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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0686 Level of Harm - 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 residents received care consistent with professional standards of practice, to prevent pressure ulcers and do not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 4 (R41, R2, R60, and R10) of 6 residents reviewed for pressure injuries. R41 developed an avoidable left heel deep tissue injury that was not comprehensively assessed or measured since September 2025. No treatment has been implemented and Surveyor had observations while on survey of R41's care plan interventions of heel boots and turning from side to side and not laying on his back, not implemented. R10 admitted to the facility on [DATE] with a pressure injury to the right heel. A comprehensive assessment was not completed until 8/6/25 when it was then documented as unstageable. R2 was observed not wearing heel boots per the plan of care while on survey. R60 was observed not wearing heel boots per the plan of care while on survey. Findings include: The facility policy titled Pressure Injury Prevention Guidelines (which was not dated) documents (in part) . . Policy: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. 1. Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment (e.g. moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). 3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and for tasks, the frequency for performing them. 7. Interventions will be documented in the care plan and communicated to all relevant staff. 8. Compliance with interventions will be documented in the medical record. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525549	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0686 Level of Harm - Actual harm Residents Affected - Few	a. For at risk residents: Treatment or medication administration records. b. For residents who have a pressure injury present: Treatment or medication administration records, weekly wound summary charting. Pressure relieving devices: . 3. Apply heel suspension devices according to the manufacturer's instructions. a. For prevention, stage 1 or stage 2: Use pillows or heel suspension devices. If using heel protectors, will still need to utilize pillows for floatation. b. For stage 3, 4, unstageable or deep tissue injury: Place foot and leg into a heel suspension boot that elevates the heel from the surface of the bed, completely offloading the pressure injury. Check the skin each shift and PRN (as needed) for signs of redness or skin breakdown related to the boot. R41 admitted to the facility on [DATE] and has diagnoses that include Cerebral infarction, Hemiplegia and hemiparesis affecting right dominant side, Multiple Sclerosis, Monoplegia of upper limb, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Moderate protein-calorie malnutrition, osteomyelitis of vertebra, sacral and sacrococcygeal region, neuromuscular dysfunction of bladder, depression, epilepsy, paraplegia, pressure ulcer of sacral region and pressure ulcer of left heel. Surveyor notes R41's hospital discharge paperwork dated 12/31/24 documents lower extremity contractures are present. R41's Braden score on 1/16/26 documents a score of 15 indicating at risk for pressure injuries. R41's Quarterly Minimum Data Set (MDS) dated [DATE] documents: Roll left and right - the ability to roll from lying on back to left and right side and return to lying on back on the bed as substantial/maximal assistance. Section M - Skin Conditions documents: Current number of unhealed pressure ulcers/injuries at each stage - number of Stage 4 pressure ulcers 1. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - 1. No other pressure injuries were documented on the MDS. R41's care plan documents: -I am at risk for alteration in psychosocial well-being r/t (related to) new environment, refusing therapy, refusing care, refusing to get out of bed, refusing to go to appointments that are scheduled, refusing to wear protective boot. Interventions include: If I am refusing care and treatment, please reapproach me, explain the reason for the care or treatment and why it's important – date initiated 7/3/25. -Pressure ulcer actual or at-risk r/t decrease bed mobility, incontinence, HX (history) of wounds: Active: Coccyx stage 4 - present on admission. HX of left ischial wound, left heel wound, Superior left buttocks stage 3, left buttocks inferior stage 3, left thigh stage 3, left great toe Stage 3, Left heel-suspected DTI (deep tissue injury), Left buttock- fluid filled blister, right gluteal cleft, I sometimes scratch my left ischial wound area, refuses Prostat supplement - date initiated 2/12/25. Interventions include: Encourage Heel boots at all times – revision on 4/14/25. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0686 Level of Harm - Actual harm Residents Affected - Few	-I have a physical functioning deficit related to: Mobility impairment, Self-care impairment date initiated 2/11/25. Interventions include: I need assist x1 for bed - revision on 10/28/25. R41's Kardex as of 1/22/26 documents: Encourage Heel boots at all times. Provide pressure reduction/relieving mattress setting at 200. Reposition every 2 hours side to side, avoid back. Surveyor review of R41's hospital discharge summary and hospital records dated 2/10/25 which document: Chronic Stage 4 decubitus ulcer with osteomyelitis s/p (status post) surgical I&D (incision and drainage). Intravenous antibiotics through 2/5/25. Also, s/p debridement including bone debridement 10/19/24. CT (Computed Tomography) abdomen/pelvis showed large abscess associated with sacral ulcer and extending deep pelvis with question of rectocutaneous fistula involving sacral ulcer but nonobvious noted intra-op. History of wound vac sacrum. Left heel DTI with improvement continue to keep covered with padded band aid. Maroon, purple, dry, non-blanchable 4.4 x 5 cm (centimeters). On 1/20/26 at 10:54 AM, Surveyor observed R41 lying in bed on his back watching TV. Air mattress on bed and functioning at appropriate setting. Head of bed elevated 30 degrees, wearing Prevalon boot on left foot. R41 reported he had a sore on the side of his foot before, so they want him to wear the boot. Surveyor observed R41 was wearing a gripper sock on the right foot and not wearing a Prevalon boot on his right foot. His right foot was resting directly on the mattress. R41 was unable to lift either foot off the bed upon request, he reported he can't because he had a stroke. R41 reports he had 3 sores - 2 on each side of butt and one on the coccyx. On 1/22/26 at 9:30 AM, Surveyor observed R41 lying in bed with the head of bed elevated approximately 30 degrees. Surveyor observed R41 was not wearing a Prevalon boot on either foot and both feet were resting directly on the mattress. Surveyor observed one Prevalon boot on a chair across the room. R41 stated, My aide last night didn't put them on, and I only wear one because of a sore that I used to have on my left foot. R41 reported staff do come in to reposition him, but he mostly stays on his back where he is comfortable. On 1/22/26 at 12:00 PM, Director of Nursing (DON)-B provided Surveyor evidence of assessments and measurements of R41's sacral pressure injury. Surveyor advised R41 reported he had a history of a sore on his left foot and was given a boot to wear on that foot only. Surveyor asked if R41 should be wearing pressure relieving boots on both feet. DON-B stated, Yes, that would only make sense to give him boots for both feet. But he may refuse at times, he does refuse cares and repositioning at times. Surveyor advised DON-B of care plan intervention to encourage heel boots at all times and observations while on survey of R41 not wearing boots and feet resting directly on the mattress. Due to Surveyor observation of R41's heels not offloaded and history of foot pressure injury, Surveyor asked to view R41's feet. On 1/22/26 at 12:27 PM, the facility MDS nurse (unknown name) assisted Surveyor to view R41's feet. Surveyor noted R41 to be wearing Prevalon boots on both feet. Assessment of R41's right foot revealed no pressure injuries or signs/symptoms of skin breakdown. Assessment of R41's left foot revealed a darkened brown necrotic area approximately the size of a half dollar. Surveyor asked the MDS nurse to palpate the area. It was reported to be dry, no open skin and no drainage. The MDS nurse reported it looked like it was a deep tissue injury. Review of R41's medical record revealed R41 is followed by [name of company] wound physician. There was no documentation or evidence R41 currently has a pressure injury to his left heel. Surveyor (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0686 Level of Harm - Actual harm Residents Affected - Few	located no assessments or measurements and no treatment of a left heel pressure injury. DON-B provided Surveyor documentation of R41's 2/10/25 admission assessment and measurements of the sacrum stage 3 pressure injury and left heel SDTI (Suspected Deep Tissue Injury) present on admission which measured 8 x 6 x 0.1 cm. Surveyor identified no concerns with R41's sacrum pressure injury. The pressure injury is chronic, dating back to at least 2024. Appropriate treatment is implemented and completed, and he is followed by the wound care physician. Current measurements as of 1/13/26 were 0.6 x 0.6 x 0.5 cm. 100% granulation tissue. Wound progress improved evidenced by decreased depth. No signs of infection. Surveyor advised DON-B of the observation of necrotic area on R41's left heel and there is no evidence of assessments/measurements or current treatment implemented. DON-B reported R41 is followed by the wound care physician. DON-B reported he does not have treatment, and the doctor does not document on it because it is to be left open to air and he assesses it weekly. The wound physician note dated 1/13/26 included documentation of the coccyx stage 3 pressure injury, however there was no documentation of an assessment or measurements of the necrotic left heel. R41 was hospitalized on [DATE] and readmitted on [DATE]. Facility documentation: Left heel Pressure ulcer/injury. Unstageable pressure injuries presenting as deep tissue injury. Wound was present on admission. Signs and symptoms of infection: None. Painful: No. Length (cm): 8 x 6 Depth (cm): 0.1. Eschar: 100%. On 3/17/25 the Advance Wound Care physician documents R41's left heel as healed. Surveyor noted there was no treatment, or assessment/measurements after 3/17/25 of R41's left heel. Surveyor had significant difficulty determining when the now observed left heel necrotic area developed. On 1/26/26 at 8:47 AM, Surveyor spoke with Wound Doctor-Z by phone. Surveyor asked about R41's left heel necrotic area and why there was no documentation in his wound progress notes and no treatment. Wound Doctor-Z reported if the area is dark black, he would use maybe betadine or if it was open maybe Medi honey. Surveyor described the area to Wound Doctor-Z and advised Wound Doctor-Z there is no documentation in his weekly wound note regarding the left heel. Wound Doctor-Z stated, I don't do a complete body assessment, I only look at the wound the patient has. If he has any other wounds, they (referring to the facility) need to tell me about it. Surveyor asked Wound Doctor-Z if he was aware of the left heel pressure injury. Wound Doctor-Z stated, If I didn't document on it then they didn't tell me about it. I'll be in tomorrow, have them remind me to look at it then. On 1/26/26 at 10:05 AM, Surveyor spoke with DON-B to clarify questions about R41's left heel pressure injury. Surveyor informed DON-B Surveyor observed R41 currently has an unstageable pressure injury with necrosis on his left heel. Surveyor is unable to determine when the pressure area developed due to no documentation of an assessment or measurements and no treatment implemented. DON-B stated, I will have to look into this. I think it's the same area as he admitted with, but even if there isn't a treatment and we're leaving it OTA (open to air) someone should be assessing it at least weekly. Surveyor informed DON-B that Wound Doctor-Z reported he has not been looking at (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0686 Level of Harm - Actual harm Residents Affected - Few	R41's heel because he was not aware there was a pressure injury, and he will look at it tomorrow. On 1/26/26 at 11:30 AM, DON-B advised Surveyor R41's heel never opened. The wound team (Tissue analytics) saw R41 on 9/24/25 and signed off. Surveyor and DON-B viewed the picture taken by Tissue Analytics – R41's heel was not open and there was no necrotic area. DON-B stated, Prior to that, on 9/17/25 the facility wound nurse documented the area as non-blanchable. When [wound care company] took over on 10/28/25 it was not open, which is why he didn't address it. Surveyor informed DON-B of the concern – if R41's heel was healed on 9/24/25 and the wound physician said it was not open on 10/28/25, then why does the resident currently have a necrotic area on his heel and when did it develop? DON-B reported she is not sure and was not aware and will have to look into it. Surveyor review of facility progress notes documented: On 8/27/25 at 6:07 PM, N Adv (Nursing Advanced) Skin Check documents - Skin issue is resolved. Location: Left heel Pressure ulcer injury. Progress: Resolved: Wound healed and/or closed. Unstageable pressure injuries presenting as deep tissue injury. Wound was present on admission. Length (cm): 0 Width (cm): 0 Depth (cm): 0 Undermining: No. On 9/10/25 at 8:27 PM, pt (patient) seen by wound MD (Medical Doctor) continue current TX (treatment) orders. Blanchable redness noted to right heel during routine skin check. On 9/17/25 at 11:47 AM, N Adv Skin Check Late Entry documents: Suspected DTI left heel - new. On 9/17/25 at 4:15 PM, Seen by wound MD today, NOR (new order received) and transcribed. Pt does have blanchable redness to left heel. The Wound Tissue Analytics documentation on 9/24/25 documented: Left heel SDTI (Suspected Deep Tissue Injury) 1.53 x 1.68 wound bed assessment - purple. The Wound Tissue Analytics documentation on 10/1/25 included no documentation of R41's left heel pressure injury and there was no documentation thereafter of an assessment, measurements or treatment. Surveyor review of R41's (Treatment Administration Record) TAR documented an order for skin prep every evening completed 9/17/25 through 10/4/25 and was then discontinued, no further treatment was documented. R41 was hospitalized [DATE] - 10/16/25 and 10/20/25 -10/27/25. Surveyor was unable to locate documentation of a left heel pressure injury in those hospital records. R41 was hospitalized [DATE] – 12/10/25. Hospital records documented: Left heel pressure injury. DTI (deep tissue injury). Wound bed/tissue type: Intact; red; purple. Peri wound callus, dry. R41's readmission