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	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	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 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide information about how to apply for and use Medicare and Medicaid benefits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to provide a contract that they provided Medicaid services as required for one of one resident (Resident (R) 9) reviewed for admission contract of 18 sample residents. The facility's contract, signed by residents and/or their representatives, stated The Facility does NOT participate in the Medicaid program. This failure had the potential to affect payor source. Findings include: Review of the Face Sheet tab of the electronic medical records (EMR) revealed R9 was admitted on [DATE] with payer as Medicare A. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/12/26 revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated R9 was severely cognitively impaired. During an interview on 06/29/26 at 4:35 PM the Business Office Manager (BOM) revealed that R9 had been under Medicare services and back to private pay at this time. During an interview on 06/29/26 at 1:54 PM, R9's guardian revealed she was given a contract at the time of R9's admission that stated the facility did not accept Medicaid as payment. R9's guardian stated she had not attempted to apply for Medicaid because of the contract she signed. Record review of R9's facility's admission agreement, dated 01/23 and located under the Misc. tab of the EMR, revealed on page eight of 72 the following language: h) Medicaid Assistance. i) Medicaid Status Eligibility. The resident is considered a Medicaid beneficiary if the Resident receives benefits from a state Medicaid Program consistent with Title 42 CFR 483. Eligibility for Medicaid assistance is determined by applicable state law and is based on the Resident's financial resources. The Facility does NOT participate in the Medicaid program. During an interview on 06/29/26 at 4:35 PM, the Business Office Manager (BOM) revealed he completed Medicaid applications with residents' and family members on a regular basis. The BOM stated he had open forms on his desk that he was assisting family members with completing. The BOM stated R9's guardian had not asked him for assistance with completing a Medicaid application. The BOM stated he was not aware of the statement in the contract that read, The Facility does NOT participate in the Medicaid program. The BOM stated they participated in Medicaid, even if the contract said they did not. During an interview on 01/07/26 at 1:23 PM, the Assistant Director of Nursing (ADON) stated the (continued on next page)

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

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F 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility had Medicaid residents and was not sure why the contract was different. During an interview on 07/01/26 at 1:23 PM, the Administrator stated the facility accepted Medicaid residents and was not sure why the contract was different.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to notify the physician that medication (Arikayce - an antimicrobial) was not administered as ordered for one out of three residents (Resident (R) 1) reviewed for physician notification of 18 sample residents. This failure had the potential to delay physician evaluation and intervention and placed R1 at risk for worsening or progression of the underlying infection. (Cross Reference F755) Findings include: Review of R1's admission Record located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with a diagnosis of mycobacterium avium complex (a chronic, sometimes progressive pulmonary infection). Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/21/26 and located under the MDS tab of the EMR, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R1 was moderately cognitively impaired. Review of R1's physician Orders located under the Orders tab of the EMR, dated 05/23/26 indicated the resident was prescribed Arikayce Inhalation Suspension 590 milligrams (mg)/8.4 milliliters (ml) (Amikacin Sulfate Liposome), 590 mg inhale orally one time a day for pulmonary infection. Review of R1's May 2026 Medication Administration Record (MAR) located under the Orders tab, indicated R1 was not administered Arikayce on 05/29/26, 05/30/26, and on 05/31/26. The medication could not be reordered through the pharmacy and noted that the family of the resident provided this medication. Review of R1's June 2026 MAR located under the Orders tab, indicated that R1 was not administered Arikayce on 06/03/26, 06/07/26, 06/17/26. The medication could not be reordered through the pharmacy and noted that the family of the resident provided this medication. Review of R1's clinical record failed to contain evidence that the resident's physician was notified that the Arikayce was not administered. During an interview on 06/30/26 at 2:48 PM, Licensed Practical Nurse (LPN) 7, who was also a supervisor and the Assistant Director of Nursing (ADON), stated that the physician should have been notified when the Arikayce was not administered. LPN 7 stated the Arikayce was in the complex refrigerator and had informed the nursing staff of its location. LPN 7 confirmed that the physician was not notified. Review of the facility's undated policy titled, Medication Administration Policy, indicated .Immediately assess residents following medication errors, notify the practitioner, monitor the resident complete required reports, and implement corrective actions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure medications were available and administered as ordered for two of three residents (Residents (R) 2 and R1) reviewed for medication availability from a total sample of 18 residents. This failure had the potential to result in adverse health outcomes which could lead to ineffective treatment. Findings include: 1. Review of R2's admission Record located under the Profile tab of the electronic medical records (EMR) revealed R2 was admitted to the facility on [DATE] with a diagnosis of hereditary spastic paraplegia. Review of R2's physician Orders, dated 01/20/26 and located under the Orders tab of the EMR, revealed an order for diazepam (an antianxiety) 0.5 milligrams (mg) to be administered twice a day (7:30 AM and 12:00 PM) for anxiety. In addition, R2 had an order for metformin 500 mg twice a day (7:30 AM and 6:30 PM) for diabetes. Review of R2's January 2026 Medication Administration Record (MAR) located under the Orders tab of the EMR revealed on 01/21/26 the 7:30 AM and the 12:00 PM doses of diazepam were documented as not administered. On 01/22/26 the 7:30 AM dose of diazepam was documented as not administered. On 01/22/26 the 7:30 AM dose of metformin was documented as not administered. There were no corresponding progress notes to show why the medications were not administered to R2 on 01/21/26 and 01/22/26. Review of R2's Five-Day Medicare Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/22/26 and located under the MDS tab of the EMR, indicated R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed R2 was cognitively intact. Review of a facility document titled Inventory Replenishment Report, provided by the facility, referred to as the Pyxis (an automated medication dispensing system), failed to identify diazepam as being available through this system. During an interview conducted on 06/30/26 at 12:26 PM, Pharmacist 2 stated that R2's metformin was ordered on 01/20/26 and sent back to the facility on the same date. Pharmacist 2 stated that the pharmacy never received the physician order for the diazepam. During an interview on 07/01/26 at 11:44 AM, Licensed Practical Nurse (LPN) 7/Supervisor confirmed that R2's diazepam was not ordered. LPN 7 stated the process was to ask the hospital to order medication if the hospital forgot to send the prescription. Review of a facility's undated policy titled, Medication Administration Policy, indicated .To ensure medications are ordered, prepared, administered, documented, stored,monitored, and disposed of safely in accordance with practitioner orders, resident rights,professional standards of practice, and applicable federal and state regulations. 2. Review of R1's admission Record located under the Profile tab of the EMR revealed R1 was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the facility on [DATE] with a diagnosis that included mycobacterium avium complex (a chronic, non-contagious infection caused by bacteria naturally found in soil and water). Review of R1's admission MDS with an ARD of 05/21/26 and located under the MDS tab of the EMR, indicated R1 had a BIMS score of 12 out of 15 which revealed the resident was moderately cognitively impaired. Review of R1's physician Orders, dated 05/23/26 and located under the Orders tab of the EMR, revealed an order for Arikayce Inhalation Suspension 590 mg (milligram)/8.4 ml (milliliter) (Amikacin Sulfate Liposome) 590 mg to be inhaled one time a day for pulmonary infection. Review of R1's May 2026 MAR located under the Orders tab, indicated R1 was not administered Arikayce on 05/29/26, 05/30/26, and 05/31/26. For the month of June 2026, R1 was not administered Arikayce on 06/03/26, 06/07/26, and 06/17/26. During an interview on 06/29/26 at 3:52 PM, LPN5, stated R1 returned from an infectious disease appointment with the Arikayce medication orders. R1 stated she contacted R1's family member to bring the medication into the facility. LPN 5 stated she was unfamiliar with the Arikayce and the administration of the medication. LPN 5 stated respiratory therapy (RT) was to administer the Arikayce Monday through Friday and the floor nurses were to administer the inhaler on the other days of the week. LPN 5 stated R1 had to show her how to set up the Lamira nebulizer system (a drug delivery device that has a vibrating mesh nebulizer to deliver a fine mist of Arikayce directly into the lung). During an interview on 06/29/26 at 4:01 PM, the Respiratory Therapist (RT) stated R1 had mycobacterium avium complex (MAC) disease and received directions on how to set up the nebulizer system through the Arikayce manufacture website. During an interview on 06/30/26 at 2:48 PM, LPN 7 and the Assistant Director of Nursing (ADON) stated the directions for setting up the nebulizer system for the administration of Arikayce was in the medication area. ADON stated she would have expected competence of the safe administration of the Arikayce; therefore, training was important. LPN 7 confirmed there was no training for the nursing staff for the administration of the Arikayce. ADON stated she would expect a check-off list. Review of the Food and Drug Administration (FDA) manufacturer's instructions for Arikayce, dated 09/18 and located at https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/207356s000lbl.pdf, revealed