (Do Not Resuscitate) bracelet (they wear them). Surveyor asked RN Q who does the code status paperwork with residents when they admit, RN Q replied the admission nurses. Surveyor asked RN Q should each resident have a code status on file in their record, RN Q stated absolutely.On [DATE] at 10:27 AM, Surveyor interviewed LPN R (Licensed Practical Nurse). Surveyor asked LPN R where you would look for a resident's code status, LPN R said EHR in the banner. Surveyor asked LPN R what would you do if you had a resident who was pulseless and nonbreathing and you could not see their code status, LPN R explained in the absence of code status paperwork, R58 would be treated like a full code. Surveyor asked LPN R who does the code status paperwork with residents when they admit, LPN R said she was not sure but thought likely the Admissions Nurse. Surveyor asked LPN R should each resident have a code status on file in their record, LPN R said yes.On [DATE] at 10:29 AM, Surveyor interviewed LPN S. Surveyor asked LPN S where you would look for a resident's code status, LPN S said in the EHR in the banner. Surveyor asked LPN S what would you do if you had a resident who was pulseless and nonbreathing and you could not see their code status, LPN S stated they would be a full code, and we would start CPR (cardiopulmonary resuscitation). Surveyor asked LPN S who does the code status paperwork with residents when they admit, LPN S replied the admission Nurse. Surveyor asked LPN S should each resident have a code status on file in their record, LPN S stated (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yes, they should.On [DATE] at 12:53 PM, Surveyor interviewed IUM T (Interim Unit Manager). Surveyor asked IUM T where you would look for a resident's code status, IUM T replied in the EHR under profile or in the banner. Surveyor asked IUM T what you would do if you had a resident who was pulseless and nonbreathing and you could not find their code status, IUM T stated we would start life saving measures, assume resident is a full code. Surveyor asked IUM T who does the code status paperwork with residents when they admit, IUM T said the Nurse on the hall. Surveyor asked IUM T if that would mean that Agency Nurses would also be responsible for completing this type of paperwork, IUM T stated sometimes the Agency staff do have to do them, there is an admission checklist, and the code status is right near the top and it is bolded. Surveyor asked IUM T should each resident have a code status on file in their record, IUM T stated yes.On [DATE] at 1:22 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B where would expect staff to look for a resident's code status, DON B explained it is in their orders, paperwork is uploaded into the miscellaneous tab, and in the banner in EHR. Surveyor asked DON B what would you expect staff to do if they had a resident who was pulseless and nonbreathing and they could not see their code status, DON B said quickly look in miscellaneous tab in EHR, resident is automatically a full code if no code status is documented. Surveyor asked DON B who does the code status paperwork with residents when they admit, DON B said the admitting nurse. Surveyor asked DON B would you expect each resident have a code status on file in their record, DON B stated yes.The facility provided Surveyor with a code status document for R58 that was dated [DATE].

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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 did not ensure adequate supervision and safety to prevent accidents from occurring for 2 of 3 residents reviewed (R53 and R85). R53 began smoking at the facility and was not assessed to be a safe, independent smoker once the facility was aware R53 began smoking. R85 was assessed to be at risk for falls. The facility did not assure that the care plan interventions were in place for R85. Evidenced by: The facility's policy titled Resident Smoking dated 12/15/23 states in part .6. Residents who smoke will be further evaluated using the Smoking Evaluation to determine supervision need and intervention.10. All safe smoking measures will be documented on the care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on the care plan.15. Documentation to support decision making will be included in the medical record, including but not limited to: .b. Evaluation of relevant functional and cognitive factors affecting ability to smoke safely. Example 1 R53 was initially admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses that include type 2 diabetes, alcoholic cirrhosis (chronic liver damage), anxiety disorder, and depression. R53's most recent MDS (Minimum Data Set) dated 7/20/25 states that R53 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R53 is cognitively intact. On 8/20/25, the Survey team entered the facility and requested a list of smokers. R53 was on the list. R53's admission assessment and provider notes indicate that R53 has a history of smoking but was not actively smoking at that time. R53 