N ADV clinical admission note on 12/10/25 includes no documentation of a left heel pressure injury. Surveyor notes R41's left heel DTI declined between R41's hospitalization 12/7/25 - 12/10/25 when (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0686 Level of Harm - Actual harm Residents Affected - Few	it was described as a DTI, intact red; purple compared to the current observation on 1/22/26 when Surveyor identified a darkened brown necrotic area approximately the size of a half dollar on R41's left heel. On 1/26/26 at 3:11 PM, during the daily exit meeting with Nursing Home Administrator (NHA)-A and DON-B, Surveyor shared concerns regarding R41's left heel pressure injury. Surveyor asked for additional information regarding Surveyors observation of R41's necrotic left heel. DON-B advised Surveyor that Wound Doctor-Z would be in tomorrow. Surveyor asked if the facility is or was aware R41 currently has a necrotic area to his left heel prior to identification by Surveyor. DON-B reported she spoke to the wound doctor, he said he was aware, and he has always had the area and will meet with Surveyor tomorrow. Surveyor informed DON-B of conversation with Wound Doctor-Z who reported to Surveyor – If I didn't document on it then they didn't tell me about it. On 1/27/26 at 11:10 AM, Surveyor met with Wound Doctor-Z. Wound Doctor-Z reported R41's left heel wound documentation was on the other (tissue analytics) documentation, and he does not have any documentation of the left heel wound. Wound Doctor-Z stated, If they don't tell me about a wound, then I don't know to look at it. Surveyor observed R41's left heel with Wound Doctor-Z. Surveyor observed the heel to have approximately 75% black necrotic tissue and approximately 25% tan necrotic tissue. The area was measured by Wound Doctor-Z's assistant as 3.5 cm x 3.2 cm. Wound Doctor-Z instructed his assistant the wound is a DTI and advised to order skin prep. Outside of R41's room Surveyor spoke with Wound Doctor-Z and DON-B. Surveyor informed DON-B of concern there is no evidence the facility was aware of R41's left heel pressure injury until Surveyor observed the area and notified the facility. Surveyor and facility are unable to determine when the pressure injury developed. There are no comprehensive assessments, measurements or treatment ordered for the pressure injury. DON-B stated, I have looked at everything as well and can't find anything related to the heel, I just don't know. On 1/27/26 at 11:41 AM, Surveyor spoke with Wound Doctor-Z. Wound Doctor-Z stated, Yes, he has a DTI. He's had one on that heel before too. It heals and reappears. Look at him, he has a lot of health problems. He's had pressure injuries for years. He has contractures, he refuses to get out of bed, he refuses care and treatment - it's his way or no way. I would say it was unavoidable with his compromised health; he's in and out of the hospital, sometimes refusing treatment he was arguing with me today about his treatment. We have the air mattress, heel boots, repositioning but he mostly won't get off his back. A normal person who would develop a DTI with say 70 mm (millimeters) pressure, he would probably need less than 30. But for someone like him all things you do can sometimes just make minimal difference. Surveyor confirmed with Wound Doctor-Z that if he was aware of the left heel pressure injury he would have assessed and documented on it weekly. On 1/27/26 at 3:15 PM, NHA-A and DON-B were informed of the concern Surveyor observed of R41's heels not offloaded while on survey. Surveyor observation of the left heel revealed a necrotic area which Wound Doctor-Z classified as a DTI. There is no evidence the facility was aware of the pressure injury until it was identified by Surveyor. Surveyor and DON-B were unable to determine when the pressure injury developed. There is no evidence of a comprehensive assessment or weekly assessments/measurements and R41 does not have a current treatment implemented. No additional information was provided. 3) R2 was admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis (a chronic disabling autoimmune disease of the central nervous system), Spastic Hemiplegia Affecting Right Dominant Side (one side of body experiences muscle stiffness and weakness), Neuromuscular (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0686 Level of Harm - Actual harm Residents Affected - Few	Dysfunction of Bladder (nerves controlling bladder and urinary sphincter are damaged and not working correctly), Irritable Bowel Syndrome with Diarrhea (common chronic functional disorder of the large intestine), Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Chronic Obstructive Pulmonary Disease (lung disease that block airflow and make it difficult to breathe), Insomnia (sleep disorder characterized by difficulty falling asleep), and Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R2 is currently his own person. R2's Quarterly Minimum Data Set (MDS) completed 12/29/25 documents R2's Brief Interview for Mental Status (BIMS) score to be 15 indicating R2 is cognitively intact for daily decision making. R2's Patient Health Questionnaire (PHQ-9) score of 6 indicates R2 is demonstrating mild depressive symptoms. R2's MDS documents R2 is not demonstrating behavior symptoms including refusal of cares/treatments. R2's MDS documents R2's primary method of locomotion is wheelchair. R2 has range of motion impairment (ROM) on one side of both upper and lower extremity. R2 requires set-up for eating. R2's MDS documents R2 requires substantial/maximum assistance with showers, upper dressing, and mobility. R2 is dependent on assistance for lower dressing and transfers. R2 has an indwelling catheter and is frequently incontinent of bowel. R2's MDS also documents R2 is at risk for developing pressure areas/injuries. R2's MDS does not document R2 has a splint. R2's Care Area Assessment (CAA) completed 4/16/25 documents pressure reducing devices are in place to minimize risks. R2's Kardex dated 1/22/26 documents care instructions for certified nursing assistants (CNAs) to place prevalon boot to left heel at all times while in bed. R2's is at risk for altered skin integrity relate bowel incontinence and impaired mobility comprehensive care plan was initiated on 8/16/25. History of shearing to buttocks and non-blanchable redness to right heel; initiated 8/16/25. The intervention prevalon boot to left heel at all times while in bed was initiated 12/23/25. Surveyor notes there is no comprehensive care plan documenting R2 refuses to wear the prevalon boot. Surveyor reviewed R2's January 2026 medication and treatment administration record (MAR/TAR) and notes there is no monitoring of the placement of R2's left heel boot at all times while in bed. R2's Braden scale for predicting pressure ulcer risk completed 1/6/26 documents a score of 17 indicating R2 is at risk for developing a pressure injury/ulcer. On 1/21/2026, at 7:35 AM, Surveyor observed R2 in bed with no heel boots on. Both heels are directly on the mattress. On 1/21/2026, at 12:57 PM, Surveyor observed R2 in bed with no heel boots on. Both heels are directly on the mattress. On 1/22/2026, at 7:44 AM, Surveyor observed R2 sleeping in bed with no heel boots on. Both heels are directly on the mattress. On 1/22/2026, at 9:51 AM, Surveyor observed R2 in bed with no heel boots on. Both heels are directly (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0686 Level of Harm - Actual harm Residents Affected - Few	on the mattress on the footboard. On 1/26/26, at 7:24 AM, Surveyor observed R2 in bed with no heel boots on. R2's heels are directly on the mattress. On 1/26/26, at 11:21 AM, Surveyor interviewed certified nursing assistant (CNA)-CC in regard to R2. CNA-CC informed Surveyor that CNA-CC is not normally assigned to R2 but is familiar with R2. CNA-CC states that CNA-CC has seen R2 wearing heal boots in the past when assigned to R2. CNA-CC is not aware of anytime that R2 has refused to wear the heel boot when in bed. CNA-CC stated that CNA-CC would check a resident Kardex if taking care of a new resident or if assigned to another unit. On 1/26/2026, at 11:41 AM, Surveyor observed R2 in bed with no heel boot on. Surveyor interviewed R2. R2 stated they used to put it on him, he only has the one heel boot, and they haven't put it on in about a month. They used to put it on me when in bed. It goes on the leg that I can't move, my right leg. I never refused it. I sometimes ask to take it off for a couple of hours and then I'm ok with it being put back on. I would wear it. R2 gave permission for Surveyor to look in R2's closet. Surveyor observed R2's green heel boot which is located on the top shelf of R2's closet. On 1/26/2026, at 2:59 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the observation R2 was not wearing their heel boots to reduce the risk of developing a pressure injury as documented on the CNA Kardex and comprehensive care plan. On 1/27/2026, at 7:09 AM, Surveyor observed R2 in bed sleeping. R2 has a heel boot on the left heel. 4) R60 was admitted to the facility on [DATE] with diagnoses of Pressure Ulcer of Right heel, Unspecified Stage, Spondylopathy (disease or disorder affecting vertebrae of the spine) in Diseases Classified Elsewhere, Muscle Wasting and Atrophy, Hyperlipidemia, Depression (mood disorder that causes persistent feelings of sadness and loss of interest), and Generalized Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities). R60 is currently his own person for decision making. R60's Quarterly Minimum Data Set (MDS) completed 12/17/25 documents R60's Brief Interview for Mental Status (BIMS) score to be 15, indicating R60 is cognitively intact for daily decision making. R60's patient Health Questionnaire (PHQ-9) has a score of 1 indicating minimal depressive symptoms. R60 has range of motion (ROM) impairment on one side of upper extremity and no lower extremity ROM impairment. R60's main method of locomotion is by wheelchair. R60 requires set-up for eating. R60 is dependent for assistance with showers, upper and lower dressing, and transfers. R60 requires substantial/maximum assistance for mobility. R60's MDS documents R60 is always incontinent of bowel and bladder and is at risk for developing pressure injury/ulcers. R60's Pressure Ulcer/Injury Care Area Assessment (CAA) completed 6/18/25 documents pressure reducing devices in place and the goal is to have improvement and minimize risks. R60's Braden Scale for Predicting Pressure Ulcer Risk completed 12/9/25 documents a score of 16 which indicates R60 is at risk for developing a pressure injury. R60's Kardex dated 1/23/26, instructs certified nursing assistants (CNAs) to place heel boots while in bed. R60 will refuse at times when in 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
	525549	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0686 Level of Harm - Actual harm Residents Affected - Few	R60's current physician orders as of 1/23/26 document to ensure prevalon boots in place while in bed every shift, document refusals, effective 9/25/25. R60's comprehensive care plan documents the following targeted problem: Surveyor notes there is a comprehensive care plan documenting R60 is at risk for impaired skin integrity related to bowel incontinence, pressure ulcer history and impaired mobility, sling underneath at all times. History of right buttocks-unstageable, admitted , right heel: pressure ulcer stage 3 admitted , left heel: pressure ulcer-suspected deep tissue injury (DTI) admitted , initiated 6/25/25. Interventions include: -Heel boots while in bed. I refuse to wear my heel boots at times when in bed. Initiated 6/25/25 Revised 1/22/26. -I prefer to wear my heel boots only when I am in bed. Initiated 9/25/25 Revised 1/22/26. Surveyor notes there are no interventions in place when R60 refuses to wear the bilateral heel boots. Surveyor notes there is no documentation in R60's electronic medical record (EMR) that R60 refuses to wear the bilateral heel boots. On 1/21/2026, at 7:29 AM, Surveyor observed R60 sleeping in bed. R60's feet are at the footboard. R60 has no heel boots on. On 1/21/2026, at 9:45 AM, Surveyor observed R60 in bed and has no heel boots on. R60 informed Surveyor that some put the boots on, and some do not.On 1/22/2026, at 7:46 AM, Surveyor observed R60 lying in bed and has no heel boots on. R60's heels are directly on the mattress. R60 informed Surveyor they did not put them on him last night. Surveyor notes staff have been documenting R60 has had prevalon boots in place per treatment administration record (TAR) for January 2026. There is only one day in January, on the 13th, that R60 was documented as not wearing bilateral heel boots. Surveyor notes during the survey, R60 was observed to not have prevalon boots in place as documented on the TAR. On 1/22/2026, at 9:11 AM, Surveyor interviewed Assistant Director of Nurse (ADON)-E. ADON-E confirmed ADON-E was responsible for monitoring pressure injuries. ADON-E states the expectation is to re-approach R60 if refusing to wear bilateral heel boots. On 1/22/2026, at 9:36 AM, R60 states they frequently don't put the heel boots on, and my heels are sore right now. R60 states they wanted him to wear the heel boots 24 hours, but he didn't want the 'big things' on all the time. Surveyor asked: Do they float your heels with a pillow or offer a pillow. R60 stated he is not offered to float R60's heels with a pillow. On 1/26/2026, at 9:32 AM, Surveyor observed R60 in bed sleeping and is wearing bilateral heel boots. On 1/26/2026, at 2:21 PM, Surveyor interviewed (CNA)-I. CNA-I stated that if a resident refused cares, heel boots, etc., CNA-I would document it and report it to the nurse. CNA-I confirmed that CNA-I usually works PM shift. CNA-I states that R60 is agreeable to wear the bilateral heel boots. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/26/2026, at 2:59 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R60 have not been wearing their heel boots to reduce the risk of developing a pressure injury as documented on the CNA Kardex and comprehensive care plan during the survey process. On 1/27/2026, at 7:09 AM, Surveyor observed R60 in bed sleeping. R60 has bilateral heel boots on. 4) R10 was admitted to the facility on [DATE] with diagnoses of repair of left femur fracture, muscle wasting, and type 2 diabetes. The admission Minimum Data Set (MDS) dated [DATE] documents R10 is cognitively intact and needs maximum assistance with dressing, bathing and bed mobility. The MDS also documents R10 does not have any unhealed pressure injuries. The Care Area Assessment (CAA) documents recent decline due to fall w fx (with fracture) hip and ORIF (open reduction and internal fixation). Daily topical skin care. Sched (scheduled) pain med.LE (lower extremity) bilat (bilateral) weakness. Skin and pain med (medication) monitored. Pressure reducing devices in place. On 1/20/26 Surveyor observed R10 dressed in grip slipper socks. R10 was unable to communicate with Surveyor due to language barrier. The admission note dated 7/25/25 documents R10 had a 1 (centimeter) cm hematoma to the right heel. Surveyor notes there is no other documentation regarding the assessment to F10's right heel until 8/6/25. A wound MD note dated 8/6/25 documents the right heel with an unstageable pressure injury with 1-25% granulation and 51-75% slough measuring 1.97 cm by 2.43 cm. The wound MD ordered a treatment to the right heel. The treatment documents, cleanse with 1/2 strength Dakin's solution and cover wound with bordered foam dressing daily. The at risk for skin alteration related to history of pressure ulcer, muscle wasting, type 2 diabetes and protein-calorie malnutrition care plan dated 8/6/25 documents the interventions: Educate the resident/representative on causes of skin breakdown; including: transfer/positioning, good nutrition and frequent repositioning, dated 8/6/25.Encourage resident to frequently shift weight, dated 12/23/25.Evaluate skin for areas of blanching or redness, dated 12/23/25.(R10) prefers to elevate heels with pillows while in bed, dated 9/16/25.Monitor bony prominences for redness dated, 12/23/25. There is no documented evidence R10's heels were offloaded p

