STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525549	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Square Health Care Center	5404 W Loomis Rd Greendale, WI 53129

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record, the facility did not ensure 1 (R7) of 1 residents were assessed by the interdisciplinary team to determine it was clinically appropriate to self-administer medication.On 8/12/25, LPN-C was observed leaving R7's medication on the over bed table without observing R7 take her medication. R7 did not have an assessment to self-administer medications.Findings include:The facility's policy titled, Self-Administration of Medications and dated 10/25/14 under Policy documents In order to maintain residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. Under Procedures documents A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process. B. If the resident indicates no desire to self-administer medications, this is documented in the appropriate place in the resident's medical record, and the resident is deemed to have deferred this right to the facility.R7's diagnoses include acute on chronic right heart failure (condition in which the heart doesn't pump blood as well as it should), diabetes mellitus (high blood sugar), asthma (condition in which the airways narrow & may produce extra mucus which can make breathing difficult), anxiety disorder (group of mental health conditions characterized by excessive & persistent worry, fear, and nervousness that can interfere with daily life), chronic kidney disease (characterized by progressive damage & loss of kidney function), bipolar disorder (mental disorder characterized by periods of depression and periods of abnormally elevated mood), hypertension (high blood pressure), chronic atrial fibrillation (irregular and rapid heartbeat), and metabolic encephalopathy (metabolic disturbances affecting how the brain functions).R7's quarterly MDS (minimum data set) with an assessment reference date of 7/18/25 has a BIMS (brief interview mental status) score of 13 which indicates cognitively intact.On 8/12/25, at 8:29 a.m., Surveyor observed Licensed Practical Nurse (LPN)-C prepare R7's medication. LPN-C cleansed the top of the Humalog KwikPen with an alcohol pad, connected a needle and placed the insulin pen on the medication cart. LPN-C dispensed one tablet Midodrine 2.5 mg (milligram), one tablet Pantoprazole Sodium 40 mg, and one capsule Probiotic oral capsule into a medication cup. LPN-C opened & poured one packet of Potassium Chloride 20 mEq (milliequivalent) into a cup. At 8:39 a.m., LPN-C dialed 2 units of Humalog and added water to R7's Potassium Chloride. On 8/12/25 at 8:40 a.m., LPN-C placed gloves on, entered R7's room with R7's medication and placed R7's medication cup & Potassium Chloride on R7's over bed table. At 8:41 a.m., LPN-C cleansed the back of R7's right upper arm and injected R7's Humalog insulin. R7 stated to LPN-C I'm supposed to get 11 pills. At 8:43 a.m., LPN-C left R7's room. Surveyor observed LPN-C did not stay in R7's room until R7's took the medication and the medication was on R7's overbed table when LPN-C left R7's room. On 8/12/25 at 8:44 a.m., LPN-C stated to Surveyor maybe she's right, it must be the internet, she gets more pills. LPN-C then dispensed into a medication cup one tablet Vitamin C 500 mg, one tablet Magnesium Oxide 400 mg, one tablet Atorvastatin Calcium 10 mg, one tablet Bumetanide 1 mg, one capsule Cephalexin 250 mg, one table Eliquis 5 mg, & one tablet Metoprolol Succinate ER (extended release) 50 mg. LPN-C cleansed the end of Glargine Solostar pen with an alcohol pad, attached needle, and dialed insulin to 5 units At 8:50 a.m., Surveyor verified the number of pills in R7's medication cup with LPN-C. On 8/12/25 at 8:52 a.m., LPN-C placed gloves on and entered R7's room. LPN-C placed the medication cup on R7's over bed table, cleansed the back of R7's right upper arm and administered R7's Glargine insulin. After LPN-C administered R7's insulin, LPN-C removed her gloves, left R7's room, and cleansed her hands. Surveyor observed LPN-C did not stay in R7's room until R7's took the medication and the medication was on R7's overbed table when LPN-C left R7's room.Surveyor reviewed R7's medical record and was unable to locate a physician order or an assessment for R7 to self-administer her medication.Surveyor reviewed R7's care plans and noted the following care plans: Physical functioning deficit initiated 4/15/25, Pressure ulcer actual initiated 4/16/25, Advanced Directive initiated 4/15/25, At risk for alteration in psychosocial wellbeing initiated 4/17/25, Recreational activities initiated 4/18/25, Nutrition and Hydration initiated 4/18/25, Assistance in planning my next steps to be able to go home safely initiated 6/1/25, At risk for falls initiated 6/9/25, and Risk for altered fluid balance initiated 5/27/25. Surveyor was unable to locate a care plan for the self-administration of medication for R7. On 8/12/25, at 10:42 a.m., Surveyor asked LPN-C if they have self-administration of medication assessments. LPN-C replied yes if they