had a Smoking Evaluation completed on 8/20/25 at 9:48 AM stating in part .Safe to smoke unsupervised. R53's care plan dated 8/20/25 states in part .Focus: The resident is a smoker. Goal: The resident will be free from complications r/t (related to) smoking independently through the next review date. Interventions: Smoking evaluations will be completed quarterly, annually, and with sig. (significant) change in condition. The resident can smoke independently. It is important to note that R53's smoking evaluation and care plan was completed after the Survey team entered the facility. On 8/20/25 at 2:05 PM, Surveyor observed R53 smoking in the designated smoking area. On 8/21/25 at 2:16 PM, Surveyor interviewed R53. Surveyor asked R53 how long she had been (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smoking, R53 stated since she was a teenager. Surveyor asked R53 if she had been smoking at the facility since she was admitted , R53 stated yes. On 8/21/25 at 2:23 PM, Surveyor interviewed CNA K (Certified Nursing Assistant). Surveyor asked CNA K if R53 has been smoking since admission to the facility, CNA K stated that R53 did not smoke when they were admitted to the facility but has been smoking for about a week or so. On 8/21/25 at 2:49 PM, Surveyor interviewed RN L (Registered Nurse). Surveyor asked RN L when did R53 start smoking at the facility, RN L stated the R53 made a new friend at the facility and has been smoking for about 2 weeks. Surveyor asked RN L if anyone at the facility completed a smoking assessment prior to R53 being allowed to smoke, RN L stated no. Surveyor asked RN L if an assessment should have been completed before a resident starts smoking at the facility, RN L stated yes. On 8/25/25 at 3:35 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when a smoking evaluation should be completed, DON B stated on admission or as soon as they are identified as a smoker. Surveyor asked DON B if a smoking evaluation should be completed prior to a resident smoking at the facility, DON B stated that they were not aware that R53 was smoking due to her taking herself outside and that she would expect that if staff were aware of R53 smoking, they should have completed the evaluation. Surveyor asked DON B if R53 should have a care plan for smoking, DON B stated yes. Example 2 R85 was admitted to the facility on [DATE] with diagnoses of cerebral infarction(stroke), moderate protein-calorie malnutrition, contracture R knee, contracture L knee, and chronic pain syndrome. The facility policy, titled Fall Prevention Program, dated 10/8/2024, states in part: . 6. High Risk Protocols: .8. Each resident's risk factors, and environmental hazards will be evaluated when developing the residents comprehensive plan of care.a. Interventions will be monitored for effectiveness b. The plan of care will be revised as needed.9. When the resident experiences a fall, the facility will: .e. Review the residents care plan and update as indicated.h. Monitor residents' condition and response to interventions as per standard of practice. R85's Minimum Data Set (MDS) assessment, dated 3/7/25, indicated that R85's Brief Interview of Mental Status (BIMS) score was a 13. This indicates R85 is cognitively intact. R85's care plan with a revision date of 8/21/25, states in part: .R85 is at risk for falls r/t (related to) hx (history) of fall and decreased mobility, and contractures. Intervention dated 3/8/25: Provide resident with a wider mattress to allow for more space to be comfortably repositioned. R85's CNA (Certified Nursing Assistant) Kardex with a date of 8/25/25, states in part: .Accident-Fall Risk. Use pillows for positioning and supporting residents back. On 8/21/25 at 7:48 AM Surveyor entered R85's room and observed R85 in a standard size bed with pressure relief mattress and bolster overlay. Bolsters on the top half of the bed were laid flat, not upright. Surveyor interviewed R85 who stated that he was supposed to get a bigger bed a long time ago but had not gotten it yet. He said when he goes to roll over the bed is too small, and he gets too close to the edge and falls out. He doesn't know why he doesn't have a bigger bed; R85 said he has (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked but no one tells him. On 8/25/25 at10:22 AM Surveyor observed R85 in a standard size bed with air mattress and bolsters, which is an overlay that fits on the bed like a sheet. The overlay was not hooked to the upper and lower right side of the mattress making the bolsters on top and bottom of bed fall out flat, which would be ineffective to prevent R85 from rolling out of bed. On 8/25/25 at 3:12 PM Surveyor interviewed CNA M (Certified Nursing Assistant). Surveyor asked if R85 had ever been in a larger bed than he has now. CNA M replied I believe it has always been the same bed. On 8/25/25 at 4:10 PM Surveyor interviewed MD N (Maintenance Director). Surveyor asked if R85 had ever had a different bed than he has now. MD N stated I think it has always been a standard