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review the facility did not ensure the Payroll Based Journal (PBJ) was accurately submitted to the Centers for Medicare and Medicaid (CMS). The facility's fourth quarter (July 1st-September 30th) PBJ data triggered for excessively low weekend staffing. This deficient practice has the possibility of affecting all 74 residents residing at the facility. Findings include:The facility's PBJ staffing data report for quarter 4 2025 (July 1st-September 30th), triggers for excessively low weekend staffing. Surveyor reviewed the weekend staffing schedules for the 4th quarter and the facility assessment. The facility assessment documents the needs of the facility for staffing, and it coincided with the staffing levels on the provided schedules.On 1/26/26 at 1:14 p.m., Surveyor interviewed Scheduler-AA. Surveyor reviewed the weekend staffing schedules with Scheduler-AA and noted that the staffing schedule document that there is sufficient staff to meet residents' needs.On 1/26/26 at 2:00p.m., Surveyor interviewed BOM-L. BOM-L stated he is responsible for collecting the payroll data and inputting it into the facility's payroll system. BOM-L stated the corporate human resource (HR) payroll staff is responsible for documenting the data into the PBJ system. BOM-L stated they have not had a corporate HR staff since 8/1/25. Surveyor asked BOM-L if he knew the reason why the PBJ report triggered low weekend staffing. BOM-L looked at the data and stated the facility's cut point is 2.9 and the facility was at 2.7. On 1/26/26 at 3:15 p.m., during the daily exit meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor explained the concern the facility's PBJ reporting triggered low weekend staffing for the 4th quarter and there is no follow-through as to the accuracy of the reporting.On 1/27/26 at 9:02 a.m. BOM-L provided Surveyor with additional information. BOM-L stated he looked at the payroll more in-depth to decipher the inaccuracy. BOM-L discovered on 8/10/25, RN-J is a salaried employee but worked extra and those hours on 8/10/25 that did not pull through into the payroll data. BOM-L also found RN-BB, who is also salaried, worked extra on 7/10/25 and her hours did not get pulled through into the payroll data. No additional information was provided.

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This deficient practice had the potential to affect all residents residing in the facility. The facility does not have a current comprehensive water management plan that includes flow charts specific to the facility to determine areas of concern or interventions implemented to prevent the spread of opportunistic pathogens (Legionella) in the facility's water systems. R11 was documented as having loose stools and had a physician's order to check stool for Clostridium Difficile (C-diff). Transmission Based Precautions (TBP) was not implemented. In addition, R11 was sent to the emergency room after coughing up bloody sputum and returned to the facility on antibiotic for pneumonia. TBP was not implemented. Surveyor observed the laundry aid sorting dirty laundry not wearing appropriate PPE and did not perform hand hygiene after. During observation of medication administration for R39, the nurse did not perform hand hygiene. R34 was in EBP and Surveyor observed staff not following appropriate PPE during cares. R2 has indwelling catheter and Enhanced Barrier Precautions (EBP) was not implemented. R35 was in EBP and Surveyor observed staff not following appropriate PPE during cares. Staff did not wear a gown, change gloves and did not conduct hand hygiene. R75 received blood sugar testing, and the glucometer was not sanitized after use. Findings include: The facility policy titled Water Management Program dated 10/1/22 documents (in part) . . It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens in the facility's water systems based on nationally accepted standards. 1. A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing. 2. The Maintenance Director maintains documentation that describes the facility's water system. 3. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. The water management team shall regularly verify that the water management program is being implemented as designed. Auditing assignments will reflect that individuals will not verify the program activity for which they are responsible. 9. The effectiveness of the water management program shall be evaluated no less than annually. Routine infection control surveillance data, water quality data, and rounding data shall be utilized to validate the effectiveness. 14. Documentation of all the activities related to the water management program shall be maintained with the water management program binder for a minimum of three years. The facility policy titled Infection Prevention and Control Program (which is not dated) documents (in part) . .It is the policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 4. Hand hygiene protocol: a. All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects and after PPE (personal protective equipment) removal. b. Staff shall wash their hands before and after performing resident care procedures. c. Hands shall be washed in accordance with our facility's established hand washing procedure. 5. Isolation protocol: b. A resident with an infection or communicable disease shall be placed on isolation precautions as recommended by the CDC guidelines for isolation precautions. 10. Linens: a. Laundry and direct care staff shall handle, store, process and transport linens so as to prevent spread of infection. e. Staff shall use PPE according to established facility policy governing the use of PPE. The facility policy titled Hand Hygiene (which is not dated) documents (in part) . .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hand Hygiene Table documents (in part) . .Between resident contacts. After handling contaminated objects. Before performing invasive procedures. Before applying and after removing PPE, including gloves. Before preparing or handling medications. Before and after handling clean or soiled dressings, linens, etc. Before performing resident care procedures. Before and after providing care to residents in isolation. After handling items potentially contaminated with blood, body fluids, secretions or excretions. After assistance with personal body functions (e.g. elimination, hair grooming, smoking). The facility policy titled Transmission Based (Isolation) Precautions (which is not dated) documents (in part) . . It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogen's modes of transmission. 10. Contact precautions: c. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning PPE upon room entry and discarding before exiting the room is done to contain pathogens. 11. Droplet precautions: a. Intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory sections (i.e. respiratory droplets that are generated by a resident who is coughing, sneezing or talking). e. Healthcare personnel will wear a facemask for close contact with an infected resident. Type and duration of transmission-based precautions recommended for selected infections and conditions: Clostridium difficile – contact precautions for duration of illness. Pneumonia, adenovirus – droplet, contact precautions for duration of illness. Pneumonia, mycoplasma – droplet precautions for duration of illness. Pneumonia streptococcus group A – droplet precautions until 24 hours after initiation of treatment. The facility policy titled Laundry (which is not dated) documents (in part) . The facility launders linen and clothing in accordance with current CDC guidelines to prevent transmission of pathogens. 1. Aligning with principles of standard precautions, staff shall consider all previously work clothing (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and used linens as potentially contaminated. 2. The facility's laundry area will provide hand washing facilities and products as well as PPE. 4. Soiled laundry shall be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces and persons. On 1/20/26 at 10:00 AM, Surveyor asked Maintenance-W if the facility has a binder for the water management plan to review. Maintenance-W reported he has only worked at the facility for 3 weeks and does not think there is a binder and was not sure what happened to it after the other maintenance man left. Surveyor asked Maintenance-W if he oversees the water management plan or if he has any information regarding water management. Maintenance-W stated, Not really, I've only been working here for 3 weeks. 1.) On 1/26/26 at 12:54 PM, Surveyor spoke with Infection Preventionist/Assistant Director of Nursing (IP/ADON)-E and asked what her role in the water management plan is. IP/ADON-E reported (a named worker) from the state of Wisconsin came and did a tour of the facility in August 2025. She reported nothing was put in place at that time, but she gave suggestions. Surveyor advised IP/ADON-E that I have asked for the water management binder several times, but the facility is unable to locate it. IP/ADON-E reported there are no closed units at this time. She stated, I go in the biohazard room every couple of weeks to flush hopper and water. To my knowledge we don't use the hopper. IP/ADON-E reported she does not really know what the water management involves and is not aware of any mapping or flow charts specific to the facility. IP/ADON-E told Surveyor to speak with Nursing Home Administrator (NHA)-A. During review of infection control, no cases of Legionella was identified. On 1/26/26 at 1:29 PM, Surveyor spoke with NHA-A and asked about the facility water management plan. NHA-A stated, We have a fella in housekeeping who goes through building and turns on faucets and flushes toilets for rooms that aren't being used at the moment. He looks at aerators on faucets, checks shower heads and replaces them if needed or if they need to be descaled. Surveyor asked if there is a binder or anything to show evidence of the facility water management plan, for example a description or flow charts specific to the facility to determine areas of concern identified or if any external hazards have been identified. NHA-A stated, Unfortunately I don't have anything to show you. I know we had a system in place, but whether the other maintenance guy took it with him or threw it out, we just don't know. I know at one point we had the water flow schematic. Going forward I'll have to bring the new man up to speed and maybe find new schematic for external and internal water. Surveyor located no evidence the facility has a current comprehensive water management plan, and no additional information was provided. 2.) Surveyor review of R11's facility progress notes documented: 1/12/26 9:11 AM - Alert Note Resident stool consistency documented as loose/diarrhea. Physicians note dated 1/19/26 documented: Seen in follow-up for diarrhea and Lyrica refill. Has been having loose stool. Recently had antibiotic therapy. No other nursing concerns all interval events noted needed refill for Lyrica as well. Plan: Check stool for C-diff. Surveyor located a physician's order dated 1/19/26 which documented: Please send stool for C-Diff. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor was unable to locate an order in the Medication Administration Record (MAR) or Treatment Administration Record (TAR) to check stool for C-Diff. During initial interview with R11 and throughout the survey, Surveyor noted there was no TBP or PPE signage posted on the door and no PPE cart outside of her room. Surveyor review of R11's medical record documented she was sent to the ER (emergency room) on 1/14/26 after coughing up bloody phlegm. The hospital HPI (History of Present Illness) dated 1/15/26 documents: [AGE] year-old presenting to the emergency department for hemoptysis (the coughing up of blood or blood-stained mucous from the lungs or airways). Pt (patient) reports she felt fine today. Went to dialysis. Back to her rehab facility to take a nap. Started to cough and felt like she had phlegm. When she coughed it up, it was blood. She proceeded continue to cough and reports coughing clots and blood which amounted to half a trash bin of blood-soaked Kleenex. Has some shortness of breath when using her wheelchair but denies any current shortness of breath or chest pain. Denies any recent fevers or chills. The hospital After Visit Summary (AVS) dated 1/15/25 documents: Summary of discharging medications Amoxicillin-clavulanate 500-125 mg (milligrams) (Augmentin) last dose 1/15 4:19 PM. Take 1 tablet by mouth daily for 7 days. Next dose due 1/16 @ 5 PM. The facility physician note dated 1/16/26 documents: Patient hemoptysis was likely due to the left lower lobe pneumonia. There is some mucous plugging. At this time, we will attempt a conservative approach for mucociliary clearance. I will hold off on bronchoscopy at this time. Agree with antibiotics for 5–7-day course. Currently on Augmentin. Will repeat CT (Computed Tomography) of chest in 6-8 weeks. The physician order dated 1/17/26 documented: Augmentin Oral Tablet 500-125 MG -give 1 tablet by mouth one time a day for pneumonia for 7 Days. R11's January 2026 MAR documented the order for Augmentin Oral Tablet 500-125 MG - give 1 tablet by mouth one time a day for pneumonia. Surveyor noted R11 had received 3 doses thus far from 1/18-1/20/26. On 1/21/26 at 12:45 PM, Surveyor spoke with IP/ADON-E and asked what the expectation is if a resident is having loose stools. IP/ADON-E stated, Contact precautions. Surveyor asked what the expectation is if the