STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not immediately notify and consult with a resident's physician when there was a change in condition. This occurred for 1 of 5 Residents (R3) reviewed for notification of change in condition.On 4/30/26 R3 had no urine output on the NOC (overnight) shift. The facility did not notify the provider of the change of conditionThis is evidenced by:The facility's policy, titled Change of Condition Process, undated, states in part: Unit Nurse Expectations: The unit nurse will identify/assess for changes of condition. All nurses will update the provider and POA (Power of Attorney) immediately of change in condition.R3 was admitted to the facility on [DATE] with diagnosis that include urinary tract infection, sepsis (extreme response to an infection), infection and inflammatory reaction due to indwelling urethral catheter, neuromuscular dysfunction of bladder (condition where the nervous system disrupts the bladders ability to control its function), retention of urine, and paraplegia (paralysis of the legs and lower body cause by a spinal cord or nerve problem).R3's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/16/26 indicates R3 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R3 is cognitively intact. R3's physician orders include the following:-Catheter Care: Irrigate Foley with 60 ml (milliliters) Normal Saline, using gentle pressure as needed for blockage/occlusion. Special instructions: May irrigate as needed. Start Date: 9/10/25. End date: Open ended.-Catheter Care: Monitor catheter for patency and provide Foley care Q shift (every shift). Start Date: 9/10/25. End date: Open ended.-Catheter Care: Monitor catheter output Q shift and document in ml. Update provider with abnormal output or if s/sx (signs/symptoms) of infection present. Special instructions: Ensure output is monitored and record Q shift of infection present. Special instructions: Ensure output is monitored and recorded Q shift. Start Date: 9/10/25. End date: Open ended.R3's Comprehensive Care Plan states, in part: .Problem: Resident requires an indwelling urinary catheter R/T (related to) neurogenic bladder. Start Date: 9/19/25. Edited: 2/27/26. Goal: Resident will have catheter care managed appropriately as evidence by: not exhibiting signs of urinary tract infection or urethral trauma. Goal Date: 5/18/26. Edited: 2/18/26. Approaches:. Catheter Care: Monitor catheter output Q (every) shift and document in mL. Update provider with abnormal output or if s/sx of infection present. Start Date: 9/19/25. Edited: 9/21/25.On 4/30/26 at 7:58 AM, a nursing progress note entered into R3's medical record states, in part: CNA (Certified Nursing Assistant) staff report that resident did not have any urine output in his bedside drainage bag at the end of NOC (overnight) shift. Resident observed to have clear colored yellow urine in his tubing. PRN (as needed) flush given to foley catheter without any resistance.On 4/30/26 at 11:09 AM, Surveyor interviewed NP E (Nurse Practitioner) about R3's output. NP E stated that it was her expectation to be notified of a resident's change of condition. NP E indicated that normally staff would notify her via a Hucu app message, and if they do not hear a response from her within an hour that they should try calling her. NP E indicated that she had not received any messages this morning about R3's lack of urine output. NP E stated that it was her expectation that staff notify her if a resident has low urine output, anything less than 240 mL in an 8-hour shift. NP E indicated that she had not been notified about R3, and she should (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been. On 4/30/26 at 11:33 AM, Surveyor interviewed CNA F (Certified Nursing Assistant) about R3's foley catheter. CNA F stated that she empties and measures R3's urine output 1-2 times per shift and documents the amount in the electronic medical record. CNA F indicated that she would notify the nurse on duty if R3 had little to no urine in his foley bag for the entire shift.On 4/30/26 at 11:38 AM, Surveyor interviewed RN G (Registered Nurse) about R3's urine output and notifying the provider. RN G stated that she would notify the provider immediately if she noticed a change in condition with R3's catheter, including any signs and symptoms of infection, or decreased urine output. RN G stated she would reach out to the provider with a Hucu app message, unless it was urgent, and then she would call the provider immediately.On 4/30/26 at 12:50 PM, Surveyor interviewed DON B (Director of Nursing) about R3's urine output and notifying the provider. DON B confirmed that there was no Hucu app message sent to the provider about R3's lack of urine output on the NOC shift. DON B stated that she would have expected the nurse to contact the provider given R3's past history of UTIs, sepsis and hospitalization.