STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525415	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menomonee Falls Health Services	N84 W17049 Menomonee Ave Menomonee Falls, WI 53051

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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 0689 Level of Harm - 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 that each resident receives adequate supervision and assistance devices to prevent accidents for 4 of 6 residents (R6, R1, R10, and R22) reviewed for accidents. * On 2/13/2025, a Certified Nursing Assistant (CNA) transferred R6 not according to R6’s plan of care and bumped R6’s leg. R6 required surgical intervention to R6’s right leg as a result of the CNA not following R6’s plan of care for transferring. * R1 had a fall on 4/11/2025 and no documentation was located that the facility did a thorough investigation. * R22 had a fall out of bed when staff did not follow R22’s plan of care. R22 was receiving cares with assist of one when R22 rolled out of bed. R22’s plan of care was to have assist of 2. * R10’s Wanderguard was incorrectly placed on R10’s wheelchair according to the manufacturer guidelines. R10’s Wanderguard was placed directly on metal which would inhibit the Wanderguard from functioning properly. Findings include: The facility policy titled “Safe Resident Handling and Transfers” reviewed/revised 8/5/2022 documents: “Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Policy Explanation: All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. … Compliance Guidelines: … 10. Two staff members must be utilized when transferring residents with mechanical lift. 11. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire. …13. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment.14. Resident lifting and transferring will be performed according to the resident’s individual plan of care. …” 1.) R6 was admitted to the facility on [DATE] with diagnoses that include peripheral vascular disease, weakness, morbid/severe obesity, osteoarthritis, major depressive disorder-recurrent, dementia with psychotic disturbance, right and left artificial knee joints, and nonrheumatic aortic (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	525415	A. Building B. Wing	08/04/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	valve disorder. R6’s quarterly Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 13, indicating that R6 had intact cognition. The MDS assessed R6 as needing extensive assist with staff member for upper and lower body dressing, repositioning, and personal hygiene and assist of 2 staff members for toileting hygiene. The MDS also documents that R6 required a Hoyer lift for transfers with 2 staff members. R6 has an activated power of attorney (POA). On 7/29/2025 at 9:58 AM, Surveyor observed R6 lying in bed with the right leg elevated on a pillow. Surveyor noted a kerlix wrap to R6’s right extremity and asked R6 what the wrap was for. R6 replied that a couple months ago R6’s leg got bumped during a Hoyer transfer and ended up needing a surgery to removed “blood build up” in the area. Surveyor asked how the area was healing. R6 stated slowly but is doing well. Surveyor asked R6 how R6’s leg got bumped during the transfer. R6 replied was not sure if R6’s leg hit the Hoyer lift or R6’s bed but stated R6’s leg swung hard into something. R6 stated the aide transferred R6 using the Hoyer lift alone. R6 could not remember who the aide was that did the transfer alone. On 7/29/2025, Surveyor reviewed R6’s medical record and noted the following in R6’s care plan and progress notes: R6’s activities of daily living (ADLs) deficit . care plan was initiated on 12/18/2023 with the following intervention:-Transfer: Hoyer lift with 2 assist, X-large sling. On 2/12/2025 at 23:52 (11:52 PM) in the progress notes nursing documented: (R6) asked for pain cream for R6’s right leg. (R6's) right leg was noted to be swollen, warm to touch, red color with a blister and some drainage present. (R6) stated that R6’s leg was bumped when transferred from R6’s chair to R6’s bed. … Order received to send out for further evaluation. On 2/13/2025 at 2:40 AM in the progress notes nursing documented: received phone call from emergency department and was informed (R6) will be admitted to the hospital for further evaluation and treatment due to a hematoma to the right leg with changes and R6 being on Eliquis (blood thinner). Surveyor reviewed R6’s hospital admission paperwork and noted that R6 underwent surgical excision of hematoma with Jackson Pratt (JP, surgical drain used to remove fluid from a surgical site) drain placement on 2/17/2025. On 2/24/2025 at 16:30 (4:30 PM) in the progress notes nursing documented: (R6) returned from the hospital following a surgical procedure for evacuation of a large hematoma (clot) to the right lower extremity. Assessment revealed a large ecchymotic (bruising) area to the extending right foot with pitting edema present. 13 centimeter incision, well approximated with 14 visible sutures, JP drain present. … On 7/29/2025 at 3:03 PM, Surveyor requested to view facility self-reports for R6 since January 2025. On 7/30/2025, Surveyor was provided a facility self-report that was initially submitted to the State Agency on 2/12/2025 at 11:52 PM. The final investigation was submitted to the State Agency on 2/18/2025 at 9:27 PM. Surveyor reviewed the facility self-report. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed a written statement from CNA-O documenting CNA-O worked with (R6) on 2/12/2025. CNA-O put R6 into bed about 6:30 PM. CNA-O documented that R6 did hit R6’s leg on the side of the bed railing but R6 did not complain during the remainder of CNA-O’s shift. Surveyor reviewed the interview between Nursing Home Administrator (NHA)-A and CNA-O which documented that CNA-O did admit to transferring R6 with a Hoyer lift with only 1 assist and did not ask other staff for assistance to transfer R6. Surveyor noted that CNA-O is no longer employed with the facility and was not able to be reached for an interview. On 7/31/2025 at 10:14 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-Q who stated R6 requested some pain cream for R6’s leg. LPN-Q stated when went to get cream and looked at area on R6’s leg it was red and swollen. LPN-Q stated R6 told LPN-Q that R6's leg got bumped during a transfer. LPN-Q stated that the Director of Nursing (DON) and physician were contacted, and an order was received to send R6 out to get evaluated. LPN-Q stated that CNA-O did not ask LPN-Q for help and LPN-Q stated the other aides on duty were not asked to assist CNA-O for putting R6 to bed with the Hoyer lift. LPN-Q stated LPN-Q was not made aware that R6 bumped R6’s leg during a transfer. LPN-Q stated that facility policy is to have 2 staff assist with all mechanical lifts. On 7/31/2025 at 10:18 AM, Surveyor shared concerns with NHA-A and [NAME] President of Success (VPS)-D regarding R6 requiring surgical intervention after CNA-O transferred R6 using a Hoyer lift with one staff member instead of two staff members as indicated on R6’s plan of care. No additional information was provided. 2.) The facility's policy and procedure titled, NSG (nursing) Accidents and Supervision, last reviewed 7/14/22 documents in part: “Policy: The resident environment will remain as free of accidents hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s)… 2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. a. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc. b. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. c. Evaluations also look at trends such as time of day, location, etc…” (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1 was readmitted to the facility on [DATE] with pertinent diagnoses that include chronic obstructive pulmonary disease (lungs become inflamed, damaged and narrowed), lymphedema (a condition characterized by swelling that occurs when the lymphatic system fails to properly drain fluid from the tissues), restless legs syndrome (a condition that causes a very strong urge to move the legs. The urge to move usually is caused by an uncomfortable feeling in the legs. It typically happens in the evening or at night when sitting or lying down), and insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep).R1's Quarterly Minimum Data Set (MDS) with an assessment reference date of 6/23/25, documents a Brief Interview for Mental Status (BIMS) score of 14, indicating that R1 is cognitively intact. The MDS documents R1 is understood and understands others. R1’s Patient Depression Questionnaire (PHQ-9) score was 00 indicating no depressive symptoms. R1 exhibited no behaviors during the look back period of the MDS assessment. R1 is documented to have had one fall since admission or prior assessment. R1’s care plan for “Resident is at risk for falls r/t (related to) Deconditioning/weakness , Disease process RESTLESS LEG SYNDROME, History of falls, Pain, use of psychotropic medications” revised on 5/14/25, has the following interventions: “4/11/25 IDT (interdisciplinary team) review fall- DOR (director of rehabilitation) provided R1 with reeducation regarding asking for assistance, remind resident to ask for assistance. Date Initiated: 4/11/2025 •Anticipate and meet the Resident's needs. Encourage the Resident to always call for assistance.Date Initiated: 9/26/2022 •Education the Resident on fall prevention measures. Assure Resident that calling for help is not a bother.Date Initiated:9/26/2022 •Ensure that the Resident is wearing appropriate footwear (specify)Date Initiated:9/26/2022 •Follow Therapy recommendations for transfers, mobility and ambulationDate Initiated:9/26/2022 •Place bed at lowest position.Date Initiated:9/26/2022 •Place call light or communication device within reach. Answer call light promptly - alwaysDate Initiated:9/26/2022 •PT (Physical Therapy) to eval (evaluate) and treat. Seat cushion to be assessed. Revision on: 5/14/2025 •Resident wheelchair needs to be halfway in the bathroom to transfer to the toilet from the wheelchair with the chair locked. Date Initiated: 10/6/2024 •Review information on past falls and attempt to determine cause of falls for prevention and to minimize injuries.”Date Initiated: 6/9/2024 R1’s care plan for “at risk for falls due to: arthritis, history of falls, impaired balance/poor coordination” revised on 9/30/2024, has the following interventions: “•Have commonly used articles within easy reach.Date Initiated: 9/30/2024 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	•Medication regimen review.Date Initiated: 9/30/2024 •Medications as ordered.Date Initiated: 9/30/2024 •Provide assist to transfer and ambulate as needed.Date Initiated: 9/30/2024 •Reinforce need to call for assistance.Date Initiated: 9/30/2024 •Reinforce w/c (wheelchair) safety as needed such as locking brakes.Date Initiated: 9/30/2024 •Reminders to resident to reposition while on the toilet to help prevent numbness in legs while on the toilet.Date Initiated: 12/23/2024 •Report development of pain, bruises, change in mental status, ADL (activities of daily living) function, appetite, or neurological status post fall.Date Initiated: 9/30/2024 •Therapy eval and treat as ordered.”Date Initiated: 9/30/2024 On 07/29/2025, at 8:58 AM, Surveyor interviewed R1 and was told that R1 had one fall, R1 stated they fell flat down. R1’s progress note dated 4/11/2025, written at 04:45 am, documents: “Resident was sitting on her butt with both legs stretched out in front and both hands by her side palms down on the ground. When asked what happened she stated that she was trying to go to the bathroom and her legs gave out. Resident was helped off the floor and back into her chair her ROM (range of motion) was WNL (within normal limits) VSS (vital signs stable), and neuro (neurological) checks have stared. All personnel have been notified per facility protocol No new orders at this time just continue wit POC (plan of care). Her immitted intervention was education her on planting her feet firmly on the ground and standing momentarily before she began to walk”. R1’s “Un-witnessed Fall” assessment dated [DATE] was reviewed. The assessment documents “no injuries at time of incident” and “no injuries observed post incident”. “Predisposing Environmental Factors” identified as “clutter”. “Predisposing Physiological Factors” identified as “sedated”. “Predisposing Situation Factors” identified as “ambulating with assist”. For “Statements” it is documented “no statements found”. On 07/30/2025, at 3:17 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding additional documentation on witness statements and investigation post fall for R1. Surveyor was told they will look to see if there's more information related to the fall. On 07/31/2025, at 3:42 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-Q, who completed the “Un-witnessed Fall” assessment on 4/11/25, and asked what is done to investigate after a fall. LPN-Q stated the nurse should get statements from people working with resident. Surveyor asked do you document when resident was last seen or toileted. LPN-Q stated that is asked in one of the assessment questions in the computer. Surveyor asked why LPN-Q had checked clutter as a predisposing environmental factor and was told it was probably on accident to be honest. Surveyor asked why LPN-Q checked ambulating with assistance for predisposing situation factors (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and was told it means R1 was using their walker. LPN-Q explained that the “Un-witnessed Fall” assessment is what nurses fill out, it is on the computer. Surveyor asked if there is a fall packet with additional information to complete and LPN-Q stated they were pretty sure there is a fall packet but may have been noncompliant and not completed it. On 08/04/2025, at 9:47 AM, Surveyor interviewed LPN-E regarding what is documented or completed post fall and was told in the computer system is the risk management documentation. The post fall assessment is all done in the computer, there is no fall packet to complete. On 08/04/2025, at 9:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-X regarding post fall sharing of information that is observed. Per CNA-X there is a form to complete that asks when last seen, toileted, where was seen, if the fall was witnessed, etc. Gave Surveyor a copy of document titled “Witness Statement” that has the following questions: name of resident, name of witness, date of event, location of event, time resident last seen, time resident last toileted, was resident in w/c (wheelchair), recliner, bed or other, was resident using walker, was resident incontinent, what was resident’s footwear, is there a change of condition noted with resident, and general statement of knowledge of the event. Surveyor noted neither the “Witness Statement” document or the information it asks for was located for R1’s 4/11/25 fall. On 08/04/2025, at 10:00 AM, Surveyor interviewed LPN-K regarding what is documented or completed post fall and was told in the computer system you document the fall under risk management. There is a section for statements, when the fall is witnessed this is completed. There is no packet or place for putting statements about when last saw or toileted the resident in the computer. LPN-K is unaware of any witness paper form to complete. On 08/04/2025, at 10:45 AM, Surveyor interviewed DON-B regarding how to document post fall and was told that vitals and neuro checks are done in the computer, the computer generates what to complete. Staff do witness statements. The medical doctor and Power of Attorney are updated, the resident is put on the 24-hour board for monitoring. On 08/04/2025, at 11:44 AM, Surveyor relayed concern regarding lack of documentation of post fall assessment for R1’s 4/11/25 fall to NHA-A and 2 consultants. No additional information regarding R1’s post fall assessment was provided. 