doctor orders to check stool for C-Diff. IP/ADON-E stated, Definitely contact precautions. Surveyor asked how she would know if a resident were having loose stools or a doctor has ordered to check stool for C-diff. IP/ADON-E stated, The clinical dashboard should alert to any such orders or changes. If the nurse manager sees it first, she will send out a message to the manager group. Surveyor asked what the expectation is if a resident is diagnosed with pneumonia. IP/ADON-E stated, Droplet precautions. Surveyor provided scenario if a resident comes to the facility with pneumonia or has a new diagnosis of pneumonia and is on an antibiotic, what the expectation is. IP/ADON-E stated, Droplet precautions. Surveyor advised IP/ADON-E of concerns R11 was having loose stools and the physician ordered stool testing for C-diff, however precautions were not implemented. IP/ADON-E reviewed R11's medical record stating, That was just Monday, I didn't even know about it. Yes, she should have been placed on contact precautions if she was having loose stools or if the doctor ordered testing for C-Diff. Surveyor advised IP/ADON-E that R11 was sent to the ER due to coughing up bloody sputum on 1/14/26 and returned on 1/15/26 with orders for antibiotic for left lower lobe pneumonia, but droplet precautions were not implemented. IP/ADON-E reviewed the hospital discharge papers and stated, I think it's because I didn't see pneumonia diagnoses. Surveyor advised R11 was sent to the ER for coughing up blood and returned the next day (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with antibiotics ordered. IP/ADON-E stated, Yes, going forward she should have been on droplet precautions. On 1/22/26 at 10:01 AM, Director of Nursing (DON)-B advised Surveyor she remembered reading R11's hospital record that pneumonia was likely aspiration pneumonia and new lower lobe nodule and it may be inflammatory. DON-B reported she spoke with the Nurse Practitioner (NP) who agreed that the antibiotic treatment was conservative for likely aspiration pneumonia and inflammation. DON-B stated, Going forward we will review and document if precautions are warranted. Surveyor advised DON-B that R11 was sent to the ER due to coughing up bloody sputum and asked if that would alert the facility to implement droplet precautions. DON-B stated, I think that wasn't new for her, she's had that before. Surveyor advised DON-B there was no documentation in R11's medical record of any episodes of R11 coughing up bloody sputum since admission until 1/14/26. On 1/22/26 at 11:27 AM, DON-B advised Surveyor she spoke with the NP who reported she was not sure why the doctor ordered to check stool for C-Diff. She reported the NP believed R11's baseline is looser stool related to dialysis and discontinued the order. On 1/22/26 at 12:00 PM, Surveyor advised DON-B and IP/ADON-E of concern the facility documented R11 was having loose stools, an order was obtained to check stool for C-Diff, but precautions were not implemented. IP/ADON-E stated, Yes, we have a protocol. As soon as we are aware of loose stools and the nurse sees the order to check for C-diff, she should have been put on precautions. Surveyor advised of concern R11 was coughing up blood clots, was sent to the ER, returned the following day on antibiotics for pneumonia, but precautions were not implemented. IP/ADON-E stated, I understand. She should have been put on precautions if she was on an antibiotic and coughing. 3.) On 1/26/26 at 8:05 AM, Surveyor entered the 1st room laundry sorting area. Surveyor observed Laundry-X sorting dirty laundry (removing dirty laundry from one bin and placing it in another) wearing a mask and gloves, but no gown. Laundry-X then entered through the door to the washing machine and clean area wearing the same gloves. She removed her gloves, threw them in the garbage, but did not wash her hands. Housekeeping-Y entered the room and reported she can answer questions because Laundry-X does not speak English. Housekeeping-Y reported the process for laundry is to wear a gown, gloves and mask when sorting dirty linen, bring linen in the bin through the door and place it in the washer, remove PPE and wash hands. While talking with Housekeeping-Y, Surveyor observed Laundry-X remove clean laundry from the washer, place it in a cart and put it in the dryer. (Surveyor noted Laundry-X had still not washed her hands). Laundry-X then walked through the door to the dirty linen area and returned with a bin of dirty clothes wearing a gown, gloves and mask. She placed the clothes in the washer, removed the PPE and washed her hands. On 1/26/26 at 3:11 PM, during the daily exit meeting with NHA-A and DON-B, Surveyor shared the following infection control concerns: The facility does not have a current comprehensive water management plan; precautions were not implemented for infections including suspected C-Diff and pneumonia; and observations of staff sorting soiled linen without proper PPE and not washing their hands after. No additional information was provided. The facility's undated Enhanced Barrier Precautions (EBP) policy and procedure documents: Purpose: .To prevent the spread of multidrug-resistant organisms through the consistent use of EBP during (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	high-contact resident care activities. Policy Statement: .The facility shall implement EBP for residents colonized or infected with MDROs as identified through laboratory testing or regional/state public health notification, and for residents with wounds, indwelling medical devices, or other high-risk conditions, in accordance with Centers Disease Control guidance. EBP is in addition to standard precautions and not as strict as contact precautions. Residents under EBP can participate in group activities and do not require room restriction. When to implement EBP: .Any resident with MDRO colonization or infection, regardless of symptoms Any resident with indwelling devices(central line, urinary catheter, feeding tube, tracheostomy) Any resident with chronic wounds or pressure injuries Continue EBP: Indefinitely for colonized residents For the duration of indwelling device or wound presence. Personal Protective Equipment(PPE) and Room Guidance: .Gown and gloves must be donned immediately before high-contact care activities. Remove PPE and perform hand hygiene before leaving resident care area. PPE may be stored in a dedicated clean area within the room. Resident is not restricted to room; may participate in communal dining and activities. Education: .All direct care staff will receive initial and annual education on EBP, including rationale, proper PPE use, donning/doffing technique, and documentation requirements. Documentation: .Staff must document implementation of EBP in the care plan and nursing notes, including reason and specific precautions used during care. Quality Assurance/Monitoring: .Infection Preventionist(IP) or designee will conduct routine audits for compliance with EBP, review (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	infection logs, and present findings to QAPI committee monthly. 4.) R35 was admitted to the facility on [DATE] with diagnoses of Spastic Hemiplegia Affecting Right Dominant Side(one side of body experiences muscle stiffness and weakness), Neuromuscular Dysfunction of Bladder(nerves controlling bladder and urinary sphincter are damaged and not working correctly), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Chronic Respiratory Failure(long-term condition where the lungs are unable to adequately exchange oxygen and carbon dioxide), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Hyperlipidemia(high levels of fat particles in blood), Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), and Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities). R35's Quarterly Minimum Data Set(MDS) completed 10/28/25 documents a Brief Interview for Mental Status(BIMS) score of 14, indicating R35 is cognitively intact for daily decision making. R35 has no behaviors. R35's Patient Health Questionnaire(PHQ-9) score is 7, indicating R35 demonstrates mild depressive symptoms. R35's MDS documents: R35 has an indwelling catheter and is frequently incontinent of bowel. On 1/20/2026, at 10:56 AM, Surveyor observed staff entering and exiting R35's room who is in EBP. Surveyor notes there is a sign on R35's room indicating R35 is in EBP, and the precautions needed. Surveyor observed through the open doorway, Licensed Practical Nurse (LPN)-U answer R35's call light without performing hand hygiene prior to entering room, with both hands lean on the end of the bed. LPN-U exited R35's room without performing hand hygiene. Surveyor asked LPN-U what R35 needed and LPN-U informed Surveyor that R35 was on the bedpan. On 1/20/2026, at 10:58 AM, Certified Nursing Assistant (CNA)-D entered R35's room without performing hand hygiene. CNA-D exited R35's room and performed hand hygiene. CNA-D informed Surveyor that R35 is getting ready for a shower. On 1/20/2026, at 11:01 AM, Surveyor observed CNA-V grab gloves out of the cart outside of R35's room and Surveyor observed CNA-V enter R35's room without performing hand hygiene. Surveyor observed CNA-V who does not don a gown on prior to entering the room. On 1/20/2026, at 11:05 AM, Surveyor observed CNA-V exit R35's room with gloves in left hand, put the gloves in CNA-V's pocket and perform hand hygiene. CNA-V was not observed to have removed a gown. Surveyor asked CNA-V what CNA-V did, and CNA-V stated that CNA-V took R35 off the bed and put the mechanical lift sling under R35. On 1/20/2026, at 11:07 AM, Surveyor observed CNA-D and CNA-V transfer R35 from bed to shower cot. R35 gave permission for Surveyor to watch the transfer. Surveyor observed CNA-D and CNA-V does not perform hand hygiene before entering R35's room. Both CNA-D and CNA-V put gloves on but did not don a gown. CNA-D and CNA-V completed the transfer utilizing the mechanical lift. At separate times, both CNA-D and CNA-V placed gloved hands on R35's indwelling catheter bag. CNA-D with same gloves on got a clean sheet to cover R35 up once on the shower cot, retrieved shampoo and body wash from closet and entered bathroom to get a bar of soap. Both CNA-D and CNA-V exited the room with R35 on the shower cot and remove their gloves. CNA-V performed hand hygiene; CNA-D did not perform hand hygiene. Neither CNA-D nor CNA-V wiped down the mechanical lift after use. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/22/2026, at 7:39 AM, Surveyor observed the PPE cart with 3 drawers outside of R35's room contains a box of surgical masks in the first drawer. There are no gowns or gloves in the cart. The other 2 drawers are empty. On 1/22/2026, at 9:52 AM, Surveyor observed Wound Nurse (WN)-T perform hand hygiene and don gloves and gown before entering room. 5.) R2 was admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis(a chronic disabling autoimmune disease of the central nervous system), Spastic Hemiplegia Affecting Right Dominant Side(one side of body experiences muscle stiffness and weakness), Neuromuscular Dysfunction of Bladder(nerves controlling bladder and urinary sphincter are damaged and not working correctly), Irritable Bowel Syndrome with Diarrhea(common chronic functional disorder of the large intestine), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Insomnia(sleep disorder characterized by difficulty falling asleep), and Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R2 is currently his own person. R2's Quarterly Minimum Data Set(MDS) completed 12/29/25 documents R2's Brief Interview for Mental Status(BIMS) score to be 15 indicating R2 is cognitively intact for daily decision making. R2's Patient Health Questionnaire(PHQ-9) score of 6 indicates R2 is demonstrating mild depressive symptoms. R2's MDS documents R2 is not demonstrating behaviors including refusal of cares/treatments. R2's MDS documents R2's primary method of locomotion is wheelchair. R2 has range of motion impairment(ROM) on one side of both upper and lower extremity. R2 requires set-up for eating. R2's documents R2 requires substantial/maximum assistance with showers, upper dressing, and mobility. R2 is dependent on assistance for lower dressing and transfers. R2 has an indwelling catheter and is frequently incontinent of bowel. R2's MDS also documents R2 is at risk for developing pressure areas/injuries. R2's MDS does not document R2 has a splint. On 1/20/2026, at 12:03 PM, Surveyor notes that R2 has an indwelling catheter and there is no sign on the door for EBP instructions, no cart with PPE supplies around R2's room. On 1/21/2026, at 7:33 AM, Surveyor observed no EBP instructions on or around R2's door. On 1/22/2026, at 7:41 AM, Surveyor observed no EBP instructions on or around R2's door. On 1/22/2026, at 9:26 AM, Surveyor interviewed Infection Preventionist (IP)-E. IP-E stated that anyone with a wound, g-tube, foley catheter, 'any open area of entry' requires EBP. IP-E stated that there are carts in the hallway containing PPE for use. All EBP residents should have a sign on the door indicating EBP, so all staff are aware in order to follow the correct precautions. On 1/22/2026, at 1:14 PM, Surveyor shared the concern that R2 has an indwelling catheter but does not have a sign on the door alerting staff to follow EBP when caring for R2. IP-E stated R2 had been in contact precautions and came out of precautions on 1/10/26. The contact precautions sign was removed from R2's door and a EBP sign should have been placed on the door at that time. IP-E acknowledges that EBP have not been in place since 1/10/26 and should have been. IP-E informed Surveyor that a sign instructing EBP would immediately be placed. Surveyor reviewed with IP-E; Surveyor's observations of care being provided to R35 on 1/20/26. IP-E confirmed that hand hygiene should be performed prior to entering the room and when exiting the room, before and after placing (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gloves on, no matter if a resident requires EBP or not. IP-E stated, I guess more education needs to be completed. IP- E understands the concern and shared that staff had last been re-educated 11/7-11/13/25. On 1/22/2026, at 3:37 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the infection control observations involving R35 and R2 who both are in EBP due to indwelling catheters. Surveyor shared that staff did not don PPE prior to performing cares to R35 and did not perform proper hand hygiene. Surveyor shared that there was no indication that R2 required EBP for staff to follow when providing cares to R2. No further information has been provided by the facility at this time. On 1/26/2026, at 11:30 AM, Surveyor observed CNA-CC enter R2's room without hand hygiene prior and brought R2's breakfast tray out. CNA-CC re-entered the room and placed gown and gloves on, did not perform hand hygiene prior to putting gloves on. Exited the room and informed Surveyor there was no sanitizer in R2's room. CNA-CC used the hand sanitizer in the hallway and performed hand hygiene. 