bed. If a bigger bed came into the facility I would know about it, and I don't remember seeing a larger bed. On 8/26/25 at 9:50 AM Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if R85 had ever had a larger bed. DON B replied that he may have had a bigger bed when he was up front (the rehab rooms). DON B stated she would have to ask maintenance if they know. DON B also stated that hospice had gotten him a new bed so the old one could have been bigger. Surveyor showed DON B R85's care plan intervention dated 3/8/25, which stated, Provide resident with a wider mattress to allow for more space to be comfortably repositioned. Surveyor asked DON B who is responsible for updating the care plans for new interventions and review of current interventions. DON B replied everyone is, the interdisciplinary team can update a care plan. Usually, the transcriber will do it. It's a team effort. Surveyor asked DON B would you expect fall interventions on the care plan to be utilized. DON B stated yes. Surveyor asked DON B should all interventions on the care plan be current. DON B replied yes or at least applicable. On 8/25/25 at 10:35 AM Surveyor was in R85's room with RN H (Registered Nurse). Surveyor observed R85 in standard size bed, bolster overlay was lying on the top of the bed, only hooked with strap around the bed frame and corners not pulled over the mattress. Surveyor asked RN H what the bolsters on the bed were used for. RN H replied fall prevention. Surveyor asked RN H if the bolsters were on the bed correctly. RN H stated I have no idea how they go on the bed I just know they are helping him not to fall. Surveyor asked RN H if the bolsters would be effective to prevent R85 from falling at this time. RN H replied it looks fine to me. It is just for fall prevention. On 8/25/25 at 10:37 AM Surveyor was in R85's room with CNA K (Certified Nursing Assistant) Surveyor showed CNA K the overlay on R85's bed and asked how the overlay fit onto the bed. CNA K responded that there are straps that go under the bed to keep it on the bed. Surveyor asked CNA K if the overlay fit on the bed like a sheet. CNA K replied yes. Surveyor showed CNA K the end of the bed and part of the sheet that should go over the edge of the bed. Surveyor asked CNA K if she would expect the overlay, the way it is now, to be effective. CNA K responded I guess it would. On 8/26/25 at 10:05 AM Surveyor interviewed DON B (Director of Nursing). Surveyor and DON B went down to R85's room. Surveyor observed R85 in bed lying on his left side close to the edge of the bed. The bolsters on the top part of the bed were down flat. Surveyor asked DON B if the bolsters on R85's bed would be effective the way they are currently. (Observed bolsters in a flat position vs upright, overlay was not completely attached to the bed.) R85 stated no. DON B attempted to pull the bolster upright but R85 was lying on part of the bolster, and she was unable to move it. DON B stated that it seemed like the overlay was not the right size for the bed and was going to have maintenance come (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and look at it right away. Surveyor asked DON B why the bolsters were not on R85's care plan or CNA Kardex. DON replied that hospice has a company come in and bring the equipment and they may not know when they come. DON B stated that R85 just got the bolsters put on his bed. Surveyor asked DON B when they were put on the bed. DON B stated she would find out. DON B returned later and stated 7/16/25. On 8/26/25 at 10:38 AM Surveyor called RN O (Hospice nurse). Surveyor asked when the bolster overlay was delivered for R85. RN O stated 7/16/25. R85 has had 4 falls since 3/8/25 care plan intervention to provide larger mattress to allow for more space to be comfortably repositioned. On 7/16/25 hospice provided a bolster overlay for fall prevention. Staff were not educated in proper use of the bolsters to effectively prevent R85 from rolling out of bed. Care plan and CNA Kardex did not have an intervention on use of the bolsters.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure the provision of routine biologicals for 1 of 9 residents observed for medication pass (R15). RN V (Registered Nurse) did not prime R15's insulin pen prior to administering 2 units of insulin. Evidence by:Facility policy entitled ?insulin pen,' states in part: .it is the guideline of this facility to use insulin pens in order to improve the accuracy of insulin dosing provide increased resident comfort and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. Explanation and compliance guidelines: .2. Insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency and expiration date.6. insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir.9. insulin pens should be disposed of after 28 days or according to manufacturer's recommendations. 