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R1) of 3 resident's reviewed for hospitalization were allowed to the facility after they were hospitalized .*R1 was hospitalized on [DATE] and was denied readmission to facility. The facility did not effectively implement a discharge plan for R1 to include the timely and appropriate 30-day discharge notice providing the basis for R1's discharge nor did the facility provide coordination to find a safe transfer.Findings include:The facility's policy titled, Bedhold Notice Upon Transfer, dated [DATE], documents in part. POLICY: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed.Policy Explanation and Compliance Guidelines: Bed Hold Notice Upon Transfer: . 3. The facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless:The transfer for discharge is necessary for the resident's welfare and the resident needs cannot be met at the facility.The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;The health of the individuals in the facility would otherwise be endangered. R1 was admitted to the facility on [DATE] with a diagnosis that include muscle wasting and atrophy, acute respiratory failure with hypoxia and chronic respiratory failure.R1's Progress Note dated [DATE], at 23:20 (11:20 PM), documents, in part, . Pt (Patient) put on her call light at 2310 (11:10 PM) upon CNA (Certified Nursing Assistant) entering room pt labored breathing; pt pulled out trach . pt was admitted to [hospital] .R1 was hospitalized on [DATE] and did not return to the facility.On [DATE] at 11:55 AM, Surveyor interviewed R1's family who stated they were told by the hospital social worker the facility would not accept R1 back and they had to find a different facility. R1's family stated they did not have any communication with the facility but believes R1 would not be readmitted to facility because the facility was told R1 had a fracture that may have occurred within the last 7 weeks. Surveyor reviewed the electronic health record (EHR) for documentation regarding communication between hospital and facility and any information relating to hospital informing facility of a fracture. No documentation was found regarding evidence facility was informed or knew of R1's fracture.On [DATE], at 12:24 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor asked if there would be any reasons not to accept a resident back to facility following a hospital admission. NHA-A stated, the facility would accept all patients back who were hospitalized and want to return. Surveyor asked if NHA-A or DON-B have any knowledge of R1's refusal to be readmitted to facility. NHA-A and DON-B both stated, not that they are aware of. DON-B stated R1 was very behavioral and frequently pulling her trach out.On [DATE], at 12:50 PM, Surveyor interviewed Admissions Director (Admissions)-E. Surveyor asked Admissions Director-E if there would be any reason not to accept a resident back to facility following a hospital admission. Admissions Director-E stated, the facility will always accept residents back after hospitalization. Surveyor asked Admissions Director-E, who is responsible to coordinate hospital to facility readmissions. Admissions Director-E stated, the Referral Specialist typically does but this position was recently vacated on [DATE] and now Admissions Director-E coordinates readmissions. Surveyor asked Admissions Director-E if she has any knowledge of R1's refusal to be readmitted to facility. Admissions Director-E stated, not that she can recall. Surveyor asked if there is any documentation in the EHR regarding the referral specialist communication with facility and hospital coordination. Admissions Director-E stated, the referral specialist did not document in the EHR. Surveyor asked if there is any written documentation or other documents that charts communication and Admissions Director-E stated, no, there is not. Admissions Director-E stated the referral specialist probably shredded any documents she may have had. Admissions Director-E stated, if there was an open bed, the facility would have taken back R1 at the time of discharge from hospital. Admissions Director-E stated a bed was held for R1 until [DATE] and then bed-hold expired. On [DATE], at 8:04 AM, Surveyor spoke with case manager-G from hospital who stated, she reviewed the social workers notes from the hospital that show the social worker did attempt to make arrangements for R1 to return to the facility but was told by facility R1 could not return. Surveyor requested the hospital notes created by the social worker.R1's Hospital Progress Note dated [DATE], at 11:49 AM, documents, in part . SW (Social Worker) is continuing to follow for placement. I contacted referral specialist in admissions at