6.) On 1/22/26, at 7:12 a.m., Surveyor observed Licensed Practical Nurse (LPN)-P prepare R39's medication which consisted of pro stat 30 cc (cubic centimeters), Amantadine 100 mg (milligrams) one capsule, Vitamin C 500 mg one tablet, Juven one packet, Levetiracetam 10 cc, Levothyroxine Sodium 25 mcg (micrograms) one tablet, Hiprex 1 gram one tablet, and Thiamine 100 mg one tablet. At 7:18 a.m., LPN-P placed gloves on, poured R39's pro stat, Levetiracetam, and Juven into individual plastic glasses, opened the Amantadine capsule and crush each medication individually. At 7:21 a.m. LPN-P picked up an article from the floor and threw the article in the garbage container on the medication cart. LPN-P removed her gloves but did not perform any hand hygiene. LPN-P removed spoons from a container and poured water into the plastic glasses. LPN-P placed a gown on, brought R39's medication into the room, removed a box from the medication cart and placed gloves on. LPN-P disconnected R39's tube feeding, checked placement, and flushed R39's tube with 20 cc of water. LPN-P added 20 cc of water to each cup containing Levetiracetam, pro stat and Juven. LPN-P administered each of these flushing with 20 cc of water in between. At 7:30 a.m. LPN-P removed her gloves, added 20 cc of water to each crushed medication and placed gloves on. LPN-P did not perform any hand hygiene after removing her gloves. LPN-P administered R39's medication individually flushing in between and then flushed R39's tube after the last medication. After administering R39's medication, LPN-P removed her gown & gloves and washed her hands. On 1/26/26, at 11:19 a.m., Surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM)-U if staff should perform hand hygiene after removing their gloves and before placing new gloves on. LPN/UM-U replied oh yes absolutely. Surveyor informed LPN/UM-U of the observation during R39's medication pass with LPN-P. The facility's policy titled, Glucometer Disinfection and not dated under policy documents The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devise to prevent transmission of blood borne disease to residents and employees. Under policy explanation and compliance guidelines documents 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instruction for multi-resident use. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7.) On 1/22/26, at 8:07 a.m., Surveyor observed Licensed Practical Nurse (LPN)-H place gloves, wipe R75's left index finger with an alcohol pad, wave to dry R75's finger, poke R75's finger and squeeze the finger to place a drop of blood on the strip. LPN-H informed R75 her blood sugar is 289 and removed her gloves. At 8:09 a.m. LPN-H cleansed her hands and then i

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 - Some	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 develop and implement policies and procedures to ensure that when Covid (Coronavirus)-19 vaccine is available to the facility, each resident is offered the vaccine unless the immunization is medically contraindicated or the resident has already been immunized for 4 of 5 (R2, R9, R35 and R54) residents reviewed for immunizations.Findings include:The facility policy titled COVID-19 Vaccination (which is not dated) documents (in part): 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.10. Individuals should receive the recommended [NAME]-appropriate vaccine product and dosage-based o their age on the day of vaccination and follow the recommended dosing intervals.11. 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 refused to receive the vaccine.14. The facility will educate and offer the Covid-19 vaccine to residents, resident representatives and staff and maintain documentation of such.17. Residents or their representatives will sign the consent form prior to administration of the Covid-19 vaccine. This information will be retained in the resident's medical record.On 1/22/26 at 11:52 AM, Surveyor asked Infection Preventionist/Assistant Director of Nursing (IP/ADON)-E about the facility's vaccination protocol. IP/ADON-E stated, Upon admit, there is a document nurses fill out asking about immunizations. If they want or consent, they are supposed to get an order, then normally I will see the order during morning meeting.R2 admitted to the facility on [DATE] with diagnoses that include Multiple Sclerosis, chronic obstructive pulmonary disease and protein calorie malnutrition.Review of R2's medical record revealed a consent for the Covid vaccine signed but not dated. Surveyor noted the consent was uploaded into R2's electronic health record on 12/26/25. Surveyor could not locate evidence that the Covid vaccine was offered or given.R9 admitted to the facility on [DATE] with diagnoses that include muscle wasting and atrophy, protein-calorie malnutrition, immunodeficiency, chronic obstructive pulmonary disease, malignant neoplasm of sigmoid colon and chronic congestive heart failure.Review of R9's medical record revealed a consent for the Covid vaccine signed 7/2/25. Surveyor could not locate evidence the Covid vaccine was offered or given to R9.R35 admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, asthma and chronic respiratory failure with hypoxia.Review of R35's medical record revealed a consent for the Covid vaccine signed 8/26/25. Surveyor could not locate evidence the Covid vaccine was offered or given.R54 admitted to the facility on [DATE] and has diagnoses that include malignant neoplasm of colon, severe protein-calorie malnutrition, immunodeficiency, chronic congestive heart failure and adult failure to thrive. Surveyor could not locate evidence the Covid vaccine was offered or given.On 1/26/26 at 10:25 AM, Surveyor spoke with IP/ADON-E regarding the above immunizations. IP/ADON-E reported R2 did not receive the Covid vaccine, and the facility got an order 1/25/26 to administer it. R9 did not receive the Covid vaccine. IP/ADON-E spoke to the resident today and it was declined. R35 did not receive the Covid vaccine. IP/ADON-E spoke to the resident today and it was declined. R54 did not receive the Covid vaccine. IP/ADON-E stated that R54 wanted the vaccine, and it was ordered today.Surveyor advised IP/ADON of concern consents were signed to receive the Covid vaccine and there was no follow up until after Surveyor identified concern. IP/ADON-E stated, I understand the concern. On 1/26/26 at 3:11 PM, Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were informed of the concerns regarding the above immunizations. No additional information was provided.

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility did not ensure 1 (R2) of 1 residents reviewed for self-administration of medications had a physician order to self-administer and for the medication.*R2 was observed with Melatonin 5mg at the bedside and did not have a physician order for Melatonin 5mg or an order to self-administer medication.Findings include:The facility's policy titled Self-Administration of Medications effective 10/25/2014 documents:Policy:In order to maintain the 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.Procedures:A. If the resident desires to self-administer medications, an assessment is conducted by the inter disciplinary team of the resident's cognitive(including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process.C. For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition.5. The resident is asked to complete a bedside record indicating the administration of the medication.D. The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notion that it may be self-administered.E. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted.G. When the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other residents, the medications of residents permitted to self-administer are stored in the central medication card or medication room. The nurse records such self-administration on the medication administration record(MAR) by placing a check mark in the appropriate space and noting in the nursing comments and the initials of the nurse who obtained the information from the resident.R2 was admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis(a chronic disabling autoimmune disease of the central nervous system), Spastic Hemiplegia Affecting Right Dominant Side(one side of body experiences muscle stiffness and weakness), Neuromuscular Dysfunction of Bladder(nerves controlling bladder and urinary sphincter are damaged and not working correctly), Irritable Bowel Syndrome with Diarrhea(common chronic functional disorder of the large intestine), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Insomnia(sleep disorder characterized by difficulty falling asleep), and Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R2's Quarterly Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status(BIMS) score to be 15, indicating R2 is cognitively intact for daily decision making. R2's Patient Health Questionnaire(PHQ-9) score of 6 indicates R2 is demonstrating mild depressive symptoms. R2's MDS documents: R2 is not demonstrating behaviors including refusal of cares/treatments; R2's primary method of locomotion is wheelchair; R2 has range of motion impairment(ROM) on one side of both upper and lower extremity; R2 requires set-up for eating; R2's documents R2 requires substantial/maximum assistance with showers, upper dressing, and mobility; R2 is dependent on assistance for lower dressing and transfers; R2 has an indwelling catheter and is frequently incontinent of bowel; R2's MDS also documents R2 is at risk for developing pressure areas/injuries and does not document R2 has a splint.R2's physician orders as of 1/21/26 do not document a physician order for R2 to self-administer medications. Surveyor could not locate a physician order for Melatonin for R2. R2's comprehensive care plan documents R2 is able to safely administer R2's medications initiated 8/8/25. The only intervention initiated on 8/9/25 and revised (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/24/25 documents to complete self-administrated evaluation of R2's ability to self-administer medications.R2's self-administration of medications assessment completed 10/27/25 documents that R2 is approved for the self-administration of medications and R2 may keep medications at bedside.On 1/20/2026, at 11:53 AM, Surveyor observed a bottle of Melatonin 5mg gummies on R2's overbed table. R2 informed Surveyor that R2 takes 2 5mg every night. On 1/21/2026, at 12:57 PM, Surveyor observed the bottle of Melatonin on R2's overbed table. R2 informed Surveyor that R2 does not keep track of taking the Melatonin on a nightly basis. On 1/22/2026, at 7:43 AM, R2's Melatonin remained on R2's overbed table. On 1/22/2026, at 3:37 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern that R2 has Melatonin 5mg at bedside but has no physician order for the Melatonin and does not have a physician order to self-administer. DON-B confirmed that R2 should have a physician order for the Melatonin and to self-administer medications. On 1/26/2026, at 7:25 AM, Surveyor observed R2's Melatonin remain on R2's overbed table. On 1/26/2026, at 8:41 AM, DON-B informed Surveyor that R2 will not give up the Melatonin and R2's physician won't give the order for the Melatonin due to conflicts. Surveyor shared that R2's electronic medical record (EMR) progress notes documents R2 is having difficulty sleeping at night and reminded DON-B that R2 has a diagnosis of insomnia. Surveyor shared the concern that staff have not addressed the Melatonin at R2's bedside and observations of the Melatonin at R2's bedside. On 1/26/2026, at 9:41 AM, Surveyor noted there is no documentation in R2's EMR of the conversation with R2's physician concerning the Melatonin at bedside. On 1/27/2026, at 7:29 AM, Surveyor noted there is no documentation in R2's EMR that R2's Melatonin at bedside had been addressed with R2's physician. Surveyor observed R2's Melatonin still at R2's bedside. Surveyor noted the facility has not provided any additional information as to why R2 does not have a physician order to self-administer and does not have an order for Melatonin which R2 has been self-administering every night for R2's insomnia. No additional information was provided.

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview the facility did not ensure a clean environment for 1 (R67) of 1 Resident.*Food and debris were observed alongside and under the wheelchair cushion on 1/20/26, 1/21/26, & 1/22/26.Findings include:On 1/20/26, at 9:45 a.m., Surveyor observed R67 sitting in a wheelchair in R67's room with his head down. R67 looked at Surveyor and then put his head back down. Surveyor observed the right side of R67's wheelchair, between the cushion and the right side, has a large accumulation of food particles and other debris.On 1/21/26, at 12:59 p.m., Surveyor observed R67 sitting in the wheelchair with an overbed table in front of him in R67's room. Surveyor observed on the right side of R67's wheelchair, between the cushion and the right side there is a large accumulation of food particles, including scrambled eggs, and other debris.On 1/22/26, at 10:58 a.m., Surveyor observed Certified Nursing Assistant (CNA)-Q, CNA-O, and Licensed Practical Nurse/Wound Nurse (LPN/WN)-T in R67's room. CNA-Q placed the sit to stand lift in front of R67 and CNA-O placed R67's feet on the foot portion of the lift. CNA-Q & CNA-O placed the sling around R67, and the sling was attached to the sit to stand lift. R67 was raised off the wheelchair and R67's pants & incontinence product were lowered. LPN/WN-T and Surveyor checked R67's buttocks and did not observe any pressure injuries. While CNA-O washed R67's frontal perineal area, Surveyor lifted up R67's wheelchair cushion. Surveyor observed under R67's cushion covering the entire seat portion of the wheelchair there is a large accumulation of food, dirt, and other debris.On 1/22/26, at 11:05 a.m., Surveyor asked CNA-Q who is responsible for cleaning resident's wheelchairs. CNA-Q replied it's supposed to be third shift.On 1/22/26, at 11:07 a.m., Surveyor asked LPN/WN-T if she happened to see under R67's cushion when Surveyor lifted the cushion up. LPN/WN-T replied no why is there supposed to be dycem. Surveyor informed LPN/WN-T R67's wheelchair is extremely dirty with food particles and debris under R67's cushion. LPN-H who was in the hallway and heard Surveyor's conversation stated third shift is supposed to clean wheelchairs. LPN-H informed Surveyor the next time R67 is toileted CNA-O will clean the wheelchair.On 1/22/26, at 4:00 p.m. LPN-H informed Surveyor R67's was cleaned. Surveyor asked LPN-H if she saw the debris and food particles under R67's wheelchair cushion. LPN-H nodded her head yes and stated all wheelchairs will be done.