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide basic life support, including CPR (Cardiopulmonary Resuscitation), to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 1 Residents reviewed (R6) this has the potential to affect 25 full code residents that reside in the facility. R6 indicated he wished his code status to be full code. R6 was found to be pulseless and not breathing. Facility staff failed to utilize life-support equipment while providing CPR on R6. Facility staff indicated the facility does not have easily accessible life-support equipment, including a backboard or Ambu bag to provide effective emergency CPR. The facility failed to have a process and procedure in place to ensure CPR certified staff members have readily available and organized life-support equipment for when a resident is found pulseless and not breathing and there is a need for emergency resuscitation. The facility's failure to provide proper basic life support, including cardiopulmonary resuscitation on a hard surface and rescue breaths, to a resident who wished to be full code created a finding of immediate jeopardy that began on [DATE]. Surveyors notified NHA A (Nursing Home Administrator), DON B (Director of Nursing), and Corporate RN Z (Corporate Registered Nurse) of immediate jeopardy on [DATE] at 3:30 PM. The immediate jeopardy was removed on [DATE]; however, the deficient practice continues at a severity/scope of E (Potential for Harm/Pattern) as the facility continues to implement its action plan. Evidenced by: Facility policy, titled CPR, dated [DATE], includes: It is the policy of this facility to adhere to resident's rights to formulate advanced directives. In accordance to these rights, this facility will implement guidelines regarding CPR. The facility will follow the American Heart Association guidelines regarding CPR. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and in accordance with the resident's advance directives. Highlights of the 2025 American Heart Association's Guidelines for CPR and ECC (emergency cardiovascular care) includes, in part: . For adult cardiac arrest, rescuers should perform chest compressions with the patient on a firm surface and with the patient's torso at approximately the level of the rescuer's knees . R6 admitted to the facility on [DATE] with the following diagnoses; persistent atrial fibrillation (abnormal heartbeat) , Nonrheumatic aortic (valve) stenosis (when the aortic valve of the heart narrows, and blood flow becomes obstructed), encounter for surgical aftercare following surgery on the circulatory system, aero-sclerosis (build up of plaque) of coronary artery bypass grafts with angina pectoris (chest pain), Type 2 Diabetes Mellitus, Obstructive Sleep Apnea, presence of prosthetic heart valve, long term use of anticoagulants, and presence of aortocoronary bypass graft (surgical procedure that creates a new path for blood to flow to the heart by bypassing blocked arteries), cardiac arrest due to underlying cardiac condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R6's Hospital Discharge Notes, dated [DATE], includes: On [DATE] R6 underwent AVR (aortic valve replacement) with a 27mm (millimeter) biological valve, CABG (Coronary artery bypass surgery) times 3 . he was ambulating in the hall when he became acutely weak, hypotensive (low blood pressure). He had a code blue with loss of pulse, CPR (Cardiopulmonary resuscitation), Vfib (ventricular fibrillation – life threatening hear rhythm) with defibrillation twice and administration of Epi (epinephrine) and amiodarone. Reintubated during the code. Return of spontaneous circulation obtained after about 7 minutes of CPR. He had some delayed cognition after code blue which was much improved at time of discharge. He has intermittent pain on the left side of the chest and has palpable disruption of the sternocostal cartilage in that location, due to CPR. He was not yet at baseline mobility or mental status so discharge to skilled nursing facility for rehabilitation was recommended and agreed to by patient and spouse. R6's Nurse Notes, dated [DATE], includes: Res arrived via WC (wheelchair) van approximately 12:10 PM. Resident status post triple by-pass. Resident is alert and oriented times 4, makes needs known. Per resident wishes, code status is Full Code. R6's Vitals Log, dated [DATE], indicates R6's weight is 268 pounds. R6's Nurse Note, dated [DATE] at 2:07 AM, includes: At approximately 1:10 AM resident activated his call light. CNA (Certified Nursing Assistant) responded and witnessed resident sitting bedside, CNA reported that she asked resident (R6), what can I do for you? Resident reacted with startled body language, and then collapsed backwards in bed, did not bump head. CNA immediately called for nurse and then dialed 