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 2 (R1 and R2) of 3 resident's reviewed for hospitalization received the proper notice of transfer and bed-hold to include; date and reason for transfer, location of transfer, duration of bed hold, appeal rights, and name and address (including mail and email) with the telephone number of the Office of the State Long-Term Care Ombudsman. * R1 was transferred to the hospital on 5/3/25, 6/6/25 and 6/9/25 and transfer and bed-hold notice was not given to R1 and/or R1's representative. *R2 was transferred to the hospital on 7/20/25 and transfer and bed-hold notice was not given to R2 and/or R2’s representative. Findings include: The facility’s policy titled, “Bedhold Notice Upon Transfer,” dated 3/1/19, documents in part… POLICY At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. …Policy Explanation and Compliance Guidelines: Bed Hold Notice Upon Transfer: 1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. b. The reserve bed payment policy in the state plan policy, if any. c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. d. Conditions upon which the resident would return to the facility: · The resident requires the services which the facility provides. · The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. 2. In the event of an emergency transfers of a resident, the facility will provide within 24 hours written notice of the facility’s bed-hold policies, as stipulated in the State’s plan. … (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident representative in the resident’s file. 1.) R1 was admitted to the facility on [DATE] with a diagnosis that include muscle wasting and atrophy, acute respiratory failure with hypoxia and chronic respiratory failure. -R1’s Progress Note dated 5/4/25 at 7:40 AM, documents, in part, . Writer went into pt (patient’s) room pt had …trach labored breathing, lungs clear difficult to arouse …contacted NP (Nurse Practitioner) pt was admitted to [hospital] with sepsis and colitis. … R1 was hospitalized on [DATE] and returned to the facility on 6/4/25. Surveyor reviewed R1's electronic health record (EHR) for documentation that a transfer and bed-hold notice was given to R1. No transfer and bed-hold notice were found. -R1’s Progress Note dated 6/6/25, at 6:19 AM, documents, in part, … Writer was making last rounds and observed res (resident) trach removed and was holding in her hand …writer made several attempts to reinsert, but res kept on crying it hurts. … Writer (sic) was sent to [name of hospital] ER (emergency room) for reinsertion of trach. R1 was hospitalized on [DATE] and returned to the facility on 6/9/25. Surveyor reviewed R1's EHR for documentation that a transfer notice was given to R1. No transfer and bed-hold notice were found. -R1’s Progress Note dated 6/9/25 at 23:20 (11:20 PM), documents, in part, … Pt (Patient) put on her call light at 2310 (11:10 PM) upon CNA (Certified Nursing Assistant) entering room pt labored breathing; pt pulled out trach … pt was admitted to [hospital]. … R1 was hospitalized on [DATE] and did not return to the facility. Surveyor reviewed R1's EHR for documentation that a transfer and bed-hold notice was given to R1. No transfer and bed-hold notice were found. On 8/11/25, at 12:24 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A (by telephone) and Director of Nursing (DON)-B. Surveyor asked who is responsible for transfer and bed-hold notices provided to the resident and/or resident family. NHA-A stated, he believes social services is responsible to issue transfer notices and bed-holds. NHA-A stated the forms are not stored in the EHR but thinks the social worker enters a note in the EHR. On 8/11/25, at 12:40 PM, Surveyor interviewed Social Services Director-N Surveyor asked who is responsible for transfer and bed-hold notices provided to the resident and/or resident family. Social Services Director-N stated, the nurses or the Admissions Director take care of transfer notices and bed-holds provided to the resident and/or resident family. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/11/25, at 12:50 PM, Surveyor interviewed Admissions Director (Admissions)-E. Surveyor asked who is responsible for transfer and bed-hold notices provided to the resident and/or resident family. Admissions Director-E stated, she is responsible to notify residents upon admission and have resident’s sign a bed-hold policy statement. Surveyor asked Admissions Director-E who is responsible for transfer and bed-hold notices provided to the resident and/or resident family when a resident is transferred to the hospital. Admissions Director-E stated she was unaware transfer and bed-hold notices were provided to the resident and/or resident family when a resident is transferred to the hospital and did not know who was responsible. On 8/11/25, at 1:16 PM, Surveyor interviewed Registered Nurse Unit Manager (RN Unit Manager)-J. Surveyor asked who is responsible for transfer and bed-hold notices provided to the resident and/or resident family. RN Unit Manager-J stated, she does not have direct contact with transfer and bed-hold notices, but the Admissions Director-E does. On 8/11/25, at 1:20 PM, Surveyor interviewed Health Unit Coordinator-F. Surveyor asked who is responsible for transfer and bed hold notices provided to the resident and/or resident family. Health Unit Coordinator-F stated, she is responsible. Health Unit Coordinator-F stated, if the situation is urgent, Health Unit Coordinator-F would go over the bed hold policy with the resident’s family member verbally, then email or fax the paperwork to the family member to sign and return to the facility, or the family member would come into the facility to sign the paperwork upon request. Health Unit Coordinator-F stated if the transfer and bed-hold notice was given, then Health Unit Coordinator-F would upload it into the resident’s EHR under the miscellaneous tab. Health Unit Coordinator-F stated if there is not a transfer and bed hold notice uploaded into a resident’s EHR, then a transfer and bed hold notice was not obtained at the time of transfer. On 8/12/25, at 9:45 AM, Surveyor informed DON-B of the concern R1 and/or their representative was not provided a transfer and bed-hold notice when R1 was transferred to the hospital on 5/3/25, 6/6/25 and 6/9/25. DON-B stated policy was followed and residents receive the transfer and bed-hold notice upon admission and each month. Surveyor stated the transfer and bed-hold notice is not required to be issued monthly but it is required to be issued when residents are transferred to the hospital or therapeutic leave per Federal regulations and the facility policy. DON-B acknowledged understanding and stated the process of training and education will begin promptly. No additional information was provided. 2) R2 was admitted to the facility on [DATE] with diagnoses including toxic encephalopathy (disturbance of brain function), urinary tract infection, depression, anxiety, chronic diastolic heart failure, and chronic kidney disease. R2 has an activated healthcare power of attorney (POA). R2 was transferred and admitted to the hospital on [DATE] and returned to the facility on 7/31/25. Surveyor reviewed R2’s Electronic Health Record (EHR) and was unable to locate a written bed hold and transfer notice for R2’s hospitalization on 7/20/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/11/25, at 1:20pm, Surveyor interviewed Health Unit Coordinator (HUC)-F. HUC-F stated HUC-F was responsible for getting the bed hold and transfer notice signed by the resident or resident’s family member when a resident is transferred out of the facility. HUC-F stated if the situation is urgent, HUC-F would go over the bed hold policy with the resident’s family member verbally, then email or fax the paperwork to the family member to sign and return to the facility, or the family member would come into the facility to sign the paperwork upon request. HUC-F stated if the bed hold policy was completed and signed, then HUC-F would upload it into the resident’s electronic health record (EHR) under the miscellaneous tab. HUC-F stated if there is not a bed hold notice uploaded into a resident’s EHR, then a bed hold notice was not obtained at the time of transfer. On 8/12/25, at 9:45 am, Surveyor informed Director of Nursing (DON)-B of the concern that R2 or R2’s representative did not receive a written bed hold and transfer notice when R2 was admitted to the hospital on [DATE]. DON-B stated residents sign a bed hold agreement on admission and every 30 days, but no bed hold and transfer notice is provided to residents or residents’ representatives upon each hospitalization. DON-B understood the concern.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not develop a comprehensive person-centered care plan to include measurable objectives and timeframes to meet the nursing needs for 2 (R4, R6) of 7 residents reviewed. *R4 did not have a comprehensive person-centered care plan developed to address R4’s urinary incontinence *R6 did not have a comprehensive person-centered care plan developed to include timeframes for how staff will meet R6’s urinary incontinence needs Findings include: The facility policy titled “Comprehensive Care Plans” dated 10/1/22 documents: . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the resident’s comprehensive assessment… The care planning process will include an assessment of the resident’s strengths and needs… The comprehensive care plan will describe, at a minimum, the following: a. the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being… The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment… The comprehensive care plan will include measurable objectives and timeframes to meet the resident’s needs as identified in the resident’s comprehensive assessment. The objectives will be utilized to monitor the resident’s progress… Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. 1) R6 was admitted to the facility on [DATE] with diagnoses that include encephalopathy (disruption of brain function), pressure ulcer sacral region stage 4, diabetes mellitus type 2, schizophrenia, bipolar disorder, depression, and anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6’s admission Minimum Data Set (MDS) completed 7/2/25 documents R6’s Brief Interview for Mental Status (BIMS) score as 01, indicating severe cognitive impairment, R6 has no behavior symptoms, and R6 is rarely/never understood and sometimes understands others. R6’s MDS documents R6 is dependent for activities of daily living (ADLs), bed mobility, and transfers, and R6 is always incontinent of bladder and has a colostomy. The facility documents the urinary incontinence Care Area Assessment (CAA) was triggered due to … resident at risk for skin breakdown and dignity issues due to requiring assistance for mobility … incontinent of bowel and bladder and had colostomy … encouraged to use call light for assistance to toilet and never uses it appropriately … due to limited mobility often cannot get to toilet … resulting in incontinence … checked and changed every 2-3 hours and as needed … preventative skin care given as needed … will proceed to care plan to maintain dryness and prevent alteration of skin integrity. Surveyor reviewed R6’s care plan which documents the following: …physical functioning deficit related to: mobility impairment, self-care impairment with the following intervention initiated 7/1/25: … total assist for toileting… -alteration in elimination of bowel and bladder related to impaired mobility and colostomy bag with the following intervention initiated 6/30/25: … provide incontinence cares… Surveyor noted there is no timeframe or frequency specified in the care plan describing how often staff should provide incontinence cares for R6. The “BDRK Bowel and Bladder” assessment dated [DATE] documents R6 is incontinent of bladder, has an ostomy … not appropriate for toileting or retraining program … On 8/11/25, at 12:36 pm, Surveyor interviewed Licensed Practical Nurse (LPN)-C, who stated R6 is dependent for all cares and transfers. LPN-C stated R6 is repositioned and checked and changed every 2 hours. On 8/12/25, at 9:37 am, Surveyor interviewed Certified Nursing Assistant (CNA)-I, who stated a resident’s assistance level for incontinence cares is located at the nursing station, but no specific timeline is usually documented in the care plan or on the CNA Kardex (care card). CNA-I stated all residents are checked on every 2 hours or when a resident activates the call light. CNA-I stated R6 does not really use the call light and sometimes requires being changed every 30 minutes due to heavy wetting. CNA-I stated CNA staff chart the total amount of times a resident urinates each shift into the resident’s electronic health record (EHR), but CNA staff do not otherwise document when a resident is provided incontinence cares. Surveyor reviewed CNA task record for R6’s bladder elimination for the last 30 days. Surveyor noted the number of times R6 urinated is documented each shift on only 8 of 30 days reviewed, and there is no documentation of how many times R6 urinated during at least one shift on the other 22 days reviewed. There is no documentation stating the increments of time between urinations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525549	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Square Health Care Center	5404 W Loomis Rd Greendale, WI 53129

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/25, at 1:17 pm, Surveyor interviewed Registered Nurse (RN) Unit Manager (RNUM)-J regarding care plan expectations for residents requiring toileting assistance. RNUM-J stated there should be an alteration in elimination care plan for residents who are determined to be less mobile or immobile and who are frequently incontinent. RNUM-J stated typically the care plan would include the frequency in which a resident requires toileting assistance or incontinence cares, and then that frequency would also be documented on the Kardex. RNUM-J reviewed R6’s care plan and confirmed it does not state how frequently R6 should be provided incontinence cares. On 8/12/25, at 2:10 pm, Surveyor informed Director of Nursing (DON)-B of the above concern. DON-B stated staff may document that a resident needs to be checked and changed frequently in the care plan, however, a timeframe is not typically utilized. DON-B understood the concern. 