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility did not ensure 1 (R25) of 5 residents were free from chemical restraints.R25 was prescribed Seroquel 25 mg (milligrams) twice daily, an antipsychotic medication, on 11/5/25 after R25's family voiced concerns about R25 yelling and swearing. The facility did not attempt any nonpharmacological interventions and did not rule out any underlying medical conditions.Findings include:The facility's policy titled, Use of Psychotropic Medication(s) and not dated documents under policy It is the intent of this policy to ensure that residents only receive psychotropic medication when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. Under police explanation and compliance guidelines include documentation of 5. The indications for initiating, maintaining, or discontinuing medication(s), as well as the use of non-pharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risk, and the preference and goals for treatment. 6. Non-pharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use of the lowest possible dose, or discontinue the medications.R25's diagnoses includes chronic kidney disease (kidneys are damaged and cannot filter blood & waste effectively), diabetes mellitus (high blood sugar), anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life), depression (serious mood disorder that causes a persistent feeling of sadness and a loss of interest in activities interfering with daily life), and dementia (loss of cognitive function that interferes with a person's daily life and activities).R25 receives hospice services and has an activated power of attorney for healthcare.R25's at risk for alteration in psychosocial well being r/t (related to) depression and anxiety diagnosis I take Buspirone for Anxiety. I take Mirtazapine for Depression. I take Seroquel for agitation care plan. Initiated 1/3/25. Documents the following interventions:*Encourage me to openly express my feelings. Initiated 1/3/25.*Observe for and report any changes in my mental status to nursing and/or social services. Initiated 1/3/25.*Provide me with activities I can do alone (ex. Books, books on tape, movies, puzzles). Initiated 1/3/25 and revised 6/2/25.*Refer to social services PRN (as needed) for additional emotional support. Initiated 1/3/25.*Update me regularly to help put my mind at ease. Initiated 1/3/25.R25's I get nervous and anxious in new situations, in new surroundings. Monitor for anxiety, restlessness, agitation. Behaviors combative with cares at times kicking, grabbing and hitting, pushing. 5/30/25 I will frequently take out my dentures and put them in blanket, clothing, drop them on the floor care plan initiated 1/23/25. Documents the following interventions:*Approach me from the front and address me by name. Initiated 1/23/25.*Call me by name or touch/hold my hand. That makes me feel secure. Initiated 1/23/25 & revised 4/27/25.*If I don't like what I'm doing, let me choose something else. Initiated 1/23/25.*If I'm upset, please re-direct the conversation or task. Initiated 1/23/25.*Offer food/fluids, toileting, massage, repositioning, soft music, quiet environment, encourage deep breathing, provide reassurance, relaxation activities, dim lighting, cold compress, diversional activities. Initiated 1/23/25 & revised 4/27/25.*Offer things that are soothing to me. Initiated 1/23/25 & revised 6/2/25.*Please avoid things that make me more anxious. Initiated 1/23/25 & revised 6/2/25.*Please give me my medication that help me with my anxiety. Initiated 1/23/25.*When I am nervous offer me a stuffed animal to hold. Initiated 4/27/25.*Be mindful when removing items from my room that my dentures are not in blankets, clothing, garbage. Initiated 5/30/25.*Ensure I have my dentures during meals. Initiated 5/30/25.R25's quarterly MDS (minimum data set) with an assessment reference date of 9/11/25 assesses R25 as having short- & long-term memory problems and is (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	severely impaired for cognitive skills for daily decision making. R25 is assessed as not having any behavior and is marked no for antipsychotic medication.R25's quarterly MDS with an assessment reference date of 12/25/25 assesses R25 as having short- & long-term memory problems and is severely impaired for cognitive skills for daily decision making. R25 is assessed as not having any behaviors and yes is marked for antipsychotic medication. R25 is assessed as requiring partial/moderate assistance for eating, and is dependent on rolling left and right, chair/bed to chair transfer, and toilet use. R25 is always incontinent of bowel and bladder.Surveyor reviewed R25's October 2025 & November 2025 MAR (medication administration record) and noted monitoring behavior symptoms starting 2/27/25. Surveyor noted 0=None Noted, 1=Frequent Crying, 2=Repeats Verbalization, 3=Repeats Movement, 4=Yelling/Screaming, 5=Kicking/Hitting, 6=Pinching/Scratching/Spitting, 7=Biting. 8=Wandering. 9=Abusive Language, 10=Threatening Behavior, 11=Sexually Inappropriate, 12=Rejection of Care, 13=Other (describe in progress note) every shift. Surveyor noted each shift has only a check mark documented and does not document any numbers listed.R25's social service note dated 10/17/25 and created on 10/21/25, written by Social Service Director (SSD)-R documents Behavior/GDR (gradual dose reduction) meeting held today. IDT (interdisciplinary team) reviewed resident medication, mood and behavior. Resident is stable at this time. Psych continues to follow. No changes recommended at this time.Surveyor noted the next progress note is dated 11/3/25 at 3:40 p.m.R25's nurses note dated 11/3/25, at 15:40 (3:40 p.m.), written by Licensed Practical Nurse (LPN)-H documents, Daughter contacted nurse in regard to pts (patient) new agitation with @ (at) times pt yelling out. Hospice contacted with call out to nurse and will contact facility at their earliest convenience.R25's nurses note dated 11/4/25, at 09:03 (9:03 a.m.), written by LPN-H documents, Nurse spoke to hospice nurse and stated she will contact pts daughter/POA (power of attorney) and will be in the facility for further assessment.R25's nurses note dated 11/4/25, at 12:02 p.m., written by LPN-H documents, no agitation AM (morning) shift with pt sleeping most of the morning, VSS (vital signs stable), attended dining room with 100% intake, no c/o (complaints of) pain or discomfort with pt sat near staff for comfort and close monitoring.R25's nurses note dated 11/4/25, at 20:53 (8:53 p.m.), written by LPN-HH documents, Resident continue to yell out at staff and peers when passing or near. Calling staff and peers names. Resident is easily redirected. Will continue to monitor.R25's nurses note dated 11/5/25, at 02:36 (2:36 a.m.), written by LPN-FF documents, No s/s (signs/symptoms) of agitation. Has been sleeping quietly. No complaints.R25's nurses note dated 11/5/25, at 08:56 (8:56 a.m.), written by LPN-H documents, Pt observed to have outbursts of yelling out during NP (Nurse Practitioner) [first name] assessment AM shift. NP reached out personally to hospice nurse for possible medication regime with NOR (new order received) for Quetiapine 25 mg (milligrams) BID (twice a day) as well as hospice nurse to reach out further to POA (power of attorney) for possible PRN (as needed) Lorazepam agreement. First dose administered with pt sat near staff and residents for comfort and close monitoring.R25's physician order with an order date of 11/5/25 documents Quetiapine Fumarate Oral Tablet 25 mg (milligrams) (Quetiapine Fumarate) Give 1 tablet by mouth two times a day for dementia with agitation.R25's nurses note dated 11/6/25, at 02:00 (2:00 a.m.), written by LPN-FF documents, Resident having occasional yelling out. When spoke with resident denies yelling out. Encouraged to rest.R25's nurses note dated 11/6/25, at 1748 (5:48 p.m.), written by LPN-HH documents, Resident continues being monitored r/t new medication Seroquel. No adverse reactions noted or reported. Resident continues to yell out to staff inappropriate comments but easily redirected. Will continue to monitor.R25's nurses note dated 11/10/25, at 10:48 a.m., written by LPN-H documents, Pt cont. (continue) close monitoring for new medication Seroquel with pt tolerating well with less agitation, pt exhibited some anxiousness and yelling out and easily calmed with attention and conversation. Pt sat near nurse for comfort and safety, good appetite with assistance needed, VSS, no s/s of pain with no further concerns at this time.R25's nurses note dated 11/12/25, at 20:05 (8:05 p.m.), written by LPN-H documents, Close monitoring cont. for new medication Seroquel as well as bx (behavior) with yelling (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted throughout AM shift and calmed with attention and conversation, good appetite, VSS with no SOB (shortness of breath), no s/s of pain or distress noted with no further concerns at this time.R25's social service note dated 11/14/25, at 14:30 (2:30 p.m.), written by DSS-R documents Behavior/GCR meeting held today. IDT reviewed resident medications, mood and behavior. Resident is stable at this time. Psych continues to follow. No changes recommended at this time.R25's nurses note dated 11/22/25, at 9:07 a.m., written by LPN-H documents, Pt cont. close monitoring for new medication Seroquel 25 mg BID with pt tolerating well. Pt attending dining room with 100% intake with staff assistance. Pt sat near nurses' station for comfort, activities and safety with no outburst or bx, VSS, no s/s of pain or discomfort with q2 (every two) change and reposition in place and obtained with no further concerns at this time.On 1/21/26, at 12:55 p.m., Surveyor observed R25 sitting in a Broda chair with a CNA sitting on the right side of her.On 1/26/26, at 9:36 a.m., Surveyor asked LPN-H if she knew why R25 was prescribed Seroquel. LPN-H replied yes, I have a note in there she was yelling out. LPN-H explained R25 was normally really pleasant. R25 was yelling out to patients and her daughters were concerned about that. Surveyor asked what interventions were tried prior. LPN-H informed Surveyor R25 was already on Buspar, didn't want lorazepam, and wanted a little something to take the edge off. Surveyor asked LPN-H who wanted this. LPN-H replied her daughters. LPN-H then looked at her phone and informed Surveyor on November 3rd the daughters wrote we noticed mom had been irritable and fisty last couple of visits the staff and residents feel same think it's dementia. LPN-H informed Surveyor she said she was going to contact hospice for any recommendations. The daughter responded okay thanks been putting fists up and calling people assholes, that's not my mom. Surveyor asked LPN-H who recommended Seroquel. LPN-H informed Surveyor first name of Nurse Practitioner (NP)-JJ and hospice agreed. Surveyor asked LPN-H if Seroquel was ordered because R25's daughters were concerned. LPN-H replied yup, I contacted hospice, but they were taking a little bit that's why I contacted [NP-JJ first name]. LPN-H stated it wasn't like a hard narcotic, think we monitored for 15 days.On 1/26/26, at 9:58 a.m., Surveyor observed R25 sitting in a Broda chair with her legs down and covered with a blanket in the hallway outside the nurse's station. R25 has her eyes closed and appears to be sleeping.On 1/26/26, at 11:00 a.m., Surveyor observed R25 sitting in a Broda chair covered with a blanket on another unit with CNA-N sitting next to resident. R25's eyes are closed and appears to be sleeping.On 1/26/26, at 11:13 a.m., Surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM)-U why R25 was prescribed Seroquel. LPN/UM-U informed Surveyor at one-point R25 was yelling, screaming or calling out. R25's family didn't want her to be on a lot of medication, medication that would put her to sleep or zonked out like Ativan. The POA was very reluctant of certain medications. Surveyor asked LPN/UM-U what nonpharmacological interventions were tried prior to Seroquel being ordered. LPN/UM-U replied just a lot of redirection, talking to [R25's name], someone would come around and talk with her, she wants someone to hold her hand, kind of calm her down with conversation. Surveyor asked if they ruled out any underlying medical conditions or if any assessments were completed such as was R25 in pain. LPN/UM-U replied I'm not for sure and informed Surveyor she didn't think they did. Surveyor asked LPN/UM-U to look into this for Surveyor.On 1/26/26, at 12:29 p.m. Surveyor spoke with Hospice Registered Nurse (RN)-II on the telephone. Surveyor inquired about R25 being started on Seroquel in November. Hospice RN-II explained to Surveyor he took over as case manager in November but thought the medication was started a couple of weeks prior. Hospice RN-II informed Surveyor the first time he saw R25 was on 11/19/25. Hospice RN-II informed Surveyor per his notes she was started on Seroquel on 11/5/25 because of increased agitation, yelling out more resistive to cares, yelling at care givers and things like that.On 1/26/26, at 1:19 p.m., Surveyor asked Social Service Director (SSD)-R if she was aware and if she was involved with R25 being prescribed Seroquel. SSD-R informed Surveyor she thinks hospice put R25 on it and didn't think the psych provider did. Surveyor informed SSD-R psych hasn't seen R25 since June 2025. Surveyor informed SSD-R Surveyor needed to take a phone call and asked if Surveyor could meet with her after.On 1/26/26, at 1:21 p.m. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor spoke with NP-JJ on the telephone. Surveyor asked NP-JJ why R25 was prescribed Seroquel. NP-JJ informed Surveyor R25 was having increased behavior with aggressive behaviors. Surveyor asked NP-JJ what R25's aggressive behaviors were. NP-JJ informed Surveyor she was verbally, doesn't use profanity and said to her daughter *itch and hospice agreed to put R25 on Seroquel. Surveyor asked NP-JJ what nonpharmacological interventions were tried prior. NP-JJ replied I would have to check with nursing on that. Surveyor asked NP-JJ if she assessed R25 for any underlying medical conditions, was she assessed for pain. NP-JJ informed Surveyor she saw R25 the day she started her on Seroquel and doesn't have any documentation of pain. Surveyor asked NP-JJ if R25's behavior were verbal or physical. NP-JJ replied they were verbal. Surveyor asked NP-JJ if there was any discussion about other medication other than antipsychotic medication. NP-JJ informed Surveyor she discussed it with her hospice team and that's the medication they decided on.On 1/26/26, at 1:29 p.m., Surveyor met with DSS-R again to discuss R25. DSS-R informed Surveyor if she remembers correctly R25 had increased agitation, yelling out hey you to anyone who would walk past. DSS-R informed Surveyor she doesn't remember name calling as nursing charted. DSS-R informed Surveyor they did call hospice, and it looks like their (the facility's) NP gave the orders. DSS-R then asked Surveyor if that's who Surveyor was speaking with. Surveyor informed DSS-R Surveyor had spoken with NP-JJ. Surveyor asked DSS-R if R25 had behavior of yelling out prior. DSS-R replied no, she would be anxious and likes someone to sit and hold her hand explaining it's a safety thing. Yelling out was new. Surveyor asked DSS-R if any non-pharmaceutical interventions were implemented prior to starting Seroquel. DSS-R stated let me take a look and informed Surveyor she would get back to Surveyor.On 1/26/26, at approximately 1:53 p.m., LPN/UM-U informed Surveyor they did a pain assessment back in February 2025 but did not do one in November.On 1/26/26, at 2:59 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were informed R25 was started on an antipsychotic, Seroquel, without nonpharmacological interventions being attempted, Surveyor was unable to locate where the facility ruled out any underlying medical conditions, and any assessments prior.On 1/27/26, at 8:50 a.m., Surveyor asked DON-B if there is any additional information regarding R25's Seroquel. DON-B informed Surveyor the only thing they have are progress notes [first name of Infection Preventionist/Assistant Director of Nursing-E] brought in before. DON-B informed Surveyor they didn't see anything.On 1/27/26, at 9:04 a.m., Surveyor met with SSD-R and Social Worker (SW)-S. Surveyor asked if there is any additional information regarding R25's Seroquel. SSD-R replied no. Surveyor asked what should have been done. SSD-R replied they should have attempted nonpharmacological interventions, further discussion of medications, and have them call psych before prescribing that.