3.) The facility policy titled “Resident Alarms”, with implementation date of 7/21/2022 and revision date of 9/9/2022 documents: “Policy: It is the policy of this facility to utilize resident alarms only in accordance with the resident’s needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practicable level of physical, mental, and psychosocial well-being. … Definition: An “alarm” is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected. … (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	… Types of alarms include: …e. wander/elopement alarms – includes devices such as bracelets, pins/buttons worn on the resident’s clothing, sensors in shoes, or building/unit exit sensors worn/attached to the resident that alert the staff when the resident nears or exists an area of the building. This includes devices that may be attached to the resident’s assistive device or other belongings. … The facility shall establish and utilize a systematic approach for the safe and appropriate use of resident alarms that includes risks vs benefits consideration… a. Interventions shall be communicated to all relevant staff, including frequency/time frames for alarm use b. When alarms are utilized, additional measures should be taken, including but not limited to: i. Verifying alarms are used in accordance with the resident’s care plan ii. Verifying alarms are working properly iii. Observing for adverse consequences associated with the use of the alarms, including psychosocial concerns. …” R10 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, dementia without behavioral disturbance, and other recurrent depressive disorders. R10’s significant change Minimum Data Set (MDS) completed 1/3/25 documents R10’s Brief Interview for Mental Status (BIMS) score as 10, indicating moderate cognitive impairment. R10’s MDS documents no mood or behavior symptoms, and a wander/elopement alarm is used daily. R10’s MDS documents R10 uses a wheelchair independently and does not ambulate, and R10 requires maximal assistance for dressing, bed mobility, and transfers. The facility documents the cognitive loss/dementia Care Area Assessment (CAA) was triggered for R10 due to … “BIMS score of 10 … contributing factors include … dementia, change in mental status, and short term/long term memory loss … cognitive loss already care planned…” R10’s most recent quarterly MDS completed 7/4/25 documents R10’s BIMS score as 7, indicating severe cognitive impairment. R10’s MDS documents no mood or behavior symptoms, and a wander/elopement alarm is used daily. R10’s MDS documents R10 uses a wheelchair independently and does not ambulate, R10 requires maximal assistance with lower body dressing, and R10 requires moderate assistance for upper body dressing, bed mobility, and transfers. The most recent wandering risk assessment for R10 completed on 6/30/25 documents a score of 19.0, indicating R10 has a high risk for wandering. R10’s care plan documents “… resident has potential for elopement due to … Alzheimer’s disease … dementia, and other recurrent depressive disorder” with the following interventions: … (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-wander guard placement had been moved to wheelchair due to [history] of swelling of ankles/wrists and rashes to skin. Resident does not ambulate without use of wheelchair…, initiated 4/7/25 and revised 4/9/25 … -at moderate risk for elopement, [history] of following family outside. Redirect and provide distraction … and remind family to notify staff when leaving, initiated 11/24/24 and revised 4/7/25 … -check placement of wander guard on wheelchair and functioning per manufacturer recommendations and MD orders, initiated 4/7/25 and revised 4/14/25 … R10 has the following orders in place: -check wander alert bracelet function and expiration date daily every shift for elopement risk, active 4/9/2025 -check wander alert bracelet placement to wheelchair every shift for elopement risk, active 8/21/24 -okay to place wander alert bracelet for safety/elopement risk to wheelchair…, active 8/21/24 Surveyor reviewed a progress note dated 4/27/25 that documented R10 became anxious … tried leaving the facility multiple times … resident was not easily redirected. Wander guard in place . On 7/29/25, at 8:48 am, Surveyor observed R10 sitting in R10’s wheelchair in the hallway, wander guard observed on a metal bar behind the wheelchair seat on the back of the wheelchair. On 7/30/25, at 7:46 am, Surveyor observed R10 sitting in R10’s wheelchair in the hallway, wander guard observed on a metal bar behind the wheelchair seat on the back of the wheelchair. On 7/30/25, at 12:20 pm, Surveyor reviewed “Code Alert” wander management user essentials manual from RF Technologies, Inc. dated 2014. On page 5 of the manual, a highlighted “note” documents: “to monitor a resident in a wheelchair, attach the transmitter to the seat or the back of the chair, as the metal on the chair can interfere with the transmitter’s signal”. On 7/30/25, at 1:11 pm, Surveyor interviewed Director of Nursing (DON)-B regarding the use of wander guards. DON-B stated a nurse would do an assessment to determine potential elopement and then place a wander guard on the resident’s ankle or wheelchair. DON-B stated nursing staff tests the wander guard alarm system with a machine weekly and takes any residents with wander guards near the alarm to make sure the alarm is working. DON-B stated DON-B was not aware the wander guard should not be placed on a metal bar of a wheelchair. On 7/31/25, at 9:45 am, Surveyor spoke with Tech Support Code Alert (TSCA)-Z regarding wander guard placement for a resident in a wheelchair. TSCA-Z stated the transmitter could be wrapped around the handle of the wheelchair if needed. When Surveyor asked if the transmitter could be placed on a metal bar on a wheelchair, TSCA-Z stated to follow the manual instructions. On 7/30/25, at 3:00 pm, Surveyor shared the above concern with Nursing Home Administrator (NHA)-A and DON-B due to risk that R10’s attempts at elopement may go undetected. NHA-A and DON-B (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	understood the concern. No additional information was provided. 4.) R22's diagnoses includes hypertension (high blood pressure), aphasia (language disorder that affects a person's ability to communicate) following cerebral infarction (condition where blood flow to the brain is disrupted leading to the death of brain tissue, also known as ischemic stroke), morbid obesity, seizure, and unspecified psychosis (mental health condition characterized by a loss of contact with reality). R22's ADL (activities daily living) self-care deficit care plan initiated 10/12/24 & revised 6/10/25 includes an intervention of BED MOBILITY: Dependent extensive assist of 2, does not ambulate. Initiated 10/12/24 & revised 5/9/25. R22's at risk for falls care plan initiated 10/12/24 & revised 4/28/25 documents the following interventions: *Encourage to transfer and change positions slowly. Initiated 12/31/24. *Have commonly used articles within easy reach. Initiated 12/31/24. *Medications as ordered. Initiated 12/31/24. *Reenforce need to call for assistance. Initiated 12/31/24. *Reenforce w/c (wheelchair) safety as needed such as locking brakes. Initiated 12/31/24. *Report development of pain, bruises, change in mental status, ADL (activities daily living) function, appetite, or neurological status post fall. Initiated 12/31/24. Therapy eval (evaluation) and treat as ordered. Initiated 12/31/24. R22's significant change MDS (minimum data set) with an assessment reference date of 6/23/25 assess R22 as having short & long term memory problem and documents that R22 has severely impaired cognitive skills for daily decision making. R22 is assessed as being dependent for toileting hygiene & chair/bed to chair transfer and substantial/maximal assistance for roll left and right. R22 has an indwelling urinary catheter and is always incontinent of bowel. R22 is assessed as not having any falls since prior assessment. R22's nurses note dated 6/24/25 written by Licensed Practical Nurse (LPN)-K documents: At approx. (approximately) 1040 am this morning Writer had resident positioned on her side in bed performing wound care to coccyx/sacrum. Resident was on her side near the center of the bed. After writer completed washing buttocks/sacral area and dried, skin prepped. During opening of the dressing prepping dressing to place resident started reaching toward window calling out Hey rolled toward side of air mattress. As writer tried to grab at resident to prevent rolling. Resident continued to roll face down and started sliding off side of air mattress and onto the fall mat on the floorHospice RN (Registered Nurse) and this writer further resident while in bed with x2 (times two) abrasions noted. Abrasions with some redness noted to left scapula and mid left side of back. Offers no s/sx (signs/symptoms) of pain or discomfort. Sites cleansed and left open to air. VSS (vital signs stable) stable T. (temperature) 97.4- P (pulse). 93- Resp (Respirations). 18- B/P (blood pressure) 122/70- POX% (pulse oximeter percentage) on room air 95. Respirations are even and unlabored. POA (power (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525415	A. Building B. Wing	08/04/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	of attorney) contact called with message left to call back for update. Sister Emergency contact 1 [Name] updated and aware. [Medical Group Name] called APNP (Advanced Practice Nurse Prescriber) not available at the time. on call service to send message for her to call facility for update. NNOR from RN hospice nurse r/t incident. Will visit again tomorrow. Instructed to call for any changes or concerns. R22's Incident report dated 6/24/25 under incident description for nursing description documents: Writer had resident positioned on her side in bed performing wound care to coccyx/sacrum. Resident was on her side near the center of the bed. After writer completed washing buttocks/sacral area and dried, skin prepped. During opening of the dressing prepping dressing to place resident started reaching toward window calling out Hey rolled toward side of air mattress. As writer tried to grab at resident to prevent rolling. Resident continued to roll face down and started sliding off side of air mattress and onto the fall mat on the floor. Under action taken for description documents writer immediately called for help to speech therapist out in hall to assist while writer unlocked the bed to pull away from resident. Checked injury, no visible injury noted noted with skin intact. Range of motion at baseline and WNL (within normal limits) to all extremities. Speech therapy assisted placement of sling to hoyer resident off floor to get into bed. [Name] RN with [Name] Hospice arrive during this time and assisted as well. Resident then hoyered off floor back to bed to further assess for any injury and take vitals. After R22's fall on 6/24/25, R22's ADL self care deficit care plan was revised with an intervention Resident cares/respositioning/wound care: Dependent extensive assist of 2 does not ambulate. Initiated 6/26/25. Surveyor noted R22's care plan prior to R22's fall on 6/24/25 already had an intervention for bed mobility of dependent extensive assist of 2. On 7/31/25, at 9:59 a.m., Surveyor interviewed LPN-K regarding R22's fall on 6/24/25. LPN-K explained it was R22's treatment day. She pulled R22 all the way over literally in the exact center of the bed, a little past center, and had the treatment supplies set up. LPN-K informed Surveyor she went to apply medi honey noticed it wasn't cut appropriately but had an extra one. LPN-K indicated she pulled R22 a little more, covered R22 with a sheet, opened the medi honey and when she was cutting the medi honey R22 yelled hey, reached forward and went flat on R22's chest. LPN-K explained R22 only had a gown on, she tried pulling on R22's gown and tried to grab R22's shoulder but R22 slid on floor mat. LPN-K informed Surveyor she yelled for the speech therapist who was out in the hall, checked for injuries, didn't see any injuries and reassessed R22 every half hour. Surveyor asked LPN-K prior when doing R22's wound treatments did you do the treatments by yourself. LPN-K replied I never had any problem. Surveyor informed LPN-K R22's ADL care plan has an intervention which documents two people for bed mobility and this intervention was implemented prior to R22's fall. On 7/31/25, at 10:50 a.m., Surveyor asked Interim Director of Nursing (DON)-B if staff should follow a resident's plan of care. Interim DON-B replied yes. Surveyor informed Interim DON-B R22's ADL self care deficit care plan had an intervention prior to R22 fall on 6/24/25 to use two for bed mobility. Surveyor informed Interim DON-B LPN-K did not follow R22's plan of care. No additional information was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection.This has the potential to affect the 35 residents currently residing in the facility. * R22 has Stage 4 sacrum pressure injury. There was no EBP (enhanced barrier precaution) sign on or around R22's door and there was no PPE (personal protective equipment) cart observed outside R22's room. Staff was observed not wearing the appropriate PPE during personal cares. * R28 is on EBP. Staff was observed entering R28's room without appropriate PPE. * The facility experienced a COVID 19 outbreak starting on 11/12/24 until 12/3/24. There is no information as to residents and/or staff tested during this outbreak and no documentation as to type of isolation residents were placed in. According to the outbreak summary health department was notified on 11/12/24. There is no information if the health department requested any information or provided the facility with an recommendations and if recommendations were provided what were these recommendations. * There is not documentation of an effective water management program to prevent the spread of Legionella. Findings include: The facility's policy, titled Enhanced Barrier Precautions and reviewed/revised 8/8/24 under Policy documents It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs). Under Policy Explanation and Compliance Guidelines documents 2. Initiation of Enhanced Barrier Precautions documents b. An order for enhanced barrier precautions (in accordance with physician-approved standing orders) will be initiated for residents with any of the following: i. Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, peripherally inserted central catheters (PICCs), hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with MDRO. Ostomies, such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions. 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). 1.) R22 has a Stage 4 sacrum pressure injury. On 7/29/25, at 9:26 a.m., Surveyor observed there is not an enhanced barrier precaution sign on or around R22's room door. Surveyor noted R22 is listed on the roster matrix has having a Stage 4 pressure injury. R22's significant change MDS (minimum data set) assesses R22 as having short & long term memory problems and is severely impaired for cognitive skills for daily decision making. R22 is assessed as being dependent for toileting hygiene & chair/chair to bed transfer and substantial/maximal assistance for roll left and right. R22 has an indwelling urinary catheter and is always incontinent of bowel. On 7/30/25, at 9:39 a.m., Surveyor observed CNA-F & CNA-BB in R22's room wearing only gloves. CNA-F & CNA-BB do not have gowns on. CNA-F informed R22 they are going to reposition her and are going to put the head of her bed down. CNA-F removed the sheet and then CNA-F & CNA-BB removed pillows from under R22's lower legs and along each side of R22. CNA-F & CNA-BB repositioned R22 towards the right side of the mattress and then rolled R22 on the left side. CNA-F placed a pillow under R22's right upper side and then checked R22's incontinence product stating she's dry. A pillow was placed under R22's left arm and then CNA-F & CNA-BB repositioned R22 up in bed. CNA-F & CNA-BB placed pillows under R22's lower extremities and covered R22 with a sheet. CNA-F & CNA-BB removed their gloves, cleansed their hands, and left R22's room. On 7/31/25, at 1:04 p.m., during the infection control interview with Licensed Practical Nurse/Infection Preventionist (LPN/IP)-E and [NAME] President (VP) of Success-D Surveyor asked what is the criteria for placing a resident on Enhanced Barrier Precautions. LPN/IP-E informed Surveyor if the resident has a foley or wounds. LPN/IP-E informed Surveyor they place a sign on the door & PPE outside the room. Surveyor asked what is staff (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	expected to wear for a resident on Enhanced Barrier Precautions. LPN/IP-E replied gowns and gloves. On 7/31/25, at 1:20 p.m., Surveyor informed LPN/IP-E R22 has a Stage 4 pressure injury and inquired why there isn't an enhanced barrier precaution sign on R22's door. LPN/IP-E replied I don't know, can't answer that. Surveyor informed LPN/IP-E Surveyor hasn't observed an Enhanced Barrier Precaution sign during the survey on R22's door. Surveyor informed LPN/IP-E of the observation of CNA-F and CNA-BB repositioning & checking R22's incontinence product without the appropriate PPE on as they were not wearing gowns. 2.) R28's diagnoses include end stage renal disease. R28 receives hemodialysis two times weekly. R28's at risk for infection r/t (related to) indwelling medical devise tessio cath (catheter) for dialysis, stem cell and bone marrow transplant initiated 4/5/24 & revised 5/2/25 has an intervention of Enhanced barrier precautions when performing high-contact care activities. Initiated 4/5/24. R28's quarterly MDS (minimum data set) with an assessment reference date of 6/13/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R28 is assessed as being dependent for toileting hygiene, requires partial/moderate assistance for rolling left and right, is frequently incontinent of urine, and always incontinent of bowel. On 7/29/25, at 9:31 a.m. Surveyor observed on R28's room door there are two signs posted. One sign states please wear face mask before entering room. The second sign is an enhanced barrier precaution sign. Surveyor also observed a PPE (personal protective equipment) cart outside R28's room. Surveyor observed these signs throughout the survey on R28's room door. R28's Certified Nursing Assistant (CNA) Kardex as of 7/30/25 under the infection control section documents Enhanced barrier precautions when performing high contact care activities. On 7/30/25, at 11:41 a.m., Surveyor observed Certified Nursing Assistant (CNA)-F cleanse her hands and enter R28's without any PPE to answer R28's call light. On 7/30/25, at 11:49 a.m. Surveyor observed CNA-F leave R28's room holding garbage bags. Surveyor asked CNA-F what R28 wanted. CNA-F replied change her. On 7/30/25, at 1:09 p.m., Surveyor asked CNA-F if PPE is kept in the residents room. CNA-F informed Surveyor there is a cart out side the room and they place PPE on before entering. Surveyor asked CNA-F why she didn't place any PPE on before entering R28's room. CNA-F informed Surveyor she put on a mask as the resident has cancer and does not have to put on any other PPE for her. On 7/31/25, at 1:04 p.m., during the infection control interview with Licensed Practical Nurse/Infection Preventionist (LPN/IP)-E and [NAME] President (VP) of Success-D Surveyor asked what is the criteria for placing a resident on Enhanced Barrier Precautions. LPN/IP-E informed Surveyor if the resident has a foley or wounds. LPN/IP-E informed Surveyor they place a sign on the door & PPE outside the room. Surveyor asked what is staff expected to wear for a resident on Enhanced Barrier Precautions. LPN/IP-E replied gowns and gloves. On 7/31/25, at 1:20 p.m. Surveyor asked LPN/IP-E if the expectation for staff is to place on gloves and a gown before entering R28's room. LPN/IP-E replied yes and masks because that's her preference. Surveyor informed LPN/IP-E of the observation of CNA-F not placing PPE prior to entering R28's room. When CNA-F was exiting room Surveyor asked what R28 wanted and CNA-F informed Surveyor to be changed. The facility's policy titled, COVID 19 Prevention, Response and Reporting last reviewed/revised 5/18/23 under Policy documents It is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections. COVID 19 information will be reported through the proper channels as per federal stand and/or local health authority guidance. Under Policy Explanation and Compliance Guidelines documents 26. Responding to a newly identified SARS-CoV-2 infected HCP (health care personnel) or resident: a. The facility should defer to the recommendations of the jurisdiction's public health authority when performing an outbreak response to a known case. b. A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. c. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based approach (e.g. unit, floor or other specific area(s) of the facility) approach is preferred if all potential contact cannot be identified or managed with contact tracing or if contact (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	tracing fails to halt transmission. d. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. (See Coronavirus (COVID-19) Testing Policy for details). e. Empiric use of Transmission-Based Precautions residents and work restriction for HCP are not generally necessary unless resident meet the criteria as noted above (#13) or HCP meet criteria as noted in the Return to Work Criteria for Healthcare Personnel with COVID-19 Infection Exposure to COVID-19 Policy. 3.) On 7/31/25, at 1:37 p.m., during the infection control interview with Licensed Practical Nurse/Infection Preventionist (LPN/IP)-E and [NAME] President (VP) of Success-D Surveyor informed staff Surveyor had reviewed the one sheet COVID Outbreak Summary November 24 which was located in the infection control binder. Surveyor inquired if there is a line listing for staff and residents for this outbreak. Surveyor informed LPN/IP-E and VP of Success-D this summary indicates the health department was notified but does not indicate if the health department requested any information or if there were any recommendations for the facility. Also the summary outbreak indicates testing but there is no information as to who was tested and does not indicate type of isolation implemented. Surveyor also inquired if there were any other outbreaks. LPN/IP-E informed Surveyor she recently started being responsible for infection control and wouldn't have any information. VP of Success-D informed Surveyor she is pretty sure they tested both staff and residents as that's their protocol but will check. Surveyor asked LPN/IP-E and VP of Success to look for any information and get back to Surveyor. VP of Success-D informed Surveyor they will look for the information but the staff who would of been involved with the outbreak are no longer with the facility. On 7/31/25, at 1:51 p.m. VP of Success-D informed Surveyor she will have to ask Nursing Home Administrator (NHA)-A if there any other outbreaks. VP of Success-D informed Surveyor they do not have any testing information or any health department recommendations. VP of Success-D provided Surveyor with mapping and line listing for the November 2024 COVID outbreak. On 7/31/24, at 2;14 p.m., VP of Success-D informed Surveyor they had no other outbreaks. The facility's policy titled, Water Management Program Policy, and dated 7/16/22 under Policy documents It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) in the facility's water systems based on nationally accepted standards (e.g., ASHRAE (American Society of Heating, Refrigerating, and Air-Conditioning Engineers), CDC (Centers for Disease Control and Prevention), EPA (Environmental Protection Agency)). Under Policy Explanation and Compliance Guidelines documents 6. Control measures will be applied to address potential hazards at each control point. A variety of measure may be used, including physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. The measures shall be specified in the water management program action plan. The facility's policy titled, Legionella Surveillance Policy, and dated 10/24/22 under Policy documents It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections. Under Policy Explanation and Compliance Guidelines documents 4. Principles of Legionella transmission: b. Legionella grows best in water temperatures of 77 degrees F (Fahrenheit) - 108 degrees F, particularly in water that is not moving or that does not have enough disinfectant (i.e. pH 6.5-8.5) to kill germs. 