11. Procedure: .e. Check the expiration date on the pen. Discard if expired.h. prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. with the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. i. set the insulin dose.R15 was readmitted on [DATE] with a diagnosis of Type 2 Diabetes mellitus. R15's Physician orders state in part: Novolog flexpen subcutaneous solution pen-injector 100unit/ml (milliliter) (insulin aspart) inject as per sliding scale: if 151 - 200 = 2 units. subcutaneously with meals for prime needle with 2 units related to Type 2 diabetes mellitus with diabetic polyneuropathy.start date [DATE]. R15's MAR (medication administration record) indicates a blood sugar of 200, which would have required 2 units to be administered. On [DATE] at 12:25 PM Surveyor observed RN V (Registered Nurse) apply gloves, take out R15's insulin pen from the cart along with a new insulin cap needle. RN V then proceeded to go to R15's room with insulin pen. RN V voiced to R15 that he's getting 2 units. RN V cleaned off the hub of the insulin pen then put the needle on R15's insulin pen, then removed her gloves. RN V did not use hand gel or wash her hands before putting on a new pair of gloves. RN V was observed dialing up 2 units and injecting the 2 units into R15's right arm. RN V did not prime the insulin pen with 2 units prior to administering 2 units of insulin to R15. (Of note, the 2 units being given to R15 would not have been delivered as ordered, due to the pen requiring 2 units to prime the pen prior to administration, therefore R15 would not of received the 2 units of insulin due to not priming the pen.)Surveyor interviewed RN V at 12:30 PM Surveyor asked RN V should the insulin pen be primed prior to administering insulin? RN V replied no, you don't waste their medication, are you asking me to waste their medication. Surveyor asked RN V what the procedure is when using insulin pens, RN V replied, what you just saw me do. Surveyor asked RN V if R15's aspart pen has an open date. RN V indicated no, it should be dated the 19th, no open date was on the pen, RN V wrote a date on the pen at this time. On [DATE] at 3:02 PM Surveyor interviewed LPN T (Licensed Practical Nurse) (LPN T is the interim unit manager) regarding insulin pens and hand hygiene. LPN T indicated for an Insulin pen you would check the MAR (medication administration record) and five rights (of medication pass), clean the top of the pen with alcohol wipe, prime it with 2 units, then set the dial to the set amount to be given, then give the units as ordered. Surveyor asked if not priming the pen would be a med error, LPN T replied yes. Surveyor asked if insulin pens are to be dated when opened, LPN T replied yes or on the bag. Surveyor and LPN T went to observe the aspart pen in the medication cart, the aspart pen has a manufacturer expiration date of [DATE], with an open date of 8/9 written on it and the bag the Kwik pen was being stored in was not labeled as aspart Kwik pen. LPN T indicated insulin is only good for 28 days after being opened.On [DATE] at 1:49 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated for insulin staff are to check for an open date/expiration date, prime the insulin pen with 2 units and administer per physician orders.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure food allergies, intolerances and preferences were accommodated and/or individualized meal tickets were followed for 2 residents (R90 and R70) reviewed for food allergies/intolerances. R90 is allergic to eggs and milk. Staff served R90 an egg muffin sandwich and offered milk for breakfast on 8/21/25. R70 is lactose intolerant. Staff did not provide a milk alternative on 8/21/25. This is evidenced by: The facility's policy Food Preparation Guidelines, dated 12/17/24, includes: It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status. Staff shall accommodate resident allergies, intolerances, and preferences, providing appropriate alternatives when needed. The facility's policy Menus and Adequate Nutrition, dated 5/26/24, includes: The facility will provide residents with nourishing, palatable, well-balanced diets that meet his or her daily nutritional and special dietary needs. Example 1 R90 admitted to the facility on [DATE] with a severe allergy to egg protein and an intolerance to milk derivatives. R90's diet order, dated 8/12/25, states LCS (Limited Concentrated Sweets) diet, regular texture, thin consistency, allergy to egg-derived products and milk related compounds. R90's comprehensive care plan, printed 8/26/25, states: Allergic: egg derived products, milk related compounds date initiated 8/14/25. Provide and serve diet as ordered. On 8/20/25 at 2:51 PM, Surveyor interviewed R90 regarding her meals. R90 stated, that since admission, the facility continues to serve her eggs and items with eggs in them. R90 stated she is allergic to eggs and has an itchy throat, will vomit, and have severe stomach pain if she eats eggs or items with eggs in them. R90 stated she was served eggs this morning for breakfast and did not eat them. On 8/21/25 at 8:50 AM, Surveyor observed the drink cart on the 100 hallway, there was no milk alternative on the drink