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 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 3 (R2, R35, and R34) of 3 residents and/or representative were notified of the reason for transfer/discharge in writing and the facility bed hold notice did not contain the required information for appeal rights. *R2 was discharged to the hospital on 8/6/25, 10/21/25, and 12/7/25. The facility's transfer and discharge notice was not provided in writing and in a language understood to R2 and/or R2's representative. The facility bed hold notice does not contain the email address for all 3 agencies listed and the ombudsman information does not include an address. The facility was not able to provide documentation that bed hold/transfer notice was provided to R2 and/or representative for R2's discharge on [DATE]. *R35 was discharged to the hospital on 8/19/25 and 12/2/25. The facility's transfer and discharge notice was not provided in writing and in a language understood to R35 and/or R35's representative. The facility was not able to provide documentation that a bed hold/transfer notice was provided to R35 and/or representative. *R34 was discharged to the hospital on 8/13/25, 9/1/25, 9/12/25,10/27/25, and 12/5/25. The facility's transfer and discharge notice was not provided in writing and in a language understood to R34 and/or 34's representative. The facility bed hold notice does not contain the email address for all 3 agencies listed and the ombudsman information does not include an address. Findings include: Upon request, the facility was not able to provide a bed hold and transfer notice policy and procedure. 1.) R2 was admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis (a chronic disabling autoimmune disease of the central nervous system), Spastic Hemiplegia Affecting Right Dominant Side (one side of body experiences muscle stiffness and weakness), Neuromuscular Dysfunction of Bladder (nerves controlling bladder and urinary sphincter are damaged and not working correctly), Irritable Bowel Syndrome with Diarrhea (common chronic functional disorder of the large intestine), Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Insomnia (sleep disorder characterized by difficulty falling asleep), and Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R2 is currently his own person. R2's Quarterly Minimum Data Set (MDS) completed 12/29/25 documents R2's Brief Interview for Mental Status (BIMS) score to be 15 indicating R2 is cognitively intact for daily decision making. On 8/6/25, R2 was discharged to the hospital. On 8/6/2025, at 1:57 AM, Licensed Practical Nurse (LPN)- FF documented: . Resident requesting to go to hospital. Call placed ambulance for transfer to hospital for evaluation. There is no documentation that a bed hold and transfer notice was provided to R2 and/or R2's representative. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was not able to provide documentation that a bed hold and transfer notice was provided in writing to R2 and that R2 acknowledged R2's appeal rights. On 10/21/25, R2 was discharged to the hospital. On 10/21/2025, at 11:00 AM, LPN-J documented: . Patient left facility via transport heading to hospital for laparoscopic resection on 10/22/25. Bed hold received at this time. R2's bed hold and notice of transfer indicates R2 was verbally informed of bed hold and transfer notice. The bed hold and notice of transfer is not acknowledged by a facility representative indicating a bed hold and notice of transfer rights was provided to R2 in a writing in a language R2 could understand. On 12/7/25, R2 was discharged to the hospital. On 12/7/2025, at 7:22 PM, LPN-H documented: . Patient complaining nausea earlier AM shift. New orders to send patient out due to poor intake and constant emesis with patient in agreement. Patient transferred with bed hold in place. R2's bed hold and notice of transfer indicates R2 was verbally informed of bed hold and transfer notice. The bed hold and notice of transfer is not acknowledged by a facility representative that bed hold and notice of transfer rights was provided to R2 in a writing in a language R2 could understand. On 1/20/2026, at 11:49 AM, R2 informed Surveyor that R2 has been out to the hospital a couple of times but never signed acknowledgment of bed hold and notice of transfer in writing. On 1/22/2026, at 10:00 AM, Surveyor interviewed LPN-H. LPN-H confirmed the nursing department handles the bed hold and transfer notice process when a resident is transferred to the hospital. LPN-H stated that if a resident can sign for self, then the resident signs, otherwise the representative gives a verbal over the phone. LPN-H confirmed that the nurse responsible for transferring a resident should acknowledge the bed hold and transfer notice by signing their name. The form is then sent with the hospital paperwork. On 1/22/2026, at 3:37 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R2 was not provided in writing a bed hold and transfer notice with the required appeal rights information. No further information was provided by the facility at this time. 2) R35 was admitted to the facility on [DATE]. R35 is currently her own person. R35's Quarterly Minimum Data Set (MDS) completed 10/28/25 documents R35's Brief Interview for Mental Status (BIMS) score of 14 indicating R35 is cognitively intact for daily decision making. On 8/19/25, R35 was discharged to the hospital. On 8/19/25, at 7:49 AM, LPN-J documented: (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. Patient admitted due to hyperglycemia and abscess on kidney. On 12/2/25, R35 was discharged to the hospital. On 12/2/25 LPN-H documented, Nurse Practitioner gave new orders: . send patient out for further assessment with patient relieved and in agreement. Bed hold in place. On 1/20/2026, at 11:28, R35 informed Surveyor that R35 has been out to the hospital and has not acknowledged bed hold or transfer notices in writing. As of 1/22/2026, at 7:18 AM, the facility has not provided bed hold and notice of transfer documentation indicating R35 was provided in writing a bed hold and notice of transfer and acknowledged appeal rights. On 1/22/2026, at 10:00 AM, Surveyor interviewed LPN-H. LPN-H confirmed the nursing department handles the bed hold and transfer notice process when a resident is transferred to the hospital. LPN-H stated that if a resident can sign for self, then the resident signs, otherwise the representative gives a verbal over the phone. LPN-H confirmed that the nurse responsible for transferring a resident should acknowledge the bed hold and transfer notice by signing their name. The form is then sent with the hospital paperwork. On 1/22/2026, at 3:37 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B R35 was not provided in writing a bed hold and transfer notice with the required appeal rights information. No further information was provided by the facility at this time. 3.) R34's diagnoses includes history of traumatic brain injury (brain dysfunction caused by outside force usually a violent blow to the head), encephalopathy (general brain dysfunction characterized by alteration in brain function or structure), and conversion disorder (condition in which a mental health issue disrupts how the brain works) with seizures (sudden burst of electrical activity in brain which can cause changes in behavior, movement and level of consciousness) or convulsions. R34 has an activated power of attorney or healthcare. R34's nurses note dated 8/13/25, at 8:20 a.m., written by Licensed Practical Nurse (LPN)-H documents Pt (patient) was assessed by NP (Nurse Practitioner) [Name] due to change in pts baseline. After assessment NOR (new order received) to send pt out for further assessment to [hospital's initials]. POA/Brother contacted with attempt to speak with pt and unable to communicate with pt at this time. No further questions or concerns, pt transferred via [ambulance name] with no issues. R34 was readmitted to the facility on [DATE]. On 1/27/26, at 7:42 a.m., Surveyor reviewed R34's electronic medical record for R34's bed hold policy and notice of transfer form for R34's transfer to the hospital on 8/13/25. Surveyor was unable to locate this form in R34's medical record and asked Nursing Home Administrator (NHA)-A for a copy. Surveyor was not provided with R34's bed hold policy and notice of transfer form for R34. R34's nurses note dated 9/1/25, at 14:02 (2:02 p.m.), written by LPN-H documents, Hospital reported pt became lethargic during dialysis late morning. Writer contacted [hospital initials] in regards to pts (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status stating pt currently has AMS (altered mental status), BP (blood pressure)-88/58 and awaiting on labs and other tests. [Name] POA contacted with message left. Will cont. (continue) to f/u (follow up) later PM (evening) shift. R34 was readmitted to the facility on [DATE]. On 1/27/26, at 7:43 a.m., Surveyor reviewed R34's electronic medical record for R34's bed hold policy and notice of transfer form for R34's transfer to the hospital on 9/1/25. Surveyor was unable to locate this form in R34's medical record and asked Nursing Home Administrator (NHA)-A for a copy. Surveyor was not provided with R34's bed hold policy and notice of transfer form for R34. R34's nurses note dated 9/12/25, at 13:50 (1:50 p.m.), written by LPN-H documents [Initials] Lab contacted facility for critical Glucose reading of 49. Writer contacted dialysis in regards to current bs (blood sugar) with reading of 103. Nurse also informed writer they were sending pt (patient) to [hospital initials] due to multiple emesis accompanied with AMS (altered mental status). Pts POA (power of attorney)/Brother contacted and aware of the situation with no further questions or concerns. Will f/u (follow up) later in the shift. R34's nurses note dated 9/12/25, at 14:41 (2:41 p.m.), written by LPN-H documents, Verbal Bed hold with POA stating he will sign when he comes to facility with email/fax unavailable. R34 was readmitted to the facility on [DATE]. On 1/27/26, at 7:45 a.m., Surveyor reviewed R34's electronic medical record for R34's bed hold policy and notice of transfer form. Surveyor noted under the miscellaneous tab there is a bed hold policy and notice of transfer form dated 9/12/25. Surveyor noted under the Appeal Procedure section for Department of Quality Assurance does not include their email address. The Long-Term Care Ombudsman does not include their mailing and email address. The Wisconsin Coalition for Advocacy does not include their email address. Surveyor noted the POA was notified verbally by LPN-H on 9/12/25. This bed hold policy and notice of transfer form does not include evidence the form was provided in writing. R34's nurses noted dated 10/27/25, at 15:50 (3:50 p.m.) written by LPN-H documents Pt sent to [hospital initials] d/t (due to) hypotension with low K+ (potassium). POA [Name] informed with questioning if bp (blood pressure) medication was sent with pt and confirmed with nurse that it was with dialysis reporting medication was administered with not much change to bp with reading from 79/47 with increase to 82/55. POA in understanding with no further questions or concerns at this time. F/U (follow up) to hospital later in the shift if pt is admitted . R34's nurses note dated 10/29/25, at 0925 (9:25 a.m.) documents Per [Name] POA bed hold in place with verbal consent via phone 10/27/25. R34 was readmitted to the facility on [DATE]. On 1/27/26, at 7:47 a.m., Surveyor reviewed R34's electronic medical record for R34's bed hold policy and notice of transfer form. Surveyor was unable to locate this form in R34's medical record and asked Nursing Home Administrator (NHA)-A for a copy. NHA-A provided Surveyor with R34's bed hold policy and notice of transfer form dated 10/27/25. Surveyor noted under the Appeal Procedure section for Department of Quality Assurance does not include their email address. The Long-Term (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Ombudsman does not include their mailing and email address. The Wisconsin Coalition for Advocacy does not include their email address. Surveyor noted the POA was notified verbally by LPN-H on 10/27/25. This bed hold policy and notice of transfer form does not include evidence the form was provided in writing. R34's nurses note dated 12/5/25, at 13:29 (1:29 p.m.), written by Licensed Practical Nurse/Unit Manager (LPN/UM)-U documents Received call from patients' dialysis at [dialysis's name], with information that they will be sending patient to the hospital for bright red blood from the rectum. No blood reported this morning prior to dialysis. All responsible parties notified. R34 was readmitted on [DATE]. On 1/27/26, at 7:48 a.m., Surveyor reviewed R34's electronic medical record for R34's bed hold policy and notice of transfer form. Surveyor noted under the miscellaneous tab there is a bed hold policy and notice of transfer form dated 12/5/25. Surveyor noted under the Appeal Procedure section for Department of Quality Assurance does not include their email address. The Long-Term Care Ombudsman does not include their mailing and email address. The Wisconsin Coalition for Advocacy does not include their email address. Surveyor noted the form indicates the POA was notified verbally on 12/5/25 but there is no facility signature as to whom provided the verbal notification. This bed hold policy and notice of transfer form does not include evidence the form was provided in writing. On 1/27/26, at 8:17 a.m., Surveyor asked LPN-H to explain the facility's process when a resident is transferred to the hospital. LPN-H explained they automatically contact the doctor, if the POA is activated they contact them to get clearance and ask if they want a bed hold. The POA gives them a verbal, and this is documented on the bed hold form. A transfer form is printed out and sent to the hospital and a copy of the bed hold policy is sent. They call the hospital to give report and inform the Director of Nursing (DON). Surveyor asked LPN-H if she was responsible for providing written notification of the bed hold policy and notice of transfer to the resident and/or their legal representative. LPN-H informed Surveyor if their POA is in the building she reads it to them and if the resident is their own person she reads it to them, and they sign. LPN-H informed Surveyor Unit Clerk (UC)-DD scans the bed hold policy and notice of transfer into the computer. On 1/27/26, at 8:54 a.m., Surveyor asked Director of Nursing (DON)-B to explain the process when a resident is transferred to the hospital. DON-B explained they put in an order to send to the hospital, contact the POA to update them on the situation, & tell the POA their bed hold policy. DON-B indicated sometimes they get a verbal or if they come in, they sign. A progress note, the e-interact change of condition form, and transfer form is completed. Surveyor asked DON-B if the POA doesn't come to the facility is the bed hold policy and notice of transfer form provided to the POA. DON-B informed Surveyor she's not sure. If they give a verbal the business office is notified the POA gave a verbal and the business office moves forward with that. On 1/27/26, at 11:15 a.m. Surveyor asked Business Office Manager (BOM)-L if he is involved with resident's bed hold policy and notice of transfers. BOM-L replied no, only if they want a bed hold then he will add it in the census. Surveyor asked if he sends the bed hold policy and notice of transfer to the resident representative. BOM-L replied to no.