2.) R4's diagnoses includes diabetes mellitus (high blood sugar), left ACA (anterior cerebral artery) stroke (an ischemic stroke that restricts blood flow to the right side of the brain), chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), hypokalemia (low potassium), and dementia (loss of cognitive function that interferes with a person's daily life & activities). R4's admission MDS (minimum data set) with an assessment reference date of 12/21/24 assesses R4 as being dependent for toileting hygiene, roll left & right, and chair/bed to chair transfer. R4 is assessed as being always incontinent of urine and bowel. R4's urinary CAA (care area assessment) dated 12/26/24 under analysis of findings for nature of problem/condition documents Resident dependent of all cares r/t (related to) stroke. Under care plan considerations for describe impact of this problem/need on the resident & your rational for care plan decision documents Brief worn r/t (related to) incontinence to prevent leakage. Resident has air mattress that will prevent skin damage. Staff will anticipate needs and check and change every 2-3 hours/prn (as needed). R4's quarterly MDS with an assessment reference date of 6/20/25 has a BIMS (brief interview mental status) score of 11 which indicates moderate cognitive impairment. R4 is dependent for toileting hygiene, roll left & right, and chair/bed to chair transfer. R4 is assessed as being always incontinent of urine and bowel. Surveyor reviewed R4's care plans and noted the following care plans: I am a long term resident at the facility initiated 12/10/24, Physical functioning deficit initiated 12/11/24, At risk for alteration in psychosocial wellbeing initiated 12/18/24, Cognitive function initiated 12/18/24, Advanced directives initiated 12/18/24, Dependent on tube feeding initiated 12/26/24, Infection actual or at risk initiated 12/20/24, At risk for pressure ulcer initiated 1/20/25, Recreational activities initiated 3/24/25, At risk for falls initiated 6/9/25, and at risk for COPD (chronic obstructive pulmonary disease) complications initiated 12/18/24. Surveyor noted R4's physical functioning deficit care plan initiated 12/11/24 documents an intervention, I require total assist x2 (times two) for toileting. Initiated 12/11/24 & revised 12/12/24. R4's Certified Nursing Assistant (CNA) Kardex as of 8/11/24 under the toileting section documents I require total assist x2 for toileting. There is no documentation on this Kardex as to when CNAs should provide incontinence care to R4. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted there is not a person-centered incontinence care plan for R4 who is incontinent of urine and bowel. On 8/11/25, at 3:38 p.m., Surveyor asked CNA-O if she has taken care of R4. CNA-O replied yes. Surveyor asked CNA-O when she provides incontinence cares for R4. CNA-O replied when I have her every two hours. CNA-O explained she gets R4 up in the morning and when she lays R4 down she changes her right before supper. Surveyor asked CNA-O how she knows she's supposed to provide incontinence cares every two hours. CNA-O replied that's what we are taught in class every two hours or prn (as needed). On 8/12/25, from 8:56 a.m., to 9:12 a.m., Surveyor observed morning cares for R4 with CNA-I. At 9:14 a.m., after CNA-I completed R4's cares, Surveyor asked CNA-I what cares she will provide to R4 for the rest of the day. CNA-I informed Surveyor she will get R4 in the chair, feed R4 breakfast, will check if she's wet, if wet will Hoyer her back to bed. She will ask R4 if she wants to rest in bed otherwise will get her up. On 8/12/25, at 1:41 p.m., Surveyor met with Licensed Practical Nurse/Unit Manager (LPN/UM)-K & LPN/UM-L. Surveyor inquired who is responsible for resident care plans. Surveyor was informed the unit managers and kind of all department heads. Surveyor informed LPN/UM-K & LPN/UM-L Surveyor noted there is a physical function deficit care plan which has an intervention which documents requires total assist times two for toileting but was unable to locate a person center incontinence care plan for R4 who is incontinent of urine and bowel. Surveyor asked who would have been responsible for developing this care plan. Surveyor was informed this would be nursing but LPN/UM-K & LPN/UM-L weren't in this role and wasn't sure if it was different with the different management. Surveyor asked if there should be an incontinence care plan. LPN/UM-L replied yes and explained she wasn't sure if it would specify the times, but they know staff does every two hours and as needed. On 8/12/25, at 2:12 p.m., Surveyor asked Director of Nursing (DON)-B who would develop an incontinence care plan. DON-B informed Surveyor MDS & sometimes nursing manager. Surveyor asked how CNAs knows when to provide incontinence care to residents who are incontinent. DON-B informed Surveyor most residents are independent and use their call lights and for the residents who are not independent they check and change every two to three hours. Surveyor informed DON-B there is no incontinence care plan developed for R4 who is incontinent of urine and bladder and the physical function deficit care plan for toileting only has an intervention which documents requires total assist times two for toileting. DON-B informed Surveyor they don't put time restrictions in care plans; they do frequent check and change. Surveyor informed DON-B a person-centered care plan should have been developed for R4.