cart. On 8/21/25 at 8:51 AM, Surveyor observed CNA E (Certified Nursing Assistant) deliver R90's meal tray to her room. CNA E offered R90 coffee or milk to drink. CNA E place R90's meal tray on her bedside table in front of R90 and left the room. On 8/21/25 at 8:51 AM, Surveyor observed R90's meal ticket. R90's meal ticket, dated 8/21/25, includes:Cereal 1/2 cup choice of cerealEntree 1 each Egg MuffinDairy 8 fl. Oz MilkAllergic to egg productsAllergic to milk On 8/21/25 at 8:51 AM, Surveyor observed an egg muffin sandwich on R90's meal tray. Surveyor interviewed R90 regarding her meal. R90 stated she would not be able to eat the sandwich or the meat on the sandwich because it was touching the egg. R90 indicated she did not accept the milk that CNA E offered because she is allergic to milk. R90 indicated she was just going to eat the oatmeal provided on the tray for breakfast. On 8/21/25 at 9:11 AM, Surveyor interviewed DM C (Dietary Manager) regarding meal preparation and delivery of meal trays. DM C indicated the process is as follows: the cook reviews the meal tray ticket and prepares the food as ordered, then the dietary aide reviews the meal ticket to ensure the correct items are on the tray and puts the tray on the meal cart for delivery. DM C indicated the CNA's review the meal ticket prior to delivering the meal tray to ensure the resident is receiving the correct meal. Surveyor asked DM C about R90's meal tray preparation. DM C indicated he was the cook today and prepared R90's tray. Surveyor showed DM C R90's meal tray which included the egg sandwich. DM C reviewed R90's meal tray ticket and stated R90 should not have received the egg sandwich since she is allergic to eggs. On 8/21/25 at 9:19 AM, Surveyor interviewed CNA E regarding meal delivery. CNA E indicated she does not review the meal ticket. CNA E indicates she looks for the resident's name and serves them what is on the tray and then she will ask the resident what they want to drink. CNA E indicated she does not compare the meal ticket to the meal tray when delivering meals. On 8/21/25 at 10:21 AM, Surveyor interviewed DON B (Director of Nursing) regarding meal delivery. DON B indicated CNAs should be reviewing the meal tickets to ensure the residents are getting the correct diets prior to delivering the meal tray. Surveyor informed DON B that R90 received an egg sandwich even though R90 is allergic to eggs. DON (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B indicated the dietary staff should have caught that prior to the tray leaving the kitchen but the CNA should have completed a double check prior to delivering the meal tray. DON B stated R90 should not have received eggs since she is allergic. On 8/21/25 at 10:33 AM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding meals. NHA A indicated R90 should not have received eggs since she is allergic to them. Example 2 R70 admitted to the facility on [DATE] with an intolerance to milk related compounds. R70's meal ticket includes:Dairy Substitute neededLactose intolerant On 8/20/25 at 2:53 PM, Surveyor interviewed R70 regarding her meals. R70 indicated she is lactose intolerant, and the facility does not always provide an alternative. R70 stated a few times a week she does not get the milk alternative. R70 stated at breakfast she cannot eat her cereal if they do not give her the milk alternative. On 8/21/25 at 9:00 AM, Surveyor observed R70's breakfast meal tray. There was no milk alternative given to R70. On 8/25/25 at 8:57 AM, Surveyor observed R70's meal tray. There was no milk alternative provided. On 8/25/25 at 9:05 AM, Surveyor observed CNA G (Certified Nursing Assistant) sitting in the dining room near the kitchen. CNA G indicated she was waiting for oatmeal. Surveyor asked CNA G if she was the staff member that delivered R70's breakfast tray this morning. CNA G indicated she did deliver R70's breakfast tray. Surveyor asked CNA G if a milk alternative was provided to R70. CNA G indicated she did not offer R70 a milk alternative. CNA G then walked over to the kitchen and asked a dietary staff if they had any Silk (milk alternative) for R70. Dietary staff gave CNA G a carton of Silk for R70. On 8/21/25 at 2:57 PM, Surveyor interviewed DM C (Dietary Manager) regarding milk alternatives. DM C indicated he does the ordering for the kitchen. DM C indicated he does order soy milk as a milk alternative but routinely runs out of soy milk. DM C indicated R70 does not need a milk alternative, but she prefers it. On 8/21/25 at 3:03 PM, Surveyor interviewed DON B (Director of Nursing) regarding residents with lactose intolerance. DON B indicated that having a lactose intolerance would qualify a resident to receive soy milk. DON B indicated R70 should receive a milk alternative because she has a lactose intolerance. On 8/21/25 at 10:33 AM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding R70's lactose intolerance. NHA A indicated a resident should not receive foods or drinks that they are allergic to or have an intolerance of.