9-11. CPR initiated for FULL CODE STATUS. Unable to auscultate (listening to) vital signs, compressions started. Resident pale, ash colored, pupils pinpoint and fixed, unresponsive to sternal rub, tactile stimuli, and verbal stimuli. At 0120 (1:20 AM), EMT (Emergency Medical team) arrived to include [County name] Sheriff, [Name of town] Police Officer, and 7 other emergency staff (total 9 EMS (emergency medical services)). EMT transferred resident from bed to floor, performed CPR for > (greater than) 35 min, administered EPI x3 and BiCarb (sodium bicarbonate) x1 during CPR . Shock not advised during entire event. LUCAS (device that provides automated chest compressions during CPR) compressions continued until 0200 (2:00 AM). EMT then notified [Hospital name] Physician who pronounced resident Time of Death 0200 on [DATE] On [DATE] at 9:05 AM, Surveyor interviewed Agency RN C (Registered Nurse) regarding R6. RN C indicated she was on the floor working with CNA D (Certified Nursing Assistant) and RN C went down to smoke. RN C indicated when she came back up CNA D said she called 911. RN C indicated that CNA D was doing night rounds and R6 had his call light on and that R6 took a huge breath and fell backwards on the bed. RN C indicated CNA D got the nurse from the other floor, who initiated CPR (Cardiopulmonary resuscitation). RN C indicated that R6 had cardiac surgery prior to coming to the facility. RN C indicated again that CPR was started (unable to remember the nurses name) CNA D dialed 911, he was a big guy, we couldn't move him to the floor, started CPR on the bed and the rescue squad came and RN C believes they moved him to the floor. Surveyor asked RN C if they obtained a crash cart or ambu-bag, RN C indicated she believed CNA D got the cart. Surveyor asked about a backboard, RN C indicated she asked about it, and checked the mattress for a CPR cord, which the bed did not have. RN C indicated they initiated CPR on the bed due to the amount of time it would take to get the board. RN C indicated there were three staff, herself, CNA D and the nurse from upstairs. Surveyor asked RN C where the emergency items for CPR were located, RN C indicated there are a number of rooms where the cart and board are, its in a utility room down the hall. RN C indicated that by the time the CNA was to get the board EMT (emergency medical team) arrived. RN C indicated the other nurse put oxygen on him. Surveyor asked RN C about the compressions on the bed, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RN C indicated they looked like good recoil and had a mask with oxygen on him. Surveyor asked RN C how many rounds of compressions were delivered before EMT's arrived, RN C was unable to say. Surveyor asked RN C, with three staff could you have rolled R6 over to put a board under, RN C indicated yes, and that she asked the CNA for a board. On [DATE] at 9:33 AM, Surveyor interviewed CNA D (Certified Nursing Assistant) regarding R6. CNA D indicated she was passing linens when R6 put his call light on, CNA D knocked and asked how she could help. CNA D indicated R6 just looked at her and started trembling and fell back on the bed. CNA D indicated her nurse was on break so she called the nurse upstairs. CNA D indicated she told the nurse upstairs that she needed a nurse now, STAT (immediately) and 911 to help. CNA D indicated she went back to the room and tried to get R6 to respond, he had a stare and would not look at her. CNA D indicated the nurse came in and checked his vitals and then started CPR. CNA D indicated the other nurse arrived so she went and called 911. CNA D indicated RN C told her to go downstairs and wait for EMS (emergency medical services). Surveyor asked CNA D if someone got a crash cart or bag, CNA D I don't think we have a jump start, Surveyor asked if CNA D meant and AED, CNA D indicated yes, haven't seen one. Surveyor asked CNA D if they had a crash cart/bag, CNA D indicated don't believe I've seen one. CNA D indicated she met the police officer. CNA D indicated while waiting for the second nurse, the nurse from upstairs started performing CPR on the bed. CNA D indicated she didn't think the bed had a CPR cord and it was a soft surface, which isn't effective based on her training. (Of note: a standard mattress would not have a CPR pull cord) On [DATE] at 12:16 PM, Surveyor interviewed CNA D a second time. Surveyor asked CNA D how she alerts staff that she needs emergency assistance. CNA D indicated they just got walkie talkies back, but that she had to use the phone at the nurses station to call the nurse as the phone for call lights does not function as a phone, it only says what room number. CNA D indicated how she gets help is by finding someone. CNA D indicated it took approximately 1 minute to get from the room to the nurse's station, then maybe 2-3 minutes to get the