4.) On 7/30/25, at 1:48 p.m., Surveyor reviewed the facility's water management plan updated 1/23/25. Surveyor noted this plan under section II. Describe your building water systems documents [Name of Facility] water system is delivered in a loop. The water enters the building in the laundry room and then sent into boiler room and there are two water softeners that the water goes through and four hot water heaters that heat the water to 155 degrees. It is then sent through a mixing valve and brought back down. The water is circulated in a loop (see diagram) to the different areas and is kept at a minimum of 110 degrees. The 155 degree water is sent to the kitchen and laundry room. The cold water is distributed in a loop to all areas. Under the section III. Areas where Legionella could grown and spread documents The areas identified (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with the best conditions for the growth of legionella are in the dead end branches. Most have been eliminated. Two of the areas have been identified as a janitors closet and med (medication) room that don't get regular use. These will be put on a regular schedule to make sure water is run through these pipes. The other is a large dead-end branch that comes off the main in the boiler room. This will be eliminated in the future. Under section IV Control measures and monitoring documents Daily water temperatures and hot water heater checks will be made by the Maintenance Department to ensure everything is working as it should. Water will be flushed through pipes in areas that are not used on a weekly basis. Water management will be reviewed after any additions or changes to the building. All residents with symptoms will be evaluated. On 7/31/25, at 2:32 p.m. Surveyor met with MD (Maintenance Director)-I to discuss the facility's water management program. Surveyor asked MD-I what he is doing for the dead legs identified. MD-I replied running them every day. Run for 10 seconds and turn then off that's about it. I use these aquacheck pool testers or Hydrion ph strips. Surveyor asked MD-I what is he looking for with these strips. MD-I replied everything should be in. Surveyor asked MD-I in regards to legionella what is he testing for. MD-I replied anything high, really anything bad, anything that can be high is alkalinity. MD-I showed Surveyor daily checking of residents rooms, whether they are occupied or not, including the janitor's closet and medication room. Surveyor asked MD-I what he's doing for the large dead end branch in the boiler room. MD-I replied I didn't know we considered that, let me read that [Surveyor's name]. Surveyor showed MD-I this documentation. MD-I stated unless that's been eliminated that doesn't sound familiar to me. The only thing I drain is my tanks for the boiler. I think we need to up date this that is what we need to do. Surveyor asked MD-I for documentation for water temperatures and when he uses the pool strips. On 8/4/25, at 10:49 a.m., Surveyor met with MD-I to discuss the water testing and dead leg drain provided to Surveyor. The water testing documentation provided to Surveyor is a one page form with months listed on the left side of the form and across the top are the following sections testing completed, testing results, issues noted and initials. Surveyor noted monthly from January through July 2025 for testing results document good and for issues noted there is a check mark. Surveyor asked MD-I what good means. MD-I replied well nothing high. I was just talking with [Name of] Nursing Home Administrator (NHA)-A we are going to have to do a picture of my sample of how it comes out. MD-I informed Surveyor this is for the test strip just to see if anything is too high, alkalinity, chlorine, all that kind of stuff. The dead leg drain is completed monthly and for issues noted documents good. Surveyor inquired about this dead leg drain completed. MD-I informed Surveyor that's the draining of my boiler tanks. Surveyor asked what good means. MD-I informed Surveyor good means no dirt, no sand, nothing bad coming out of the tanks. Surveyor informed MD-I Surveyor has not been provided with any water temperatures for resident's rooms and requested these. On 8/4/25, at 12:00 p.m., Surveyor reviewed the water temperature logs taken Monday to Friday. Surveyor noted the facility's water management plan indicates water should be kept at a minimum of 110 degrees. Surveyor noted during June 2025 there are 165 documented temperatures under 110 degrees. In July starting 7/7/25 to 7/31/25 there are 154 documented temperatures under 110 degrees. Surveyor asked MD-I when the water temperatures in resident's rooms were below 100 degrees did he do anything. MD-I replied no because the water temperature can be between 105 and 110 degrees. Surveyor informed MD-I the water management plan states the water should be a minimum of 110 degrees. Surveyor informed MD-I the water management plan also documents dead ends, like the one in the boiler room, should be flushed weekly. MD-I informed Surveyor that needs to be changed and stated it's a bad water management plan. No additional information was provided. 08/03/2025 2:36 PM diagnoses includes:end stage renal disease, asthma, fibromyalagia, gerd, insomonia, chronic migraine without aura, chronic myeloid leukemia, BCR/ABL positive not having achieved remission, morbid obesity, pleural effusion, quarterly mds 6/13/25bims 15, eating set up, toileting hygiene dependent, roll left and right parital moderate, chair/bed to chair dependent frequently incontinent of urine, always incontinent of bowel, yes for dialysis

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility did not ensure 1 of 5 Certified Nursing Assistants (CNA-S) received the required 12 hours of training per year. This has the potential to affect the total census of 35 residents.Findings include:On 7/29/25, Surveyor requested from Nursing Home Administrator (NHA)-A, evidence that CNA-S had completed the required 12 hours of annual training. Surveyor noted CNA-S was hired on 1/5/23.On 7/30/25, at 2:11 PM, NHA-A provided annual training that was completed by CNA-S. Surveyor noted to NHA-A that CNA-S completed 7.08 hours of training and did not receive the 12 hours of annual training as required. Surveyor notified NHA-A of concerns with CNA-A not receiving the required 12 hours of annual training. NHA-A acknowledged these concerns and stated NHA-A would investigate further.On 7/31/25, at 1:47 PM, NHA-A notified Surveyor she was unable to find additional training for CNA-S and acknowledged CNA-S did not complete the 12 hours of annual training required. Surveyor requested additional information if available. No additional information was provided.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 8 (R2, R6, R3, R23, R4, R8, R22, and R28) of 9 residents were notified of the reason for transfer/discharge and bed hold policy in writing to the resident and their representative and the rate to reserve the resident bed was not documented in the facility’s transfer/ bed hold notice forms. * R2 was transferred to the hospital on 5/12/2025 and 7/23/2025, a transfer notice and bed hold rate was not provided in writing to R2 and/or R2’s representative. * R6 was transferred to the hospital on 2/13/2025, a transfer notice and bed hold rate was not provided in writing to R6 and/ or R6’s representative. * R3 was transferred to the hospital on 3/20/2025, 5/4/2025, and 5/14/2025, a transfer notice and bed hold rate was not provided in writing to R3 and/ or R3’s representative. * R23 was transferred to the hospital on 6/4/2025, a transfer notice and bed hold rate was not provided in writing to R23 and/ or R23’s representative. * R4 was transferred to the hospital on 3/2/2025, 5/22/2025, and 5/27/2025, a transfer notice and bed hold rate was not provided in writing to R4 and/ or R4’s representative. * R8 was transferred to the hospital on 3/7/25, 4/8/25 & 5/1/25. A transfer notice and bed hold rate was not provided in writing to R8 and/ or R8’s representative. * R22 was transferred to the hospital on 6/11/2025, a transfer notice and bed hold rate was not provided in writing to R22 and/ or R22’s representative. * R28 was transferred to the hospital on 4/5/2025, a transfer notice and bed hold rate was not provided in writing to R28 and/ or R28’s representative. Findings include: The facility policy titled “Transfer and Discharge (including Against Medical Advise (AMA)” reviewed/ revised on 7/15/2022 documents: “Policy: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except as initiated by resident, necessary for the health and safety of resident or other individuals are endangered, or as otherwise permitted by applicable law. … 7. Emergency transfers/ Discharges … i. Provide a notice of the resident’s bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer.j. Provide transfer notice as soon as practicable to resident and representative. …” 1.) R2 was admitted to the facility on [DATE] and has diagnoses that include cognitive communication deficit, traumatic hemorrhage of cerebrum and concussion with loss of consciousness, chronic kidney disease stage 3, and bradycardia. R2 had an activate power of attorney (POA). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525415	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/12/2025, at 1600 (4:00 PM) in the progress notes nursing documented: Order received to send R2 to emergency room for evaluation for distended abdomen, nausea, and vomiting. R2’s POA called and notified of transfer to emergency room. R2 was readmitted to the facility 5/16/2025. On 7/23/2025, at 11:00 AM, in the progress notes nursing notes it documented: Resident in bathroom with aide, resident lethargic, diaphoretic, dark and loose stools on the toilet. … sent to emergency room for further evaluation. On 7/23/2024, at 18:02 (6:02 PM), in the progress notes nursing notes it documented: Call placed to hospital for follow up on R2 … R2 admitted to the hospital. … Bed hold initiated. Surveyor reviewed R2’s medical record and noted a verbal confirmation of transfer and bed hold was obtained form R2’s POA. There is no documentation that R2’s POA was provided a written copy of transfer notice or bed hold rate for R2’s hospitalization on 5/12/2025 and 7/23/2025. 2.) R6 was admitted to the facility on [DATE] and has diagnoses that include peripheral vascular disease, major depressive disorder, and dementia with psychotic disturbance. R6 has an activated power of attorney (POA). R6's nursing note documents that R6 was transferred to the hospital on 2/13/25. Surveyor was unable to locate any documentation that R6 or R6's representative was provided with a bed hold and or transfer notice as required. On 7/31/2025, at 10:12 AM, a Surveyor interviewed licensed practical nurse (LPN)-K what the process was when a resident is sent to the hospital for further evaluation. LPN-K stated if a residents POA is activated the nurse will typically call to get an ok to send the resident to the hospital. LPN-K stated there is a bed hold form that gets filled out when a verbal is provided from the POA and then the sheet goes to social services coordinator (SSC)-J, director of nursing (DON)-B, or nursing home administrator (NHA)-A. LPN-K was not aware what happened to the bed hold form after filled out. On 7/31/2025, at 10:22 AM, a Surveyor interviewed SSC-J who stated nursing staff handles the paperwork when a resident is sent to the hospital for further evaluation. SSC-J stated that at times SSC-J will assist with any paperwork but not on a routine basis. SSC-J replied no when asked if send resident representatives the bed hold policy. On 7/31/2025, at 10:30 AM, a Surveyor interviewed DON-B who stated nursing does the bed hold when a resident gets sent to the hospital and the bed holds are given to business office manager (BOM)-L. DON-B was not sure what staff provided the resident representative a transfer notice or bed hold policy in writing. On 7/31/2025, at 10:38 AM, a Surveyor interviewed BOM-L who stated BOM-L receives the bed holds and scans them into point click care (PCC, Healthcare software). BOM-L stated that is all that BOM-L does with the bed hold paperwork and replied no when asked if BOM-L gives the resident’s representative a bed hold/ transfer notice. On 7/31/2025, at 10:42 AM, a Surveyor interviewed NHA-A and asked what the process was for (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfer notice/ bed hold policy was for when a resident gets sent out to the hospital for further evaluation. NHA-A stated the nurse that is calling the resident’s representative should fill out the bed hold form after getting verbal confirmation that the representative would like to do a bed hold, then the bed hold form goes into medical records and is scanned into PCC. A Surveyor asked is a transfer reason and bed hold policy/ rate sent to the resident representative, NHA-A replied no, the facility does not mail them a transfer notice or bed hold policy/rate. On 7/31/2025, at 3:10 PM, Surveyor shared concerns with NHA-A, DON-B, DON-C, and vice president of success (VPS)-D when R2 was transferred to the hospital on 5/12/2025 and 7/23/2025, a transfer notice and bed hold rate was not provided in writing to R2 and/or R2’s representative. Surveyor also informed concern when R6 was transferred to the hospital on 2/13/2025, a transfer notice and bed hold rate was not provided in writing to R6 and/ or R6’s representative. 3.) R3 was admitted to the facility on [DATE], with diagnoses that include chronic kidney disease (advanced stage of kidney disease where the kidneys are not functioning properly), dependence on renal dialysis (a life sustaining treatment that replaces the function of failing kidneys by removing waste products and excess fluid from the blood), absence of right leg below the knee, absence of left leg below the knee, and history of venous thrombosis and emboli (history of blood clot). R3’s Electronic Medical Record (EMR) documents R3 was transferred to the hospital on 3/20/25, 5/4/25, and 5/14/25 for a change in condition. There is no documentation that R3 was provided a written copy of transfer notice or bed hold rate for R3’s hospitalizations on 3/20/25, 5/4/25, and 5/14/25. 4.) R23 was admitted to the facility on [DATE], with diagnoses that include hemiplegia (weakness affecting one side of the body), hemiparesis (weakness affecting one side of the body), weakness, aphasia (inability to properly communicate), chronic kidney disease (disease where the kidneys are not functioning properly), and history of Urinary Tract Infection (UTI (infection in the urine). R23’s EMR documents R23 was transferred to the hospital on 6/4/25 for a change in condition. There is no documentation that R23’s POA was provided a written copy of transfer notice or bed hold rate for R23’s hospitalizations on 6/4/25. On 7/31/2025, at 10:12 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-K about bed hold notice when a resident is transferred to the hospital. LPN-K stated the resident receives verbal notice then facility staff will fill out the bed hold form and gives to the Director of Nursing (DON), Nursing Home Administrator (NHA)-A, or Social Worker (SW). On 07/31/2025, at 10:22 AM, Surveyor interviewed Social Services Coordinator (SSC)-J regarding bed hold policy. SSC-J stated the bed hold policy is at the nurse’s station but stated it does not get sent to the resident or resident’s representative. On 07/31/2025, at 10:30 AM, Surveyor interviewed Interim DON-B regarding bed hold notices. Interim DON-B stated staff would ask the resident if the resident would like a bed hold, or the resident’s representative would give verbal consent. Interim DON-B stated the bed hold notices are given to the Business Office Manager (BOM). On 07/31/2025, at 10:38 AM, Surveyor interviewed BOM-L regarding bed hold notices who stated BOM-L only uploads the bed hold notice into the resident’s EMR and was unaware if 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