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure there was a medication error rate below 5 percent. There were 2 medication errors in 34 observed opportunities which resulted in a medication error rate of 5.88%. Two medication errors were identified for R7.R7's Humalog insulin pen was not primed prior to dialing the amount of insulin R7's physician ordered. R7's Glargine insulin pen was not primed prior to dialing the amount of insulin R7's physician ordered, and the insulin pen was not dated when opened.Findings include:The facility's policy titled, Insulin Pen and not dated under Policy documents It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. Under Policy Explanation and Compliance Guidelines documents 2. Insulin pens must be clearly labeled with the resident's name, physician name, date dispensed, type of insulin, amount to be given, frequency and expiration date. Under 11. Procedure documents h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears.On [DATE], at 8:29 a.m., Surveyor observed Licensed Practical Nurse (LPN)-C prepare R7's medication. LPN-C cleansed the top of the Humalog KwikPen with an alcohol pad, connected a needle and placed the insulin pen on the medication cart. LPN-C dispensed one tablet Midodrine 2.5 mg (milligram), one tablet Pantoprazole Sodium 40 mg, and one capsule Probiotic oral capsule into a medication cup. LPN-C opened & poured one packet of Potassium Chloride 20 mEq (milliequivalent) into a cup. At 8:39 a.m., LPN-C dialed 2 units of Humalog and added water to R7's Potassium Chloride. Surveyor observed LPN-C did not prime the insulin pen with 2 units. Surveyor then verified the number of pills in R7's medication cup with LPN-C. At 8:40 a.m., LPN-C placed gloves on and entered R7's room with R7's medication and placed R7's medication cup & Potassium Chloride on R7's over bed table. At 8:41 a.m., LPN-C cleansed the back of R7's right upper arm and injected R7's Humalog insulin. R7 stated to LPN-C I'm supposed to get 11 pills. At 8:43 a.m., LPN-C left R7's room. At 8:44 a.m., LPN-C stated to Surveyor maybe she's right, it must be the internet, she gets more pills. LPN-C then dispensed into a medication cup one tablet Vitamin C 500 mg, one tablet Magnesium Oxide 400 mg, one tablet Atorvastatin Calcium 10 mg, one tablet Bumetanide 1 mg, one capsule Cephalexin 250 mg, one table Eliquis 5 mg, & one tablet Metoprolol Succinate ER (extended release) 50 mg. LPN-C cleansed the end of Glargine Solostar pen with an alcohol pad, attached needle, and dialed insulin to 5 units. Surveyor observed LPN-C did not prime the pen with 2 units and the insulin pen is not dated. At 8:50 a.m., Surveyor verified the number of pills in R7's medication cup with LPN-C. At 8:51 a.m., Surveyor asked LPN-C if she is going to give R7 her medication now. LPN-C replied yes. Surveyor informed LPN-C Surveyor did not see a date when R7's Glargine insulin pen was started and asked LPN-C how does she know the insulin is not expired. LPN-C informed Surveyor insulin pens are supposed to be dated and if she had started the pen she would have dated it. At 8:52 a.m., LPN-C placed gloves on and entered R7's room. LPN-C placed the medication cup on R7's over bed table, cleansed the back of R7's right upper arm and administered R7's Glargine insulin. LPN-C removed her gloves, left R7's room, and cleansed her hands.At 8:53 a.m., Surveyor asked LPN-C if she is supposed to prime insulin pens prior to dialing the order amount. LPN-C replied no, I don't.On [DATE], at 10:52 a.m., Surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM)-K if insulin should be dated when opened. LPN/UM-K replied yes and explained insulin expires 28 days after being opened. Surveyor asked LPN/UM-K if insulin pens should be primed prior to dialing the amount of insulin the physician ordered. LPN/UM-K informed Surveyor should be primed 2 units every time. Surveyor informed LPN/UM-K of the observations during R7's medication pass with LPN-M.Not priming R7's Humalog insulin pen and not priming & administering R7's Glargine's insulin pen which was not dated resulted in 2 medication errors for R7.No additional information was provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 2 (R3 & R4) of 5 residents were free of significant medication errors.