nurse down here before the nurse got to the resident. CNA D indicated the nurse took the elevator from 3rd floor to 2nd floor. CNA D indicated she was standing in the doorway of the room saying, hurry up, get over here. CNA D indicated R6 was still breathing when she left the room to call for help. CNA D indicated with three people they could have moved him but he was a large man. CNA D indicated she is CPR certified, did not start CPR due to R6 was still breathing while in the room when she went to get help. CNA D indicated R6 was sitting on the bed side of the bed, and fell backwards on his back with his legs still off the bed . Surveyor reviewed the Emergency Medical Services Transport Report, dated [DATE], includes:. Ambulance and Engine 312 responded for a report of pulseless non-breather, Units arrived on scene and made their way to the patient's apartment. Crews found a .male lying on a hospital bed not breathing and without a pulse. A police officer was performing chest compressions and had their AED (automatic external defibrillator, portable device that detects life threatening rhythms during CPR) placed. A rhythm check was indicated by the officer's AED as crew was moving patient to the floor. The officers AED had no shock advised. Compressions were continued until the next rhythm check. Crew began cutting off the patient's sweatshirt and t-shirt to facilitate placing cardiac monitor pads. Once the patient's chest was exposed, the officers AED pads were removed and the cardiac monitors pads were placed. A rhythm check was indicated. Once the monitor was charged, compressions were paused to assess a rhythm. An IV (intravenous- line in a vein) was attempted in the right AC (antecubital, elbow crease) without success. Staff advised that the patient had a triple bypass surgery a month prior. A rhythm check was indicated. Once the compressions were paused to assess (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	rhythm. PEA (Pulseless Electrical Activity- a non-shockable rhythm) was noted during the rhythm check. The charge was dumped and compressions were resumed until next rhythm check. An IO (intraosseous-an emergency procedure used to gain rapid vascular access for fluid and medication administration) was attempted in the left femur but was unsuccessful. An OPA (oropharyngeal airway- a J shaped plastic device inserted into the mouth of an unconscious person who lacks a gag reflex) was placed and crew began ventilating with a BVM (bag valve mask- a handheld, manual resuscitator device used to provide positive pressure ventilation to patients who are non-breathing). An IO was attempted in the right humeral head and was successful. The patient was intubated.Placement was confirmed by end-tidal monitoring, lung sounds, and misting in the tube. A rhythm check was indicated. Once monitor was charged, compressions were paused to assess rhythm. PEA (pulseless electrical activity) was noted during the rhythm check. The charge was dumped and compressions were resumed until the next rhythm check. The LUCAS mechanical CPR device was placed and took over compressions for the duration of the call. Medical Control was called and advised of the encounter so far along with actions taken. The Medical Doctor stayed on the phone with the crew for the next two rhythm checks. The Medical Doctor advised the crew to cease resuscitation efforts. Crew stopped resuscitation efforts and notified staff members of the situation. Crew cleaned up equipment and cleared shortly after. On [DATE] at 3:50 PM CNA P (Certified Nursing Assistant), CNA Q, CNA R, LPN N (Licensed Practical Nurse), and LPN S indicated the facility does not have a crash cart or a crash kit for readily accessible emergency equipment, but it should. LPN N and LPN S indicated if a resident was found to be pulseless and nonbreathing in bed they could get the resident on the floor or put a backboard under the resident to perform CPR. LPN N and LPN S indicated they do not know if the facility has a backboard. LPN N and LPN S indicated they do not know if the facility has a crash cart. On [DATE] at 4:00 PM LPN H and CNA T indicated they were unsure if the facility had a crash cart or crash kit or readily accessible emergency equipment such as a backboard, suction machine, and ambu bag. LPN H and CNA T indicated they are unsure where these things would be located, but the facilities they previously worked at had all of these things on a cart. Surveyor asked LPN H and CNA T if there was a staff member they could ask. LPN H flagged down RN U (Registered Nurse) who indicated the facility does not have a crash cart and it does have a backboard, but it is not where it is supposed to be stored. RN U indicated she would assist Surveyor in looking for the backboard. Surveyor observed RN U use her key to unlock doors and look for a