the medication must be prepared and administered using the Lamira nebulizer system (vibrating mesh nebulizer system specifically designed to be used with Arikayce). The instructions indicated Arikayce should be brought to room temperature by removing it from the refrigerator at least 45 minutes before use. The instructions also indicated that the medication should not be used if it had been frozen. The instructions directed staff to shake the vial for at least 10 to 15 seconds until the medication looked the same throughout and was well mixed. The instructions then directed staff to remove the vial cap, metal band, and rubber stopper before pouring one vial of Arikayce into the medication reservoir. The instructions indicated staff should not use more than one vial for each treatment. The instructions directed staff to attach the medication cap to the medication reservoir, turn the cap clockwise until it stopped, and then turn on the Lamira device. The instructions indicated the resident should sit upright, place the mouthpiece in the mouth, close the lips around the mouthpiece, and breathe through the mouthpiece until the treatment was complete. The instructions indicated the treatment should (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take approximately 14 minutes but could take up to 20 minutes. Review of a facility's policy titled, Training Requirements, dated 10/01/22, indicated .It is the policy of this facility to develop, implement, and maintain effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles.All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program.The Staff Development Coordinator maintains a training schedule and documentation system for completed training by all staff, contracted staff, and volunteers. Review of a facility's undated policy titled, Medication Administration Record, indicated .Verify every medication order before administration and clarify questionable orders.Nursing staff shall follow this policy during every medication pass.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a significant medication error for 1 (R1) of 18 sampled residents reviewed for medications.R1 was prescribed the medication Arikayce, an antimicrobial medication related to a diagnosis of mycobacterium avium complex (a chronic, non-contagious infection caused by bacteria naturally found in soil and water - causing a pulmonary infection). R1 did not receive the medication as ordered on 6 different dates.Findings include:Review of R1's admission Record located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with a diagnosis of mycobacterium avium complex (a chronic, sometimes progressive pulmonary infection). Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/21/26 and located under the MDS tab of the EMR, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R1 was moderately cognitively impaired. Review of R1's physician Orders located under the Orders tab of the EMR, dated 05/23/26 indicated the resident was prescribed Arikayce Inhalation Suspension 590 milligrams (mg)/8.4 milliliters (ml) (Amikacin Sulfate Liposome), 590 mg inhale orally one time a day for pulmonary infection. During an interview on 06/29/26 at 3:52 PM, LPN5, stated R1 returned from an infectious disease appointment with the Arikayce medication orders. R1 stated she contacted R1's family member to bring the medication into the facility. LPN 5 stated she was unfamiliar with the Arikayce and the administration of the medication. LPN 5 stated respiratory therapy (RT) was to administer the Arikayce Monday through Friday and the floor nurses were to administer the inhaler on the other days of the week. LPN 5 stated R1 had to show her how to set up the Lamira nebulizer system (a drug delivery device that has a vibrating mesh nebulizer to deliver a fine mist of Arikayce directly into the lung). Review of R1's May 2026 Medication Administration Record (MAR) located under the Orders tab, indicated R1 was not administered Arikayce on 05/29/26, 05/30/26, and on 05/31/26. The medication could not be reordered through the pharmacy and noted that the family of the resident provided this medication. Review of R1's June 2026 MAR located under the Orders tab, indicated that R1 was not administered Arikayce on 06/03/26, 06/07/26, 06/17/26. The medication could not be reordered through the pharmacy and noted that the family of the resident provided this medication. Review of R1's clinical record failed to contain evidence that the resident's physician was notified that the Arikayce was not administered. During an interview on 06/30/26 at 2:48 PM, Licensed Practical Nurse (LPN) 7, who was also a supervisor and the Assistant Director of Nursing (ADON), stated that the physician should have been notified when the Arikayce was not administered. LPN 7 stated the Arikayce was in the complex refrigerator and had informed the nursing staff of its location. LPN 7 confirmed that the physician was not notified.