*R3 was admitted to the facility on [DATE] & discharged on 7/15/25. The after visit summary & Discharge summary dated [DATE] documents bacitracin-polymyxin B ophthalmic ointment with instructions to place into R3's right eye every 12 hours. The facility did not process this physician order and R3 did not receive bacitracin-polymyxin B ophthalmic ointment. R3 missed 10 doses of this medication.*On 12/10/24, R4's Humulin R 8 units before meals and Potassium & sodium phosphates 280-150-250 mg (milligrams) two packets twice daily documented in the hospital after visit summary & discharge summary was not processed by facility staff. R4 missed 8 doses of Humulin R and 6 doses of Potassium & sodium phosphates.Findings include:1.) R3 was admitted to the facility on [DATE] with diagnoses which includes congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should), hypertension (high blood pressure), chronic atrial fibrillation (irregular and rapid heart beat), and chronic kidney disease (characterized by progressive damage & loss of kidney function). R3 discharged from the facility on 7/15/25. R3's hospital after visit summary dated 7/10/25 under summary of your discharge medications documents bacitracin-polymyxin B ophthalmic ointment. Commonly known as Polysporin. Last Dose: July 10, 2025 8:47 a.m. Place into right eye every 12 hours. R3's hospital Discharge summary dated [DATE] under summary of your discharge medications documents bacitracin-polymyxin B ophthalmic ointment Commonly known as: Polysporin. Place into right eye every 12 hours.Surveyor reviewed R3's medical record including physician orders and July 2025 MAR (medication administration record) and was unable to locate R3's bacitracin-polymyxin B eye ointment.On 8/11/25, at 12:46 p.m., Surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM)-L to inquire regarding admission orders. LPN/UM-L informed Surveyor informed they look at hospital orders and they also have a sheet. Surveyor asked LPN/UM-L if she was involved with R3's admission orders. LPN/UM-L informed Surveyor she may have put the medication orders in and another nurse did the assessment. Surveyor informed LPN/UM-L the hospital after visit summary and Discharge summary dated [DATE] includes bacitracin-polymyxin B ophthalmic ointment every 12 hours to the right eye and Surveyor did not see where this was picked up by facility staff and there is no evidence R3 received this medication while he was at the facility. LPN/UM-L informed Surveyor she would review R3's medical record and get back to Surveyor.On 8/12/25, at 9:37 a.m., Director of Nursing (DON)-B informed Surveyor R3's eye medication was not documented so the facility did not administer them to R3. Surveyor informed DON-B Surveyor was not able to locate an order for the R3's eye medication. DON-B replied correct, we own that one, admitting that R3's eye medication was not administered per physician's order. Surveyor asked DON-B what is the process for new admission's medication to ensure the medication ordered by the hospital is picked up by the facility. DON-B informed Surveyor once a resident arrives the nurse on the floor reviews the paperwork. DON-B stated that sometimes facility staff have to call the hospital as the hospital forgets to send paperwork. The resident's vitals are checked, the Certified Nursing Assistant (CNA) weighs the resident, the nurse begins to enter medications into the computer and faxes the med list to the pharmacy. Surveyor asked DON-B is there a second nurse who checks the resident's medication. DON-B replied yes and explained its always done by two nurses. One nurse Q's (checks) the order, the other nurse will verify the medication and then the medication goes into active orders. Surveyor asked DON-B how does she think R3's right eye medication was missed. DON-B informed Surveyor somedays are heavy with admissions, five or six admissions. DON-B stated I will own that we missed it.Surveyor noted from 7/10/25 until R3 was discharged on 7/15/25, R3 missed 10 doses of bacitracin-polymyxin B ophthalmic ointment.2.) R4 was originally admitted to the facility on [DATE] with diagnoses which includes diabetes mellitus (high blood sugar), left ACA (anterior cerebral artery) stroke (an ischemic stroke that restricts blood flow to the right side of the brain), chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), hypokalemia (low potassium), and dementia (loss of cognitive function that interferes with a person's daily life & activities).R4's after visit summary dated 12/10/24 under the medication list documents insulin regular 100 unit/ml (milliliters) injection Commonly known as Humulin R Inject 8 units under the skin in the morning and 8 units at noon and 8 units in the evening. Inject before meals. Indications: High blood sugar. Potassium & sodium phosphates 280-150-250 mg (milligrams) pack. Commonly known as PHOS-NAK. Administer 2