	525415	A. Building B. Wing	08/04/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hold notice was provided in writing to residents or resident’s representative. On 7/31/25, at 11:27 AM, NHA-A notified Surveyor the facility does not have bed hold notices and transfers for R3 and R23. Surveyor notified NHA-A of concerns with R3 and R23 not having bed hold and transfer notices. NHA-A acknowledged these concerns. 5.) R4 was admitted to the facility on [DATE] with diagnoses including idiopathic gout, cognitive communication deficit, DMT2, alcoholic cirrhosis of liver without ascites, hypertensive chronic kidney disease stage 5, end stage renal disease, dependence on renal dialysis, polyneuropathy, and depression. R4 is their own person. R4 was transferred and admitted to the hospital on [DATE], 5/22/25, 5/28/25, and 6/13/25. R4 readmitted to the facility on [DATE], 5/23/25, 5/31/25, and 6/28/25. Surveyor reviewed R4’s electronic medical record and could not locate a transfer and bed hold notice for R4’s hospitalizations on 3/2/25 or 5/22/25. Surveyor located a bed hold and notice of transfer document dated 5/27/25, however, there is no documentation of R4’s consent, and there is no documented bed hold rate. On 7/31/2025, at 10:12 AM, a Surveyor interviewed Licensed Practical Nurse (LPN)-K about bed hold notice when a resident is transferred to the hospital. LPN-K stated the resident receives verbal notice then staff fills out the bed hold form and gives to the Director of Nursing (DON), NHA, or social worker. On 07/31/2025, at 10:22 AM, a Surveyor interviewed Social Services Coordinator (SSC)-J regarding bed hold policy. SSC-J stated the bed hold policy is at the nurse’s station but stated it does not get sent to the resident or resident representative. On 07/31/2025, at 10:30 AM, a Surveyor interviewed Interim DON-B regarding bed hold notices. Interim DON-B stated staff would ask the resident if the resident would like a bed hold, or the Power of Attorney (POA) would give verbal consent, then the bed hold notices are given to the Business Office Manager (BOM). On 07/31/2025, at 10:38 AM, a surveyor interviewed BOM-L regarding bed hold notices. BOM-L replied BOM-L only uploads the bed hold notice into the resident’s electronic health record and was unaware if the bed hold notice was provided in writing to residents or resident representatives. On 07/31/2025, at 10:42 AM, a Surveyor interviewed NHA-A regarding the process on bed hold notices when a resident is transferred to the hospital. NHA-A stated typically the nurse on the floor would initiate the bed hold notice or would ask NHA-A or SSC-J for assistance, and if a resident’s POA is activated, staff would get verbal consent from POA. NHA-A stated the bed hold policy is part of the admission agreement, but no written notification is provided to the resident or the resident representative when transferred to the hospital. On 8/4/25, at 8:48 am, Nursing Home Administrator NHA-A confirmed no bed hold and notice of transfer documentation was found for R4’s hospitalizations on 3/2/25 or 5/22/25. NHA-A confirmed only the first page of the bed hold and notice of transfer document was located for R4’s hospitalization on 5/27/25 which does not include R4’s consent or bed hold rate information. NHA-A understood Surveyor’s concern with R4 not receiving a written bed hold notice No additional information was provided. (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6.) R8 was admitted to the facility on [DATE] with diagnoses that include bladder cancer and anemia. Surveyor reviewed R8’s electronic medical record. R8 was discharged to the hospital for evaluation on 3/7/25, 4/8/25 and 5/1/25. There is no documentation that R8’s POA was provided a written copy of transfer notice or bed hold rate for R8’s hospitalizations on 3/7/23, 4/8/25 and 5/1/25. On 7/31/2025, at 10:12 AM, a Surveyor interviewed LPN-K what the process was when a resident is sent to the hospital for further evaluation. LPN-K stated if a residents POA is activated the nurse will typically call to get an ok to send the resident to the hospital. LPN-K stated there is a bed hold form that gets filled out when a verbal is provided from the POA and then the sheet goes to SSC-J, DON-B , or NHA-A. LPN-K was not aware what happened to the bed hold form after filled out. On 7/31/2025, at 10:22 AM, a Surveyor interviewed SSC-J who stated nursing handles the paperwork when a resident is sent to the hospital for further evaluation. SSC-J stated that at times SSC-J will assist with any paperwork but not on a routine basis. SSC-J replied no when asked if send resident representatives the bed hold policy. On 7/31/2025, at 10:30 AM, a Surveyor interviewed DON-B who stated nursing does the bed hold when a resident gets sent to the hospital and the bed holds are given to business office manager (BOM)-L. DON-B was not sure what staff provided the resident representative a transfer notice or bed hold policy in writing. On 7/31/2025, at 10:38 AM, a Surveyor interviewed BOM-L who stated BOM-L receives the bed holds and scans them into point click care (PCC, Healthcare software). BOM-L stated that is all that BOM-L does with the bed hold paperwork and replied no when asked if BOM-L gives the resident’s representative a bed hold/ transfer notice. On 7/31/2025, at 10:42 AM, a Surveyor interviewed NHA-A and asked what the process was for transfer notice/ bed hold policy was for when a resident gets sent out to the hospital for further evaluation. NHA-A stated the nurse that is calling the resident’s representative should fill out the bed hold form after getting verbal confirmation that the representative would like to do a bed hold, then the bed hold form goes into medical records and is scanned into PCC. A Surveyor asked is a transfer reason and bed hold policy/ rate sent to the resident representative, NHA-A replied no, the facility does not mail them a transfer notice or bed hold policy/rate. On 8/4/25 at 11:00 AM, Surveyor shared concerns with NHA-A and vice president of success (VPS)-D when R8 was transferred to the hospital on 3/7/25, 4/8/25 and 5/1/25 that a transfer notice and bed hold rate was not provided in writing to R8 and/or R8’s representative. No additional information was provided by the facility at this time. 7.) R22's diagnoses includes hypertension (high blood pressure), aphasia (language disorder that affects a person's ability to communicate) following cerebral infarction (condition where blood flow to the brain is disrupted leading to the death of brain tissue, also known as ischemic stroke), morbid obesity, seizure, and unspecified psychosis (mental health condition characterized by a loss of contact with reality). R22’s nurses note dated 6/11/25 documents On 6/10 at approximately 1745 (5:45 p.m.), writer was called to res (resident) room by floor nurse regarding res having seizure-like activity. writer (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entered res room and observed res lying in bed with jerking movement noted, eyes opened starring, writer asked staff to call 911, floor nurse was asked to obtain res vitals and to stay with res ensuring res safety, writer placed a call to POA (Power of Attorney), left a message to call facility for an update, writer printed res face sheet/med list/ code status, writer gave all documents to EMT (emergency medical technician) staff, called placed to [Name] Community Memorial Hospital Menomonee Falls, triage nurse received a report regarding res current status, res left facility approximately 1800 (6:00 p.m.) in route to [hospital initials], [Name] NP (Nurse Practitioner) gave verbal order to send res out for further eval (evaluation), writer will f/u (follow up) with hospital for an update regarding res current status R22 was readmitted to the facility on [DATE]. R22’s Wisconsin Bed Hold and Notice of Transfer form for date of transfer 6/10/25 is checked for the transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility, including hospital transfer. Under the section Bed Hold Request Form phone confirmation has been completed with a date of 6/11/25. Surveyor was unable to locate in R22’s medical record evidence R22 and R22’s POA were provided in writing a bed hold policy and reason for transfer for R22’s discharge on [DATE]. 8.) R28’s diagnoses includes end stage renal disease, chronic myeloid leukemia (cancer), pleural effusion (accumulation of excessive fluid in the pleural space that surrounds each lung), and bradycardia (slow heart rate). R28’s nurses note dated 4/5/25 documents Call from hospital doctor with results of resident blood culture and is positive for bacteria. Orders received to send to [Hospital name] main campus for admission to room [ROOM NUMBER]C fac Bed 4. Mother [Name] is aware of transfer. R28 was readmitted to the facility on [DATE]. Surveyor reviewed R28’s medical record and was unable to locate a transfer notice and bed hold policy was provided to R28 and/or R28’s representative. On 7/31/25, at 12:33 p.m., [NAME] President (VP) of Success-AA informed Surveyor they were unable to locate the bed hold policy and transfer notice for R28. No additional information was provided.

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	525415	A. Building B. Wing	08/04/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure MDS (minimum data set) assessments were coded correctly for 4 (R22, R28, R5, & R3) of 13 reviewed for MDS accuracy. R22's significant change MDS with an assessment reference date of 6/23/25 was incorrectly coded for PASRR (preadmission screening and resident review), pressure injuries, and insulin. R28's quarterly MDS with an assessment reference date of 6/13/25 was incorrectly coded for antibiotic. R5's Significant Change in Status Minimum Data Set (MDS) with an assessment reference date of 5/20/25, did not accurately reflect that R5 has current tobacco use and antipsychotic medication. R3's quarterly MDS with an assessment reference date of 7/2/25 was incorrectly coded for dialysis. Findings include: The facility's policy titled, Conducting an Accurate Resident Assessment and dated 4/28/25 under Policy documents The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. On 7/31/25, at 9:04 a.m., Surveyor asked Senior Director of Clinical Reimbursement (SDCR)-G if Licensed Practical Nurse/Minimum Data Set Assessment Coordinator (LPN/MDS Assessment Coordinator)-H works at the facility or is remote. SDCR-G replied both and explained this facility is smaller and can't support a full time person. LPN/MDS Assessment Coordinator-H is in the building onsite two days a week otherwise is available by email or phone and if she is not available they contact her. SDCR-G explained LPN/MDS Assessment Coordinator-H calls in at least one day a week, goes into PCC (PointClickCare), the electronic medical record system, daily to see if there are any changes regarding new admissions, discharges, changes in payor, hospice and looks at the utilization review logs for residents that are skilled. Surveyor asked when LPN/MDS Assessment Coordinator-H is completing resident's MDS does she complete the MDS onsite. SDCR-G replied both. SDCR-G explained all documentation is uploaded and if the MDS is completed offsite and is unsure of documentation, she will notify the center to get clarification so they can be as accurate as they can. SDCR-G explained LPN/MDS Assessment Coordinator-H reviews the documentation in the record, any hospital paper work, labs, nurses notes, etc everything they have available. SDCR-G informed Surveyor if LPN/MDS Assessment Coordinator-H is in the facility she will assess the resident herself, she goes and talks with the resident and does a physical assessment. Surveyor asked SDCR-G if the assessments are completed by a LPN how does she ensure the assessments are accurate. SDCR-G replied my job is not to ensure that the coding is correct, I'm signing that it is complete. The RN signature is not for accuracy. On 7/31/25, at 9:38 a.m., Surveyor asked SDCR-G why are there so many items miscoded in the MDS. SDCR-G replied I don't know and explained it's very unusual to have that many. SDCR-G informed Surveyor she will get these modified & corrected and stated it is concerning. 1.) R22's diagnoses includes unspecified psychosis (a mental disorder characterized by a (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disconnection from reality), anxiety disorder, major depressive disorder and diabetes mellitus (high blood sugar). R22's Level II Referral Summary with a referral date of 4/1/25 for the question does the data about the person meet the federal definition of a serious mental illness documents yes. On 7/30/25, at 12:24 p.m., Surveyor reviewed R22's significant change MDS (minimum data set) with an assessment reference date of 6/23/25. Section 1500 Preadmission Screening and Resident Review (PASRR) for the question is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, no is coded. On 7/31/25 at 9:13 a.m. Surveyor asked Senior Director of Clinical Reimbursement (SDCR)-G why no was answered for the question is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. SDCR-G informed Surveyor should of been marked yes so that was coded incorrectly. SDCR-G stated I will modify and correct that by the way. R22's nurses note dated 6/17/25 at 13:30 (1:30 p.m.) by Licensed Practical Nurse (LPN)-K documents Returned on stretcher via ambulance at this time from [Hospital Name]. Alert at baseline. Skin warm an dry color WNL (within normal limits). Offers no s/sx (signs/symptoms) of pain or discomfort. Lungs clear, no SOB (shortness of breath) noted with respirations even and unlabored. Abdomen is soft with bowel sounds hypoactive. Per RN (Registered Nurse) report resident has not had a BM (bowel movement) in 7 days. Writer did rectal check with BM noted. MOM (milk of magnesia) given and took well with no complaints. Bruises noted to Bilateral arms/hands on left hand top of, right hand top of hand and near thumb. Right antecubital bruising noted post IV (intravenous) site. Stage 2 wound left buttock measuring 1x2.2, stage 3 to coccyx measuring 1.1x1.2x0.2. Redness to groin, redness under left breast. Nystatin applied after soap and water wash. General diet thin liquids to continue. Takes medications crush in applesauce or pudding. [Name] Hospice to come in this afternoon to admit into services, complete medications and to see