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interviews and observation, the facility failed to ensure a qualified individual was designated to serve as the director of food and nutrition services with the potential to affect 65 of 76 residents consuming food in the dietary department. This failure had the potential to contribute to improper kitchen sanitation practices. Findings include: The facility failed to provide a copy of the Dietary Manager (DM) job description when requested on 06/30/26 at 12:35 PM, on 06/30/26 at 4:30 PM, and on 07/01/26 at 10:15 AM. During observation of the kitchen on 06/30/26 at 11:00 AM, no certificates of training were observed in the kitchen or office area. During an interview on 06/30/26 at 12:35 PM, the DM stated, I've been in this position for about two months, I do not have any certifications. During an interview on 06/30/26 at 4:30 PM, the Administrator stated, The current DM does not have any certifications. I just hired a Certified Dietary Manager (CDM) who will be starting in two weeks.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure facial hair was properly restrained while serving food with the potential to affect 65 out of 76 residents consuming food in the dietary department. This had the potential for physical contamination of the food being served. Findings include: During an observation on 06/30/26 at 11:35 AM, the [NAME] (C) 1 was observed to have a goatee approximately 0.25-0.50 in length. C1 was working at the steam table, plating food for lunch service and was not wearing a beard restraint. During the same observation Dietary Aide (DA) 1 was observed to have a goatee approximately 1.00-2.00 inches in length. DA1 was prepping (placing drinks, silverware, and condiments) meal trays for service on the tray line and was not wearing beard restraint. During the same observation DA2 was observed to have a goatee approximately 0.25-0.50 inches in length. DA 2 was prepping (placing drinks, silverware, and condiments) meal trays for the service on the tray line and was not wearing a beard restraint. During an interview on 06/30/26 at 12:10 PM, the Dietary Manager (DM) stated, They are not wearing beard guards and they should be, hair is supposed to be restrained. Review of the facility's policy titled, Food Safety Requirements, dated 2026, revealed Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by the federal, state, and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Policy Explanation and Compliance Guidelines . 7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects. d. Dietary staff must wear hair restraints (e.g. hairnet, hat, and/or beard restraint) to prevent hair from contacting food.

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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 staff interviews, document review, and policy review, the facility failed to maintain a comprehensive water management program, including hot and cold-water temperature monitoring, a water system risk assessment, and a water distribution flow diagram. Additionally, the facility failed to provide an infection surveillance system to identify, track, trend, analyze, and respond to infectious illnesses within the facility. These deficient practices had the potential to contribute to the transmission of infectious diseases and adversely affect all 76 residents residing in the facility. Findings include: 1. During an interview on 07/01/26 at 9:10 AM, the Maintenance Director (MD) was asked to provide water temperature monitoring records for the previous three months. The MD stated that water temperature testing had not been conducted during that period. The MD further stated that no water treatment activities had been completed since the start of his employment and that he was unable to locate documentation of any previous water treatment program or monitoring activities. Specifically, the facility was unable to provide a written water management plan, hot and cold-water temperature monitoring logs, a documented water system risk assessment, a water distribution flow diagram, or documentation of corrective actions related to water system management. The MD stated he had not seen water temperatures and had not completed any. He stated he had not seen a written management plan nor water system risk assessment. He stated he did not have a distribution flow diagram of the water and was not aware that there was any corrective action noted. Review of the facility's policy titled, Legionella Surveillance, implemented 10/01/22, revealed 5. Primary prevention strategies.c. Physical controls: i. Cooling towers and potable water systems shall be routinely maintained.iii. Non-potable water systems shall be routinely cleaned and disinfected.d. Temperature controls: i. Cold water shall be stored and distributed below 68 degrees F [Fahrenheit]. ii. Hot water shall be stored above 140 degrees F and circulated at a minimum return temperature of 124 degrees F. 2. Review of the infection control tracking and trending documentation, dated from February 2026 through May 2026, provided by Licensed Practical Nurse (LPN) 7 and Assistant Director of Nursing (ADON) on 06/30/26 at 9:45 AM, revealed pages of unclear resident tracking. They both stated that they could not understand it by the way it was sent by the Director of Nursing (DON). They stated this was the first time seeing it written down. During an interview on 06/29/26 at 1:42 PM, the LPN7/ Supervisor revealed that the DON did not share the Infection Prevention (IP) information with her. LPN7 stated she had never seen a book, and the DON stated it was on her computer. LPN7 noted that by working the floor she was aware of who had infections and who was on antibiotics. LPN7 stated she was not aware of how the DON got that information. LPN7 stated was not aware of how DON did the tracking and trending. The DON was unavailable for interviews during the survey.