backboard. On [DATE] at 4:11 PM Surveyor and RN U observed the facility's backboard in a locked utility room at the end of the hallway. RN U indicated all staff should know where to find the facility's emergency equipment. RN U indicated the facility should have a process in place for having emergency equipment accessible for when a resident is found to be pulseless and non-breathing. On [DATE] at 8:03 AM during an interview LPN O indicated the facility does not have a crash cart or a kit with easily accessible emergency supplies. On [DATE] at 8:05 AM, Surveyor spoke with RN G. Surveyor asked RN G, if she found a resident pulseless and not breathing what would she do. RN G stated, she would yell for help (call 911) and on NOC (night) shift she would use her walkie talkie in her pocket to notify floor staff and start CPR (Cardiopulmonary Resuscitation). Surveyor asked RN G, if a resident is in bed when you find them pulseless and not breathing what do you do. RN G stated most beds are too soft to perform CPR. RN G stated, she would immediately lower the bed and slide the resident to the floor prior to starting CPR. RN G stated, it is easy to move residents to the floor as the beds at this facility lower all the way to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the floor. Surveyor asked RN G, where is the crash cart located. RN G stated, As far as I known we don't have one and if we do, I don't know where it is. On [DATE] at 8:08 AM during an interview, LPN N indicated this facility does not have a crash cart or crash kit. On [DATE] at 8:15 AM, CNA M indicated if staff witness a full code resident code on the bed staff should get the resident on a backboard or onto the floor to administer CPR. CNA M indicated the facility has a board and it usually hangs in the room across from the nurse station, but it is not there now. CNA M and Surveyor observed the area with 2 wall hooks and no backboard. CNA M indicated the facility should have a bag with CPR supplies, but they don't. CNA M indicated the facility does not have a procedure for paging help if a resident codes, but she would use her radio to call the nurse. On [DATE] at 8:21 AM, CNA L indicated CPR supplies and a back board should be by the nurse station, but she has never seen them and is unsure if the facility has a crash cart. On [DATE] at 8:25 AM, CNA K indicated CPR on a soft surface such as a bed is not effective. CNA K indicated she would try to get the resident onto the floor or put a backboard behind them to administer CPR. On [DATE] at 8:30 AM, CNA J indicated she would use her walkie to get the nurse right away if she found a resident pulseless and non-breathing. CNA J indicated she would have to get resident on a hard surface like the floor to administer CPR or use the facility's back board. CNA J indicated CPR bags are in the cupboard of the nurse's station. Surveyor asked CNA J to show her the bags. CNA J and Surveyor observed the cabinet in the nurse station and there were no bags there. CNA J indicated the facility should have a crash kit where everything is easily accessible. On [DATE] at 8:50 AM, Surveyor interviewed Paramedic/Firefighter W, Paramedic/Firefighter X, EMT/Firefighter V, and Lieutenant Y, who indicated they responded to the call on [DATE] and when they arrived R6 was on a soft bed and there was no hard surface underneath R6. Paramedic/Firefighter W, Paramedic/Firefighter X, EMT/Firefighter V, and Lieutenant Y indicated they did not believe the staff had provided R6 any rescue breathing, but they did provide R6 compressions while he was on the soft bed. Paramedic/Firefighter W, Paramedic/Firefighter X, EMT/Firefighter V, and Lieutenant Y indicated compressions are generally not effective on a soft surface and that is why they immediately put R6 on the floor to administer CPR. On [DATE] at 10:17 AM DON B (Director of Nursing), SW BB (Social Worker), and Interim ADON AA (Assistant Director of Nursing) indicated they were not sure if the facility calls a code color overhead or has a procedure for getting as many staff as possible to the area if a resident were found to be pulseless and non-breathing. DON B indicated the facility does not have a crash kit with supplies all in one place for when an emergency arises. DON B indicated the facility does have a back board and she put it where it is supposed to be on one resident floor but is still trying to locate the one for the other resident floor. DON B and Corporate RN Z indicated staff should not have to run around looking for supplies when a resident is found to be non-breathing and pulseless. DON B indicated staff should have everything in one place to grab and go. DON B indicated staff are to provide rescue breaths when performing CPR and they should be getting resident on a hard surface like the floor or placing a backboard under