resident. The pressure injury weekly tracker dated 6/17/25 which documents for site 53) sacrum, type is pressure, length 1.2, width 1.3, depth 0.4, & Stage 3. The pressure weekly tracker dated 6/17/25 which documents for site 31) Right buttocks, type Pressure, length 1.0, width 2.2 depth 0.1 and Stage 2. The pressure weekly tracker dated 6/19/25 which documents for site 31) sacrum, type is pressure, length 2, width 2, depth 0.1, and Stage is 3. The weekly pressure injury tracker dated 6/19/25 which documents for site 31) Right buttocks, type is pressure, length 1.5, width 3, depth 0.1 and Stage 2. R22's significant change MDS with an assessment reference date of 6/23/25 under section M0100 Determination of Pressure Ulcer/Injury Risk for the question Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device, no is answered. Under section M0210 Unhealed Pressure Ulcers/Injuries for the question does this resident have one or more unhealed pressure ulcers/injuries no is answered. On 7/31/25, at 9:15 a.m., Surveyor informed SDCR-G R22's medical record includes pressure injury weekly trackers dated 6/17/25 & 6/19/25 which documents stage 3 sacrum pressure injury and stage 2 right buttocks and nurses notes which reference R22's pressure injuries but the significant change (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS is coded as R22 not having any pressure injuries. SDCR-G reviewed R22's electronic medical record and informed Surveyor the MDS should have been marked as a stage 2 & stage 3 as the documentation does support this. SDCR-G informed Surveyor the MDS was incorrect. Surveyor reviewed R22's physician orders and was unable to locate an order for insulin. Surveyor also reviewed R22's June 2025 MAR (medication administration record) and was unable to locate documentation insulin was administered to R22. R22's significant change MDS with an assessment reference date of 6/23/25 under section N0350 Insulin for A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days, 7 is coded. On 7/31/25, at 9:17 a.m., Surveyor informed SDCR-G Surveyor reviewed R22's physician orders and June 2025 MAR and was unable to locate R22 received insulin. Surveyor informed SDCR-G R22's significant change MDS is coded as having received 7days for insulin injections. SDCR-G stated let me go back and pull her MAR. Surveyor asked SDCR-G if she noted insulin for R22. SDCR-G replied no. R22's significant change MDS was incorrectly coded for insulin injections. 2.) R28's quarterly MDS (minimum data set) with an assessment reference date of 6/13/25 under section N0415 High-risk Drug Classes: Use and Indication for F. Antibiotic is checked for is taking and indications noted. According to the RAI manual for is taking, check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. Surveyor reviewed R28's physician orders and noted a order dated 4/12/25 for Linezolid 600 mg (milligrams) every day until 4/26/25. Surveyor was unable to locate an antibiotic order after R28's 4/12/25 order. On 7/31/25, at 9:19 a.m., Surveyor informed SDCR-G R28's quarterly MDS with an assessment reference date of 6/13/25 is marked yes for an antibiotic. Surveyor noted an antibiotic order 4/12/25 but was unable to locate another antibiotic order. SDCR-G reviewed R28's electronic record and informed Surveyor there was an antiviral not antibiotic. SDCR-G informed Surveyor the MDS is miscoded. No additional information was provided. 3.) R5 was admitted to the facility on [DATE] with pertinent diagnoses that include malignant neoplasm of rectum (a cancerous tumor in the rectum, the final section of the large intestine), bipolar disorder (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression), and post-traumatic stress disorder (a mental health condition that can develop after a person experiences or witnesses a traumatic event, such as a natural disaster, accident, or act of violence). R5's Significant Change in Status Minimum Data Set (MDS) with an assessment reference date of 5/20/25, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R5 is cognitively intact. The MDS documents R5 is understood and understands others. R5’s Patient Depression Questionnaire (PHQ-9) score was 01 indicating no depressive symptoms. R5 exhibited no behaviors during the look back period of the MDS assessment. (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5’s care plan for “tobacco use r/t (related to) smoking” initiated on 5/12/25, has the following interventions that were initiated on 5/12/25: •Determine if resident has desire to quit. •Educate on facility policy. •Educate resident/family on risks and health effects of tobacco use. •If resident would like to quit, contact provider to prescribe cessation aides. •Provide tobacco cessation information/assistance/resources. •Provide tobacco cessation material(s).” R5’s “Nicotine Assessment” forms were completed on 4/27/25 and 7/28/25 by the facility and R5 was deemed safe to smoke without supervision. R5’s Significant Change in Status MDS for “Current Tobacco Use” indicated “no” and was signed on May 22, 2025, at 11:32:53 AM. Surveyor noted a smoking care plan was initiated and a “Nicotine Assessment” was completed prior to the MDS being completed. On 7/31/25, at 2:43 pm, Surveyor interviewed Senior Director of Clinical Reimbursement-G and was told they would look at the MDS coding and get back to Surveyor. On 7/31/25, at 2:50pm, Senior Director of Clinical Reimbursement-G informed Surveyor that R5 had a care plan in place for smoking and “Nicotine Assessments” were done in April and July. A “Nicotine Assessment” should have been done with the Significant Change in Status MDS. Had Senior Director of Clinical Reimbursement-G done the MDS, they probably would have marked R5 as a smoker based on the assessment and care plan in place. Senior Director of Clinical Reimbursement-G stated they will do a correction MDS. On 7/31/25, during the end of day meeting, Surveyor let the facility representatives know the concern that R5’s 5/20/25 Significant Change in Status MDS was coded incorrectly indicating that R5 did not use tobacco. No additional information was provided regarding R5’s MDS being coded incorrectly for tobacco use. R5's Significant Change in Status Minimum Data Set (MDS) with an assessment reference date of 5/20/25, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R5 is cognitively intact. The MDS documents R5 is understood and understands others. R5’s Patient Depression Questionnaire (PHQ-9) score was 01 indicating no depressive symptoms. R5 exhibited no behaviors during the look back period of the MDS assessment. R5’s care plan for “at risk for adverse effects r/t (related to) use of antipsychotic medication” initiated on 5/12/25, has the following interventions that were initiated on 5/12/25: • Antipsychotic Medication: Report adverse effects such as dry mouth, constipation, blurred (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea, vomiting, lethargy, drooling, EPS (Extrapyramidal symptoms) symptoms (tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue). •Notify MD (medical doctor) of decline in ADL (activities of daily living) ability or mood/behavior related to a dosage change. •Provide resident teaching of risks and benefits of medications as needed. •Psychiatrist consult and follow up as needed. •Reduce environmental noise/distractions to facilitate sleep. •Sleep assessment per facility guidelines (Upon admission, initiation of, change of, quarterly, and PRN (as needed)). •TARGET BEHAVIOR 1: RuminatingIntervention #1: Let resident ventIntervention #2: Letting resident express themselves through art and provide art suppliesIntervention #3: offer resident a change of scenery to get mind off of things.” R5’s “Psychosocial Assessment” and “Mood Interview” forms were completed on 5/20/25 by the facility. R5’s physician order dated 5/10/25 documents “Seroquel oral tablet 100mg. Give 2 tablet by mouth at bedtime related to bipolar disorder…”. Surveyor noted R5 was on Lamotrigine 25 mg before starting the Seroquel. The Seroquel was increased by 50mg every 3 days from 5/1/25 until the current dose was reached on 5/10/25. R5’s Significant Change in Status MDS for “antipsychotic medication” indicated “no” and was signed on May 22, 2025, at 11:32:53 AM. Surveyor noted an antipsychotic care plan was initiated before the assessment, R5 had a physician order for Seroquel, and the “Psychosocial Assessment” and “Mood Interview” were completed in relation to the MDS. On 7/31/25, at 2:43 pm, Surveyor interviewed Senior Director of Clinical Reimbursement-G and was told they would look at the MDS coding and get back to Surveyor. On 7/31/25, at 2:50pm, Senior Director of Clinical Reimbursement-G informed Surveyor that R5 should have been marked yes for antipsychotic on the MDS. Senior Director of Clinical Reimbursement-G stated they will do a correction MDS. On 7/31/25, during the end of day meeting, Surveyor let the facility representatives know the concern that R5’s 5/20/25 Significant Change in Status MDS was coded incorrectly indicating that R5 did not take an antipsychotic medication. No additional information was provided regarding R5’s MDS being coded incorrectly for antipsychotic medication use. 4.) R3 was admitted to the facility on [DATE], with diagnoses that include chronic kidney disease (advanced stage of kidney disease where the kidneys are not functioning properly) and dependence (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on renal dialysis (a life sustaining treatment that replaces the function of failing kidneys by removing waste products and excess fluid from the blood). On 07/29/2025, at 8:59 AM, Surveyor reviewed R3’s Quarterly Minimum Data Set (MDS) dated [DATE]. Section O0100 Dialysis for the question is the resident currently receiving dialysis treatments, no is coded. On 7/31/25, at 9:04 a.m., Surveyor asked Senior Director of Clinical Reimbursement (SDCR)-G if Licensed Practical Nurse/Minimum Data Set Assessment Coordinator (LPN/MDS Assessment Coordinator)-H works at the facility or is remote. SDCR-G replied both and explained this facility is smaller and can't support a full-time person. LPN/MDS Assessment Coordinator-H is in the building onsite two days a week otherwise is available by email or phone and if she is not available, they contact her. SDCR-G explained LPN/MDS Assessment Coordinator-H calls in at least one day a week, goes into PCC (PointClickCare), the electronic medical record system, daily to see if there are any changes regarding new admissions, discharges, changes in payor, hospice and looks at the utilization review logs for residents that are skilled. Surveyor asked when LPN/MDS Assessment Coordinator-H is completing resident's MDS does she complete the MDS onsite. SDCR-G replied both. SDCR-G explained all documentation is uploaded and if the MDS is completed offsite and is unsure of documentation, she will notify the center to get clarification so they can be as accurate as they can. SDCR-G explained LPN/MDS Assessment Coordinator-H reviews the documentation in the record, any hospital paperwork, labs, nurses notes, etc everything they have available. SDCR-G informed Surveyor if LPN/MDS Assessment Coordinator-H is in the facility she will assess the resident herself, she goes and talks with the resident and does a physical assessment. Surveyor asked SDCR-G if the assessments are completed by a LPN how does she ensure the assessments are accurate. SDCR-G replied my job is not to ensure that the coding is correct, I'm signing that it is complete. The RN signature is not for accuracy. Surveyor then asked SDCR-G if LPN/MDS Assessment Coordinator-H is responsible for filling out section O on the MDS. SDCR-G replied yes part of it and clarified LPN/MDS Assessment Coordinator-H is responsible for filling out all of section O except the therapy section. Surveyor asked SDCR-G why dialysis was marked no on R3’s Quarterly MDS dated [DATE]. SDCR-G stated it should have been marked yes and SDCR-G stated she will get it corrected. On 7/31/25, at 1:52 PM, Surveyor notified Nursing Home Administrator (NHA)-A of concerns with R3’s Quarterly MDS dated [DATE], as discussed with SDCR-G. NHA-A acknowledged these concerns. Surveyor requested additional information if available. None was provided.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility did not ensure that it did not employ individuals who were found guilty of abuse, neglect, exploitation or mistreatment by failing to conduct and maintain completed criminal background checks for 5 of 8 Certified Nursing Assistant (CNA) (CNA-S, CNA-T, CNA-U, LPN-V, and RN-W) facility staff reviewed.Findings include:On 7/30/25, Surveyor reviewed facility employee files to ensure completed background checks.Certified Nursing Assistant (CNA)-S, with a hire date of 1/5/23, was noted to not have a Department of Justice (DOJ) background check completed until 11/21/23, a Background Information Disclosure (BID) check completed until 10/14/23 and an Integrated Background Information System Letter (IBIS) check completed until 11/21/23.CNA-T, with a hire date of 5/16/23, was noted to not have both a DOJ and IBIS background check completed until 4/18/24.Licensed Practical Nurse (LPN)-V, with a hire date of 8/15/23, was noted to not have a BID background check completed until 8/1/24, DOJ and IBIS background check completed until 4/10/25.Registered Nurse (RN)-W, with a hire date of 9/13/24, was noted to not have a BID background check completed until 6/27/25.On 7/30/25, at 2:11 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Business Office Manager (BOM)- L. Surveyor asked the facility process for completing background checks. BOM-L states the BID, DOJ, and IBIS are completed after a new employee is given an offer letter of employment. BOM-L states the employee cannot work prior to the background check process is completed, which includes completion of the BID, DOJ, and IBIS.NHA-A stated Corporate performed audits of background checks on 6/25/25. Surveyor notified NHA-A and BOM-L of concerns with the above findings. NHA-A and BOM-L acknowledged these concerns. Surveyor requested additional information if available. No additional information was provided.