the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The failure to ensure R6, a resident who had chosen to be full code, received basic life support according to current standards of practice when he was found pulseless and non-breathing, the failure of not having readily accessible emergency supplies, and the failure of not having a procedure for getting as many staff as possible to the scene when a resident is found in need of life saving efforts created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility removed the immediate jeopardy on [DATE] when the facility completed the following: ~Charts were audited for similar instances going back through [DATE]. No other residents were impacted by this incident nor were other like incidents identified evidenced by review of other resident deaths that occurred in the facility. This review occurred on 4.30.26 by the Chief Nursing Officer. ~All nursing staff are to be educated on expectations to perform CPR in accordance with professional standards of practice, to include placing the resident on a hard surface or using a back board, to provide ventilations or rescue breaths along with compressions. Education began on 4.30.26 and will continue for each nurse before they work their next shift ~All nursing staff are to be educated on the CPR policy and Medical Emergency Response Policy. This includes the provision of CPR in accordance with professional standards of practice to include CPR on a hard surface, with ventilations or rescue breaths. Education began on pm shift 4.30.26 and will continue for each nurse before they work their next shift ~All nursing staff are to be educated on the creation of emergency kits on a cart that contain supplies for medical emergencies including CPR; one for each 2nd and 3rd floor and expectation to restock the cart after each use and to audit the cart each night shift to ensure it contains all needed supplies. Education began on 4.30.26 and will continue for each nurse before they work their next shift. ~All nursing staff are to be educated as to the location of the emergency carts and that they are to be checked every night shift by the charge nurse for required supplies and restocked by the charge nurse after use. ~A quiz will also be administered to all nurses working to validate competency. (All training noted above to be completed by next working shift. Any nurses who do not compete the competency will not be scheduled until they completed. Competencies and education will be conducted by nursing management and/or a nurse who has the competency education and has been designated to give education.) ~CPR policy and Medical Emergency Response policies were reviewed 0n 4.30.26 for the foundation of education. Chief Nursing Officer developed staff education on providing CPR in accordance with professional standards of practice, to include where to find equipment, that CPR must be done on a hard surface such a backboard or the floor, that ventilations and rescue breaths must be completed along with chest compressions and that the process for obtaining help in an emergency, such as CPR includes calling a Code Blue over the walkie talkies and the charge nurse taking charge of assigning duties during the emergency/code. Education also included review of emergency carts, their contents and location. Education began on pm shift on 4.30.26 by DON B and Interim ADON AA. All nurses will continue to be educated prior to the start of their shift until all nurses are educated. ~Additionally, mock code drills were conducted on both 2nd and 3rd floor on 4.30.26, and will be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	conducted each shift through Monday, 5.4.26. Education will continue on each shift until all nurses are educated. Education will be added to facility new hire orientation and agency staff education. Mock codes assess that employees know where to find equipment, how to call for help in a Code Blue, to ensure CPR is completed on a firm surface and that ventilations are given in addition to compressions. ~IJ Removal Plan, policies and mock code drill provided to medical director for review. ~All nursing staff will receive education on the facility CPR policy and Emergency Procedures Policy. ~A quiz will be administered to all nursing staff to validate competency of their education. Mock code drills will be conducted daily x 5 days, weekly x 4 weeks, monthly x next 3 months. ~Results of mock code drills will be reviewed at facility QAPI meeting for any further recommendations. Facility assessment will be updated related to need to conduct mock CPR drills routinely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 out of 3 total sampled Residents (R1).R1 experienced a change of condition following onset of nasal congestion and a productive cough. R1 was not assessed by a RN (Registered Nurse) prior to being hospitalization for 2 weeks. This is evidenced by:The facility's policy, Change of Condition Process, undated, documents in part, as follows: Unit Nurse Expectations: The unit nurse will identify/assess for changes of condition. All nurses will update the provider and POA (Power of Attorney) immediately of change in condition. The nurse will document the assessment, what the interventions are including any new orders. Unit nurses will assess the resident with COC (change of condition) every shift for 48 hours. The unit nurse will notify the Nurse Manager on call.R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, as follows: inclusion body myositis (a rare progressive muscle disease characterized by chronic inflammation and wasting), functional paraparesis (functional movement disorder causing weakness in both legs), and Chronic Obstructive Pulmonary Disease (progressive lung disease causing inflammation, airway damage and mucus blockage). R1's Minimum Data Set (MDS) dated [DATE], indicates R1 scored 15 out of 15 on his Brief Interview for Mental Status (BIMS) indicating R1 is cognitively intact.On 2/11/26 at 3:16 PM, RN I (Registered Nurse) documented a Progress Note for R1 as follows: Due to symptoms explained by floor staff, resident was tested for flu (influenza) and covid. All results were negative.(no evidence was provided to show that RN I assessed R1 at this time)On 2/11/16 at 3:35 PM, an LPN (Licensed Practical Nurse) documented a Progress Note for R1 as follows: Resident reported not feeling his best today. He stated he has some nasal congestion and a moist productive cough. Writer has not observed and [sic] when asked resident to describe (color) he told writer he didn't know because he doesn't look at it and when writer suggested he put tissue aside and call writer to observe he said he doesn't find that process appealing. Lung sounds are coarse throughout. Temp (temperature) 97.3 and O2 sats (saturation) 90% on room air. He reported no nausea and no specific pain-just tired and wore out. He is drinking fluids but reports his appetite is not really there. Writer updated PCP (primary care provider) via hucu; awaiting response. Resident remained in bed for breakfast and got up before lunch. He ate his meals in his room d/t (due to) not feeling well and he fed himself after set up assist using adaptive silverware. Resident transfers with hoyer lift and uses an electric w/c (wheelchair) for mobility.On 2/12/26 at 2:09 PM, an LPN (Licensed Practical Nurse) documented a Progress Note for R1 as follows: Resident continues to feel tired this shift. Tracheal congestion and audio [sic] wheezing present. Resident told writer he doesn't feel like he needs to cough to clear his throat and writer encouraged him to try to cough and he made a soft attempt to do so with no progress. Temp 97.3 O2 sats 89-91% on room air. Lung sounds coarse. He ate 100% of breakfast while in bed and fed himself after set up assist using adaptive silverware. After breakfast he received his scheduled shower. Resident chose to stay in bed after his shower and he has been sleeping soundly off and on. He wakes to verbal stimuli but goes back to sleep. Writer updated PCP (primary care provider) via Hucu on status. Orders received from NP (Nurse Practitioner) for Mucinex 600 mg (milligrams) BID (twice a day) x 14 days and Duo neb every 6 hours PRN (as needed) for SOB (shortness of breath) and/or wheezing. Writer gave PRN Duo neb at 1:14 PM for SOB/wheezing. After neb resident did have a more powerful cough. Resident slept through lunch but woke after his nebulizer and staff warmed tray up for him.On 2/12/26 at 11:24 PM, LPN H (Licensed Practical Nurse) documents a note in Hucu to the provider: T (Temperature) 96.6 pulse is bouncing between 30-40's O2 90% BP (blood pressure) 81/48, audible wheezes. Lungs pleural friction rub through out [sic] . He is super sick. Can I send him out?(No documentation was provided indicating an RN assessed R1 while being super sick)On 2/12/26 at 11:26 PM, LPN H (Licensed Practical Nurse) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented a note in Hucu to the provider: I got report that he was trying to eat the O2 mask when she gave him a breathing treatment on PMs and he's [sic] baseline is a&ox4 (alerted to person, place, time and event).On 2/12/26 at 11:28 PM, a Nurse Practitioner documented a note to the facility in Hucu: Send out to be evaluated.On 2/12/26 at 11:28 PM, LPN H (Licensed Practical Nurse) documented a note in Hucu to the provider: Thank u [sic]On 2/12/26 at 11:39 PM, LPN H (Licensed Practical Nurse) documented a Progress Note for R1 as follows: I went to check R1 after report and he has a very loud audible wheeze and pleural friction rub sounds in his left lung and his vitals are all running low O2 (oxygen saturation)is at 90% and