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	525415	A. Building B. Wing	08/04/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents with a pressure injury or at risk for pressure injuries received necessary treatment and services, consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 2 (R22 & R2) of 2 Residents reviewed for pressure injuries. *R22 was readmitted to the facility on [DATE] with a right buttocks & sacrum pressure injury. The facility did not comprehensively assess R22's right buttocks pressure injury on admission as there are no percentages of the wound bed listed in R22's admission assessment. R22's right buttock pressure injury was incorrectly staged on 6/17/25, 6/19/25, 6/27/25, & 7/3/25. On 6/27/25, R22's sacrum pressure injury was incorrectly staged as Stage 4. The assessment documents a depth of 0.1 and the wound bed is 50% slough and 50% granulation. This assessment does not document any exposed bone, tendon, or muscle and there is no tunneling or undermining. *R2 did not have a comprehensive wound assessment done on R2’s mid thoracic upper back pressure injury when admitted to the facility on [DATE] until 5/9/2025. R2 did not have a comprehensive wound assessment done on R2’s mid thoracic upper back pressure injury when R2 readmitted into the facility on 5/16/2025 until 5/23/2025. Findings include: The facility's policy dated as reviewed/revised 7/20/22 and titled, Pressure Injuries and Non pressure injuries documents: This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. The following protocols should guide prevention and treatment efforts, unless specified by a physician otherwise. Under the Pressure Injury Staging for Stage 2 Pressure Injury section it documents: Partial thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Under the Policy Explanation and Compliance Guidelines section it documents: 1. Upon admission: a. A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the Admission/readmission Evaluation UDA. If skin is compromised: i. If pressure injury: initiate the Pressure Injury Weekly Tracker UDA - one per wound. (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R22's diagnoses includes hypertension (high blood pressure), aphasia (language disorder that affects a person's ability to communicate) following cerebral infarction (condition where blood flow to the brain is disrupted leading to the death of brain tissue, also known as ischemic stroke), morbid obesity, seizure, and unspecified psychosis (mental health condition characterized by a loss of contact with reality). R22's nurses note dated 6/17/25 at 1330 (1:30 p.m.) by Licensed Practical Nurse (LPN)-K documents: Returned on stretcher via ambulance at this time from [Hospital Name]. Alert at baseline. Skin warm an dry color WNL (within normal limits). Offers no s/sx (signs/symptoms) of pain or discomfort. Lungs clear, no SOB (shortness of breath) noted with respirations even and unlabored. Abdomen is soft with bowel sounds hypoactive. Per RN (Registered Nurse) report resident has not had a BM (bowel movement) in 7 days. Writer did rectal check with BM noted. MOM (milk of magnesia) given and took well with no complaints. Bruises noted to Bilateral arms/hands on left hand top of, right hand top of hand and near thumb. Right antecubital bruising noted post IV (intravenous) site. Stage 2 wound left buttock measuring 1x2.2, stage 3 to coccyx measuring 1.1x1.2x0.2. Redness to groin, redness under left breast. Nystatin applied after soap and water wash. General diet thin liquids to continue. Takes medications crush in applesauce or pudding. [Name] Hospice to come in this afternoon to admit into services, complete medications and to see resident. R22's nurses note dated 6/17/25 at 17:16 (5:16 PM) written by Interim Director of Nursing (DON)-B documents: Skin impairments are present, complete appropriate weekly tracker UDA. admission Wounds 6/17: tx (treatment) in place, CP (care plan), updated, res (resident) added to Nurse Practitioner (NP)-N wound nurse roster. The pressure injury weekly tracker dated 6/17/25 for site documents: 31) right buttock, type is pressure, length is 1.0, width 2.2, and depth 0.1. Stage is II (2), tissue type documents granulation, drainage is serosanguinous light and for the question verbalizes or demonstrates signs of pain related to wound no is answered, This assessment was completed by Interim DON-B. Surveyor noted there is no percentage for wound bed and Stage 2 pressure injury does not have granulation tissue. The pressure injury tracker dated 6/19/25 for site documents: 31) right buttocks, type is pressure, length is 1.5, width 3, depth is 0.1 and stage is II (2). Tissue type documents granulation, drainage is serosanguinous, & amount of drainage is light. This assessment was completed by Registered Nurse (RN)-M. Surveyor noted there is no percentage for wound bed and Stage 2 pressure injury does not have granulation tissue. Wound NP-N wound evaluation and management summary dated 6/19/25 for right buttocks documents: Etiology- pressure, MDS (minimum data set) 3.0 Stage documents 2. Wound size (L (length) x (times) W (width) x D (depth)) documents 1.5 x 3 x 0.1 cm (centimeters). Exudate is light sero sanguinous and dermis documents open areas with exposed dermis. R22's pressure injury weekly tracker dated 6/27/25 documents: Site 31) right buttocks, type is pressure, length 5, width 2.5, depth is 0.2 and stage is II (2). Tissue type is granulation. Granulation % (percentage) documents 50 and Slough % documents 52. Drainage is serosanguinous and amount of drainage documents moderate. This assessment was completed by Interim DON-B. (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted R22's right buttocks pressure injury was incorrectly staged and should have been staged as unstageable. Wound NP-N wound evaluation and management summary dated 6/27/25 for right buttocks documents: Etiology- pressure, MDS 3.0 Stage documents 2. Wound size is 5 x 2.5 x 0.1 cm. Exudate is moderate sero-sanguinous and dermis documents open areas with exposed dermis. Surveyor noted the facility's pressure injury weekly tracker and Wound NP-N's assessment do not match. R22's pressure injury weekly tracker dated 7/3/25 documents: Site 31) right buttocks, type is pressure, length 6, width 4 depth 0.1 Stage III (3). Tissue type is slough, slough % documents 100%. Drainage is serosanguinous and amount of drainage documents moderate. This assessment was completed by Interim DON-B. Wound NP-N 'swound evaluation and management summary dated 7/3/25 documents: Right buttocks, Etiology- pressure, MDS 3.0 Stage documents 3. Wound size is 6 x 4 x 0.1 cm. Exudate is moderate sero-sanguinous and slough documents 100%. Surveyor noted the facility's pressure injury weekly tracker and Wound NP-N's assessment incorrectly stages R22's right buttocks pressure injury. 100% slough should be staged as Unstageable. R22's right buttocks pressure injury healed on 7/10/25. On 8/4/25, at 9:11 a.m., Surveyor asked Interim DON-B if a stage 2 pressure injury has granulation tissue. Interim DON-B replied usually no but I go according to the notes from Wound NP-N. Surveyor informed Interim DON-B her assessment dated [DATE] & 6/19/25 does not indicate the percentages of the wound bed. Interim DON-B informed Surveyor she refrains from percentages until the wound NP sees the resident and goes by her. Interim DON-B stated not really my area of expertise. The pressure injury weekly tracker dated 6/17/25 documents: 31) sacrum, type is pressure, length is 1.2, width 1.3, and depth 0.4. Stage is III (3), tissue type documents granulation and drainage is serosanguinous, and amount of drainage is moderate. This assessment was completed by Interim DON-B. Surveyor noted there is no percentage for wound bed. The pressure injury weekly tracker dated 6/19/25 documents: 31) sacrum, type is pressure, length is 2, width 2 and depth 0.1. Stage is III (3), tissue type documents granulation, drainage is serosanguinous and amount of drainage is light. This assessment was completed by RN-M. Surveyor noted there is no percentage for wound bed. Wound NP-N's wound evaluation and management summary dated 6/19/25 for R22's Sacrum documents: Etiology pressure, MDS 3.0 Stage documents 3. Wound size (L (length) x (times) W (width) x D (depth)) is 2 x 2x x 0.1 cm. Exudate is light sero-sanguinous, slough documents 10% and granulation tissue is 90%. Reason for no sharp debridement documents Chronic stable wound with insignificant amount of necrotic tissue and no signs of infection. Monitor closely for now. (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pressure injury weekly tracker dated 6/27/25 documents: 31) sacrum, type is pressure, length is 3.5, width 2.8, and depth 0.1. Stage is IV (4), tissue type documents granulation, granulation % documents 50 and slough % documents 52. For presence of exposed structures: bone, tendon, muscle. None is checked. Drainage is serosanguinous, and amount of drainage is moderate. Tunneling or undermining is no. This assessment was completed by Interim DON-B. Wound NP-N's sacrum wound evaluation and management summary dated 6/27/25 documents: etiology pressure, for MDS 3.0 Stage documents 4. Wound size is 3.5 x 2.8 x 0.1 cm. Exudate is moderate sero-sanguinous, slough documents 50% and granulation tissue is 50%. R22's sacrum pressure injury was surgical debrided. Surveyor noted further weekly assessment for R22's sacrum stage 4 pressure injury. On 8/4/25, at 9:14 a.m. Surveyor asked Interim DON-B how it was determined R22's sacrum pressure injury on 6/27/25 was a Stage 4. Surveyor informed Interim DON-B the wound bed was 50% granulation & 50% slough, documentation doesn't indicate presence of bone, tendon or muscle and there was no tunneling or undermining. Interim DON-B informed Surveyor R22's pressure injury looked worse and this is the stage Wound NP-N stage it at. Interim DON-B informed Surveyor she takes Wound NP-N's information and then does the wound tracker. On 8/4/25, at 9:27 a.m. Surveyor telephoned Wound NP-N and left a message asking for a return call. Wound NP-N did not return Surveyor's call. No additional information was provided. 2.) R2 was admitted to the facility on [DATE] and has diagnoses that include fractured superior rim of left pubis, cognitive communication deficit, weakness, traumatic hemorrhage of cerebrum with loss of consciousness and concussion, and pressure ulcer of the back. R2’s admission Minimum Data Set (MDS) dated [DATE] indicated R2 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15. The facility assessed R2 to be a high risk for pressure injury risk with a Braden score of 16.0. R2 was documented to have an unstageable pressure injury to the mid upper back on admission. R2’s hospital discharge paperwork had the following documented R2 presented to the hospital on 4/26/2025 after a fall at home. Per R2’s family member it is unknown how long R2 was on the floor. Wound assessments completed in the hospital documents the following skin assessments for R2: …4/28/2025:1. Spine, unstageable pressure injury- full thickness, 2.5 X 3.3 X unable to determine (UTD) (length X width X depth)-base is 100% yellow slough (dead, moist, stringy/fibrous tissue on wound surface), light amount of serous (clear, watery fluid) drainage- Peri wound (around the wound) with erythema (redness) … 5/1/2025:1. Spine, unstageable pressure injury- Full thickness, 2.5 X 2.5 X UTD- base is 100% yellow slough, light amount of serous drainage- peri wound with erythema Surveyor reviewed R2’s admission skin assessment dated [DATE] that documented:1. Vertebra (mid-upper back), unstageable pressure injury- 3.0 X 2.6 On 5/9/2025 there was a VOHRA wound assessment note that documented:1. Mid- thoracic upper (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525415	A. Building B. Wing	08/04/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back, Stage 4 Pressure injury- Full thickness, 3 X 3 X not measurable- 100% slough, moderate purulent drainage- Additional note: post- debridement assessment of this previously unstageable wound has revealed the underlying deep tissue at the muscle/fascia level, which had been on obscured by slough prior to this point. This wound has now revealed itself to be a stage 4 pressure injury. This is not wound deterioration. Surveyor noted that a comprehensive assessment was not completed on admission for R2’s mid thoracic upper back pressure injury until 5/9/2025 when the wound nurse practitioner (wound NP)-N assessed R2’s pressure injury on 5/9/2025. R2 was sent to the hospital on 5/12/2025 and readmitted to the facility on [DATE]. Surveyor reviewed R2’s admission skin assessment dated [DATE] that documented:1. Mid-thoracic upper back, Unstageable- 3 X 2.6 On 5/23/2025 there was a VOHRA wound assessment note that documented:1. Mid- thoracic upper back, stage 4 pressure injury- 2.5 X 2.5 X 0.1- 90% slough, 10% granulation tissue, moderate serosanguinous drainage Surveyor noted that a comprehensive assessment was not completed on re-admission for R2’s mid thoracic upper back pressure injury until 5/23/2025 when wound NP-N assessed it on 5/23/2025. Surveyor noted R2 continues to get weekly assessments showing improvement in R2’s mid thoracic upper back pressure injury with the most recent measurements documenting. 7/31/2025:1. Mid thoracic upper back, stage 4 pressure injury- 0.8 X 0.7 X 0.1, light pink wound bed, no erythema noted around the wound- 50% slough, 50% granulation tissue, no drainage noted- Wound NP-N scraped off biofilm (slimy/ discolored film on the wound bed that can prevent healing of a wound) On 8/4/2025, at 9:03 AM, Surveyor interviewed Director of Nursing (DON)-B who stated when a resident is admitted / readmitted to the facility or a new area of concern is noted, nursing is to get a comprehensive assessment documented. Surveyor asked what the expectation for a comprehensive assessment is for a wound. DON-B stated the comprehensive assessment would state if the area is swollen, red, and has drainage. Surveyor asked who completes the comprehensive wound assessments. DON-B stated a registered nurse (RN) would complete the comprehensive wound assessment, and if DON-B is in the facility at the time DON-B would complete the comprehensive assessment. Surveyor asked how a wound base would be described and staged. DON-B stated DON-B refrains from describing the wound base or staging until wound NP-N is able to assess the wound because DON-B is not comfortable with the staging of a wound. Surveyor shared concern that R2 did not have a comprehensive wound assessment completed on admission on [DATE] and readmission on [DATE] to R2’s mid thoracic upper back pressure injury. DON-B stated that DON-B was not the DON a the time R2 was admitted and noted that wound comprehensive assessments were not always completed accurately and the facility has been working on educating staff. DON-B stated DON-B would look to see if any information could be found regarding comprehensive assessments on 5/7/2025 and 5/16/2025 for R2’s pressure injury. (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/2025, at 10:05 AM, [NAME] President of Success (VPS)- D stated a comprehensive wound assessment for R2’s mid thoracic upper back pressure injury was unable to be located for R2’s admission on [DATE] and readmission on [DATE]. On 8/4/2025, at 12:48 PM, Surveyor shared concerns with nursing home administrator (NHA)-A, DON-B, DON-C, and VPS-D that R2 did not have a comprehensive assessment completed on admission on [DATE] to R2’s mid thoracic upper back pressure injury until 5/9/2025 and on readmission on [DATE] until 5/23/2025. No additional information was provided.

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	525415	A. Building B. Wing	08/04/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility did not ensure medications were labeled or properly stored for 1 of 2 medication carts reviewed for medication storage. The facility did not ensure expired medications were properly removed from facility stock and individually prescribed medications. * R2 had medication stored in a medication cart with no date listed as to when medication had been opened*During the medication storage task, six vials of expired magnesium supplements were discovered in the facility's medication room and 1 vial of opened expired magnesium supplement was discovered in a medication cart.Findings include:On 8/4/25 at 9:20 AM, Surveyor observed the Magnolia unit medication cart named with Surveyor observed R2's lubricant eye drop vial without an open date. On 8/4/25 at 9:25 AM, Surveyor showed Licensed Practical Nurse/Infection Preventionist (LPN/IP)-E R2's lubricant eye drop vial and asked if they could see any opened date on the vial. LPN/IP-E responded that they could not see an opened date on R2's lubricant eye drop vial. The medication was removed from the Magnolia unit medication cart.On 8/4/25 at 9:10 AM, Surveyor observed the facility's medication room. Surveyor noted six vials of Major brand Magnesium 500 mg with an expiration date of 6/2025. Surveyor reviewed medication cart. Surveyor noted 1 opened vial of Major brand Magnesium 500 mg with an expiration date of 6/2025. On 8/4/25 at 9:25 AM, Surveyor showed IP the opened vial of Major brand Magnesium 500 mg with an expiration date of 6/2025 that was discovered on the Magnolia unit medication cart. The medication was removed from the Magnolia unit medication cart.On 7/19/21 at 11:30 AM, Surveyor met with Nursing Home Administrator (NHA)-A to share concerns related to R2's undated opened lubricant eye drops. Surveyor shared concerns related to the six vials of Major brand Magnesium 500 mg with an expiration date of 6/2025 found in the facility's medication room and one opened vial of Major brand Magnesium 500 mg with an expiration date of 6/2025 found on the medication cart. No additional information was provided to Surveyor related to undated and expired medications.

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	525415	A. Building B. Wing	08/04/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure a resident's hospice notes were readily available for communication and collaboration of care in accordance with professional standards of practice for 1 (R5) of 2 residents reviewed for hospice services.Hospice visit notes were not updated in R5's medical record or in R5's hospice binder until Surveyor requested the information.Findings include:The facility's policy and procedure titled, Hospice Services Facility Agreement, dated 7/15/2022 was reviewed. The policy documents: Policy Explanation and Compliance Guidelines.:4. The written agreement(s) will set out at least the following.:d. A communication process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.R5 was admitted to the facility on [DATE] with pertinent diagnoses that include malignant neoplasm of rectum (a cancerous tumor in the rectum, the final section of the large intestine), bipolar disorder (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression), and post-traumatic stress disorder (a mental health condition that can develop after a person experiences or witnesses a traumatic event, such as a natural disaster, accident, or act of violence).R5's Significant Change in Status Minimum Data Set (MDS) with an assessment reference date of 5/20/25, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R5 is cognitively intact. The MDS documents R5 is understood and understands others. R5's Patient Depression Questionnaire (PHQ-9) score was 01 indicating no depressive symptoms. R5 exhibited no behaviors during the look back period of the MDS assessment. R5 is documented to receive hospice care.R5's care plan for R5 choose hospice care due to invasive metastatic rectal CA (cancer), secondary liver mets (metastatic) prognosis revised on 5/19/25 has the following interventions that were initiated on 5/14/25:-Administer medications per MD (medical doctor) orders.-Allow resident/family to discuss feelings, etc.-Assist to reposition.-Assist with ADL (activities of daily living) care and pain management as needed.-Dietary to evaluate and modify meal and snack plan as needed.-Encourage to participate in activities as able.-FYI (for your information): Vitas Hospice.-Hospice staff to visit to provide care, assistance, and/or evaluation.-Provide supportive, private environment for resident and family.-Report skin breakdown, lack of analgesia effectiveness, unexpected weight loss or decline in appetite.The Vitas Hospice contract dated 12/12/24 documents in part 4.3 Communication - The parties will communicate pertinent information with each other verbally or in the Residential Hospice Patient's record at least weekly and/or at each hospice patient visit to ensure that the needs of each Residential Hospice Patient are addressed and met 24 hours per day. Documentation of such communication shall be included in the Residential Hospice Patient's medical record. On 7/31/25, at 10:10 am, Surveyor reviewed R5's hospice binder and was unable to locate any documentation of communication within the binder. Surveyor then reviewed R5's electronic medical record and was unable to locate any documentation of communication.On 7/31/25, at 11:19am, Surveyor interviewed Licensed Practical Nurse (LPN)-K regarding how to communicate with hospice and was told by phone or when the nurse visits, they come and always talk to the facility nurse. Surveyor asked if there is any written communication and LPN-K replied not that that they are aware of.On 07/31/2025, at 1:35 PM, Surveyor requested documentation of communication of hospice visits from Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A.On 08/04/2025, at 8:06 AM, Surveyor reviewed paperwork provided that documented hospice visits starting 5/12/25 through 7/30/25. All the documents had Run by Vitas Hospice Coordinator-Y on 7/31/25 on the bottom.On 08/04/2025, at 10:08 AM, Surveyor interviewed Social Services Coordinator (SSC)-J who is the facility hospice coordinator and asked what the expectation for communication is related to hospice visits. SSC-J- stated that before and after (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospice sees a resident, they should follow up with multiple people in the facility regarding order changes and what is going on with resident. Surveyor asked if paperwork is provided and was told if it was not left then hospice will send over schedule and post visit summaries electronically. Surveyor asked who Vitas Hospice Coordinator-Y is and was told they are the Vitas Hospice Coordinator.On 08/04/2025, at 11:44 AM, Surveyor relayed concern of hospice communication not being in the medical record or binder to NHA-A and 2 consultants.No additional information was provided regarding R5's hospice visit notes not being updated in R5's medical record or in R5's hospice binder that was provided.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review the Facility did not ensure 2 (R4 & R2) of 5 Resident reviewed were offered the influenza and/or pneumococcal immunization. R2 received the pneumococcal 23 on 5/18/12. R2's medical record does not have evidence R2 was offered and/or declined the pneumococcal vaccine 15, 20, or 21. R2's medical record does not have evidence R2 was offered and/or declined the influenza vaccine. R4's medical record does not have evidence R4 was offered and/or declined the Pneumococcal vaccine 15, 20, or 21. Findings include: The facility's policy titled, Pneumococcal Vaccine (Series) and last reviewed/revised 3/25/25 under policy documents It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC (Centers for Disease Control and Prevention) guidelines and recommendations. Under Policy Explanation and Compliance Guidelines documents 3. Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization with the education documented in the clinical record. a. The individual receiving the immunization, or the resident representative, will be provided with a copy of CEDC's current vaccine information statement (VIS) relative to that vaccine. b. If necessary, the vaccine information statement will be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding. 4. The resident/representative retains the right to refuse the immunization. The facility will document in the clinical record the reason for refusal or the medical contraindication of the immunization. 6. The type of pneumococcal vaccine (PCV15, PCV20, PCV21 or PPSV23) offered will depend upon the recipient's age, having certain risk conditions, and previously received pneumococcal vaccines, in accordance with current CDC guidelines and recommendations. The facility's policy titled, Influenza Vaccination and last revised 9/13/24 under Policy documents It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer works annual immunization against influenza. Under Policy Explanation and Compliance Guidelines documents 1. Influenza vaccinations will be routinely offered annually when it becomes available to the facility, unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine. 9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization and that the resident received or did not receive the immunization due to medical contraindication or refusal. Consider the use of the Risk vs Benefit UDA in the electronic medical record as a means to capture the resident's choice to not receive the influenza vaccination. 1.) R4 was admitted to the facility on [DATE] and is [AGE] years old. Diagnoses includes hypertension (high blood pressure), diabetes mellitus (high blood sugar) and end stage renal disease. On 8/4/25, at 12:49 p.m., Surveyor reviewed R4's immunizations and noted R4 received the PPSV23 (pneumococcal poly-saccharide vaccine) on 5/18/12. There is no evidence in R4's medical record R4 (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was offered and/or refused the PCV 15, PCV 20, or PCV 21. According to current CDC recommendations age [AGE]-49 years with certain underlying medical conditions or other risk factors (R4 has end stage renal disease and receives dialysis) who have previously received only PPSV23: 1 dose PCV15, or 1 dose PCV20 or 1 dose PCV21, at least 1 year after the last PPSV23 dose. Surveyor was unable to locate in R4's medical record R4 had received the influenza vaccine prior to admission, received the influenza vaccine after being admitted or refused the influenza vaccine. On 8/4/25, at 1:42 p.m., Surveyor informed Licensed Practical Nurse/IP (LPN/Infection Preventionist)-E, Surveyor was unable to locate R4 was offered and/or declined the PCV15, PCV20, or PCV21 and the influenza vaccine. LPN/IP-E informed Surveyor she will look into this and get back to Surveyor. On 8/4/25, at 2:32 p.m., [NAME] President (VP) of Success-D informed Surveyor they do not have documentation that R4 was offered and/or declined the PCV15, PCV20, or PCV21 and the influenza vaccine. No additional information was provided. 2.) R2 was admitted to the facility on [DATE] and is [AGE] years old. Diagnoses includes Cognitive Communication Deficit, Chronic Kidney Disease and Weakness On 8/4/25 at 12:30 p.m., Surveyor reviewed R2's immunizations and noted R2 received the PPSV23 (pneumococcal poly-saccharide vaccine) on 5/6/04. There is no evidence in R2's medical record R2 was offered and/or refused the PCV 15, PCV 20, or PCV 21. On 8/4/25 at 1:42 p.m., Surveyor informed Licensed Practical Nurse/IP (LPN/Infection Preventionist)-E, Surveyor was unable to locate whether R2 was offered and/or declined the PCV15, PCV20, or PCV21 vaccine. LPN/IP-E informed Surveyor she will look into this and get back to Surveyor. On 8/4/25 at 2:32 p.m., [NAME] President (VP) of Success-D informed Surveyor they do not have any additional information regarding R2 being offered and/or declining the PCV15, PCV20 or PCV21 vaccine. No additional information was provided.

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	525415	A. Building B. Wing	08/04/2025

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure medical records contained documentation related to COVID-19 immunizations for 3 (R5, R4, and R2) of 5 residents reviewed for immunizations. * R5’s medical record does not contain any documentation as to whether R5 was offered, received, or declined the COVID-19 immunization. * R4’s medical record does not contain any documentation as to whether R4 was offered, received, or declined the COVID-19 immunization. *R2’s medical record does not contain any documentation as to whether R2 was offered, received, or declined the COVID-19 immunization. Findings include: The facility's policy and procedure dated as revised 9/17/2024 and titled, Covid-19 Vaccination documents: “Policy: It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine… 8. COVID-19 vaccinations will be offered to residents when supplies are available, as per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine… 11. The facility will educate and offer the COVID-19 vaccine to residents and staff and maintain documentation of such… 14. Consent will be signed prior to admission of the COVID-19 vaccine. This information will be retained in the resident’s medical record or the staff’s medical file… 16. Residents or resident representatives retain the right to accept, decline or change their decision about COVID-19 immunization. If declined, the residents will adhere to the protocols set forth by specific facility policy. Facility should consider completion of Risk Vs Benefit UDA for residents declining immunization. 17. The resident’s medical record will include documentation of the following: a. Education to the resident or resident representative regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. Each dose of the vaccine administered to the resident, or; c. If the resident did not receive the COVID-19 vaccine due to medical contraindication or (continued on next page)

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	525415	A. Building B. Wing	08/04/2025

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refusal…” 1.) R5 was admitted to the facility on [DATE] with pertinent diagnoses that include malignant neoplasm of rectum (a cancerous tumor in the rectum, the final section of the large intestine), bipolar disorder (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression), and post-traumatic stress disorder (a mental health condition that can develop after a person experiences or witnesses a traumatic event, such as a natural disaster, accident, or act of violence). R5's Significant Change in Status Minimum Data Set (MDS) with an assessment reference date of 5/20/25, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R5 is cognitively intact. The MDS documents R5 is understood and understands others. R5’s Patient Depression Questionnaire (PHQ-9) score was 01 indicating no depressive symptoms. R5 exhibited no behaviors during the look back period of the MDS assessment. Surveyor reviewed R5's electronic medical record and was unable to locate evidence whether R5 was offered, received, or declined the COVID-19 immunization. On 08/04/2025, at 1:42 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E regarding R5 being offered or receiving the COVID-19 immunization. LPN-E stated they review R5's medical record and get back to surveyor. On 8/04/2025, at 2:23 PM, [NAME] President of Success-D let Surveyor know there is not documentation of risk versus benefit regarding R5’s COVID-19 vaccination. Surveyor stated this is a concern. No additional documentation of R5 being offered or refusing the COVID-19 vaccination at or since admission to the facility was provided. 2.) R4 was admitted to the facility on [DATE] with diagnoses that include hypertension (high blood pressure), diabetes mellitus (high blood sugar) and end stage renal disease. On 8/4/25, at 12:49 p.m., Surveyor reviewed R4's immunizations and noted R4 received the Covid 19 vaccine on 4/20/21. Surveyor was unable to locate in R4's medical record R4 was offered and/or refused the Covid 19 vaccination after she was admitted on [DATE]. On 8/4/25, at 1:42 p.m. Surveyor informed Licensed Practical Nurse/Infection Preventionist (LPN/IP)-E Surveyor noted in R4's medical record R4 received the Covid 19 vaccination on 4/20/21 but was unable to locate in R4's medical record R4 was offered and/or refused the Covid vaccine after she was admitted . LPN/IP-E informed Surveyor she will look into this and get back to Surveyor. On 8/4/25, at 2:23 p.m. [NAME] President (VP) of Success-D informed Surveyor that the facility had no documentation regarding R4 being offered a Covid vaccine for R4. 3.) R2 was admitted to the facility on [DATE] with diagnoses that include Cognitive Communication Deficit, Chronic Kidney Disease and Weakness. On 8/4/25 at 12:30 p.m., Surveyor reviewed R2's immunization. Surveyor was unable to locate in R2's medical record if R2 was offered and/or refused the Covid 19 vaccination after she was admitted on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525415	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menomonee Falls Health Services	N84 W17049 Menomonee Ave Menomonee Falls, WI 53051

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE]. On 8/4/25 at 1:42 p.m. Surveyor informed Licensed Practical Nurse/Infection Preventionist (LPN/IP)-E Surveyor noted they were unable to locate in R2's medical record whether R2 was offered and/or refused the Covid vaccine after she was admitted . LPN/IP-E informed Surveyor she will look into this and get back to Surveyor. On 8/4/25, at 2:25 p.m. [NAME] President (VP) of Success-D informed Surveyor that they had no documentation on whether or not R2 was offered and/or refused the Covid vaccine after their admission to the facility.