B/P (blood pressure) is 81/48 I have contacted the NP (Nurse Practitioner) and have received an ok to send him out, I have update the POA (Power of Attorney), ambulance called and he is going to the hospital (name) for evaluation.On 2/13/26 at 12:38 AM, DON B (Director of Nursing) documented a Progress Note for R1 as follows: Call from floor nurse, per report. Resident continues to be lethargic as reported earlier in the day and per Hucu notes on provider's page, resident seems more confused, data collected below. T 96.6 pulse is bouncing between 30-40's O2 (oxygen saturation) 90% BP (blood pressure) 81/48, audible wheezes Lungs pleural friction rub through out [sic] . Per floor nurse provider was updated and resident is to be sent out.R1 was hospitalized from 2/13 - 2/27/26 with diagnoses of pneumonia of right lung due to infectious organism unspecified part of lung (an infection in the lungs make causing breathing difficulties), healthcare-associated pneumonia, sepsis (a life-threatening response to an infection) due to undetermined organism, bradycardia (slow heart rate), acute respiratory failure with hypoxemia (life-threatening emergency where the lungs cannot adequately transfer oxygen to the blood), and sepsis associated hypotension (severe infection causing low blood pressure). The hospital documented, Given the severity and the congested nature of his cough, he underwent a CT of the chest without contrast, that was personally reviewed showing fairly significant infiltrates in the right middle and right lower lobes, as well as early infiltrates in left lower lobe. He was ordered Zosyn and Vancomycin as well as DuoNebs in the ER (emergency room).On 4/29/26 at 10:35 AM, Surveyor spoke with R1. R1 recalls being hospitalized however he does not recall the reason for the hospitalization or events leading up to the hospitalization. It is important to note, R1 was not assessed by an RN (Registered Nurse) upon symptom onset and prior to being hospitalized . On 4/30/26 at 11:07 AM, Surveyor spoke with NP E (Nurse Practitioner). NP E reviewed the Hucu notes related to R1's change in condition. Surveyor asked NP E, would you expect an RN (Registered Nurse) to assess R1 when he was first noted with respiratory symptoms and to continue assessing R1's condition. NP E stated, yes, an RN should have assessed R1. On 4/30/26 at 1:05 PM, Surveyor spoke with RN I (Registered Nurse). Surveyor asked RN I, did the previous DON (Director of Nursing) ask you to monitor R1. RN I stated, yes, the previous DON asked her to touch base with R1. RN I stated, she and the previous DON did not think R1 had any serious issues going on. RN I stated, they thought it was allergies. Surveyor asked RN I, did you assess R1. RN I stated from what she recalls she assessed R1. Surveyor asked RN I, what did you assess. RN I stated, I do not recall. Surveyor asked RN I, did you document the assessment. RN I stated, she does not know.It is important to note, RN I did not document any assessment for R1. On 4/30/26 at 2:00 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, from 2/11-2/12/26 should a RN (Registered Nurse) have assessed R1. DON B stated, RN I (Registered Nurse) tested R1 for influenza and Covid - all tests were negative. Surveyor asked DON B, would you expect RN I or another Registered Nurse to assess R1. DON B stated, yes. Surveyor asked DON B, what would you expect RN I or another Registered Nurse to assess. DON B stated, R1's respiratory status and listen to R1's lungs. Surveyor asked DON B, would you expect RN I or another Registered Nurse to document that assessment. DON B stated, yes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd. Edgerton, WI 53534

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility did not provide evidence that MAs (Medication Aide) had 4 hours of medication based in-service training per year for 1 of 1 MA reviewed for in-service training.MA CC did not have documentation of 4 hours of medication based in-service. Evidenced by:The facility's Continuing Education policy, dated 2/9/26, states, in part: . 1. All levels of employees are expected to complete required trainings within designated time frames.MA CC has a hire date of 8/14/13. MA CC education record for 2025 indicates 2.5 hours of medication related in-service, including:*Medication Administration Pass 1 contact hours*Medication Administration: Antibiotics 0.5 contact hours*Medication Administration: Controlled Substances 0.5 contact hours*Medication Assistance for Medication Aides 0.5 contact hoursOn 5/14/26 at 12:43 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked how many hours of medication related in-service are required for MAs. NHA A stated 4 hours every year. Surveyor asked how many hours MA CC had completed for 2025. NHA A stated 2.5 hours; I would expect that MA CC would have 4 hours.