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure 1 (R2) of 4 Residents reviewed with limited range of motion, received appropriate treatment and services to increase range of motion/mobility and/or to prevent further decrease in range of motion/mobility.*R2 was observed not wearing a right hand splint to prevent further decrease in range of motion/mobility. Findings include:The facility's undated Use of Assistive Devices policy and procedure documents:Policy: The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity .Policy Explanation and Compliance Guidelines:2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care.4. Facility staff will provide appropriate assistance to ensure that the resident can sue the assistive devices. This may include education or therapy sessions for training on the use of the device, set up assistance, supervision, or physical assistance as needed.5. Direct care staff will be trained on the use of the devices as needed to carry out their roles and responsibilities regarding the devices. Training will also include when to refer to other departments for changes in condition or problems with the device.6. A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed.R2 was admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis(a chronic disabling autoimmune disease of the central nervous system), Spastic Hemiplegia Affecting Right Dominant Side(one side of body experiences muscle stiffness and weakness), Neuromuscular Dysfunction of Bladder(nerves controlling bladder and urinary sphincter are damaged and not working correctly), Irritable Bowel Syndrome with Diarrhea(common chronic functional disorder of the large intestine), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Insomnia(sleep disorder characterized by difficulty falling asleep), and Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R2's Quarterly Minimum Data Set(MDS) completed 12/29/25 documents a Brief Interview for Mental Status(BIMS) score of 15, indicating R2 is cognitively intact for daily decision making. R2's Patient Health Questionnaire(PHQ-9) score of 6 indicates R2 is demonstrating mild depressive symptoms. R2's MDS documents that R2 is not demonstrating behaviors including refusal of cares/treatments. R2's also MDS documents:R2's primary method of locomotion is wheelchair; R2 has range of motion impairment(ROM) on one side of both upper and lower extremity; R2 requires set-up for eating; R2's documents R2 requires substantial/maximum assistance with showers, upper dressing, and mobility; R2 is dependent on assistance for lower dressing and transfers; R2 has an indwelling catheter and is frequently incontinent of bowel; R2 is at risk for developing pressure areas/injuries and the MDS does not document R2 has a splint.R2's functional abilities(self care and mobility) care area assessment(CAA) completed 4/16/25 documents: R2 has ROM impairment and the goal is minimize risks and demonstrate improvement.R2's current physician orders printed 1/21/26 documents: R2 is to have a right-hand resting splint on at night as tolerated, in the evening effective 12/30/25.Surveyor reviewed R2's January 2026 medication and treatment administration record(MAR/TAR) and notes that R2's right-hand resting splint is not being monitored for placement every evening.Surveyor reviewed R2's occupational therapy(OT) notes. On 4/14/25, Occupational Therapist (OT)-F documents R2 was provided with a right-hand splint to be worn during sleeping hours.On 6/20/25, OT-F documents R2 continues to tolerate right resting hand splint with good skin integrity. Staff demonstrates proper technique for donning/doffing splint.On 9/8/25, OT-F documents R2 wears resting hand splint to right (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upper extremity and continues to demonstrate good skin integrity and staff is able to assist with donning and doffing.On 1/7/26, OT-F documents R2 is currently wearing a right resting hand splint during sleeping hours and off during the day with no complaints of pain and with good skin integrity. Certified Nursing Assistants (CNAs) are helping with donning and doffing.R2's bedside Kardex as of 1/22/26 to assist CNAs in the care of R2, documents: R2 has a right resting hand splint on at night, as tolerated.R2's current comprehensive care plan documents: R2 has a physical functioning deficit related to mobility impairment and self-care impairment initiated 4/9/25. The intervention of right resting hand splint on at night as tolerated was initiated 4/16/25 and revised 12/30/25.Surveyor notes there is no comprehensive care plan documenting R2 consistently refuses the splint to be placed.On 1/20/2026, at 11:52 AM, Surveyor observed a black splint, when facing R2, on the left corner of the bedside table which is located next to R2's bed. Surveyor observed R2's right hand significantly contracted with all fingers bent into the palm of R2's right hand. Surveyor interviewed R2 at this time about the splint. R2 stated the splint was not placed on R2's right hand last night. R2 informed Surveyor that R2 would wear the splint every night if the staff would help R2 with putting the splint on.On 1/21/2026, at 7:33 AM, Surveyor observed R2 in bed sleeping and the splint is not on R2's right hand. Surveyor observed the splint to be in the same exact spot on the bedside table as on 1/20/26.On 1/22/2026, at 7:43 AM, Surveyor observed R2 sleeping in bed. R2's splint is not on. Surveyor observed the splint is located in the exact same spot on the left corner of the bedside table as 1/21/26.On 1/22/2026, at 8:15 AM, Surveyor reviewed R2's progress notes located in R2's electronic medical record(EMR). Surveyor noted there was no documentation of R2 refusing to wear the right resting hand splint at night. On 1/26/2026, at 7:24 AM, Surveyor observed R2 in bed sleeping. R2's splint is not on. Surveyor observed the splint is located in the exact same spot on the left corner of the bedside table as last week.On 1/22/2026, at 9:40 AM, Surveyor interviewed OT-F. OT-F confirmed OT-F has worked with R2 in therapy and that R2 should be wearing the right resting hand splint at night. OT-F stated OT-F has never been told R2 was refusing to wear the splint or that it was painful to wear. OT-F stated that R2 has mentioned to OT-F that R2 has had to consistently remind staff to put the splint on. OT-F stated that staff have to help R2 place the splint on. OT-F informed Surveyor that with any restorative program, staff are educated every time a resident is released from therapy. On 1/26/2026, at 11:21 AM, Surveyor interviewed (CNA)-CC. CNA-CC stated CNA-CC is not normally assigned to R2 but has helped to take care of R2. CNA-CC is unaware if R2 is supposed to be wearing a splint. CNA-CC would check a resident's Kardex for instructions when taking care of a new resident or when assigned to a different unit. On 1/26/2026, at 2:21 PM, Surveyor interviewed (CNA)-I. CNA-I informed Surveyor that if a resident refuses cares, heel boots, splints, etc, CNA-I would document it and inform the nurse. CNA-I consistent schedule is PMs and assists R2 on a regular basis. CNA-I is not familiar with R2 having a right-hand splint. On 1/26/2026, at 2:59 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R2 has not been wearing R2's right resting hand splint as documented on R2's Kardex and comprehensive care plan. Surveyor shared that staff indicated they were unaware R2 had a right-hand splint. No additional information was provided by the facility as to why R2 has not been wearing R2's right hand splint to decrease any further range of motion impairment.

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 2 (R25 & R34) of 6 residents received adequate supervision and assistance devices to prevent accidents.*R25 was observed without a fall mat and body pillow while in bed according to R25's plan of care.*R34's falls on 8/12/25, 10/24/25, 11/23/25, 12/13/25, & 1/3/26 were not thoroughly investigated and the root cause was not consistently determined to help prevent further falls.Findings include:The facility's undated policy titled, Fall Prevention Program documents: Each resident will be assessed for fall risk and will receive care and services in accordance with their individual level of risk to minimize the likelihood of falls.1.) R25's diagnoses includes chronic kidney disease (kidneys are damaged and cannot filter blood & waste effectively), diabetes mellitus (high blood sugar), anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life), depression (serious mood disorder that causes a persistent feeling of sadness and a loss of interest in activities interfering with daily life), and dementia (loss of cognitive function that interferes with a person's daily life and activities).R25's at risk for falls care plan initiated 1/3/25 documents the following interventions:*Assess me for pain. Initiated 1/3/25 & revised 1/18/25.*Clear and monitor environmental obstacles (tubing, cords, etc.). Initiated 1/3/25.*I need my call light and personal items available and in easy reach or provide reacher. Initiated 1/3/25 & revised 1/18/25.*Encourage meals in dining room, common space. Initiated 2/28/25.*Nonslip shoes/socks. Initiated 2/28/25 & revised 3/2/25.*Prompt toileting before meals. Initiated 2/28/25 & revised 3/2/25.*Staff will ensure that resident is in view when family leaves and staff will educate family to make sure that resident is brought back to the nurses station. Initiated 2/28/25.*Body pillows to be applied door side of bed. Initiated 5/28/25.*Floor mat applied to door side of bed. Initiated 6/2/25 & revised 6/6/25.*Staff to ensure that bed linens are tucked in at the foot of the bed. Initiated 6/2/25.R25's fall CAA (care area assessment) dated 6/11/25 under analysis of findings for nature of the problem/condition documents: Fall 6/1. Speech is weak and a few words at a time. Clear. Allow time to express self. IDDM (insulin dependent diabetes mellitus), ref (refuse) to wear dentures (upper). No obvious issues noted. Sched (scheduled) Tylenol. Fall 6/1 w (with) pain to knee. Taking antidepressant, antianxiety. On Hospice. Pressure reducing devices in place. Skin and pain monitored. Monitored for changes. Under care plan considerations for describe impact for this problem/need on the resident and your rationale for care plan decision documents Speech is weak and a few words at a time. Clear. Allow time to express self. IDDM, Ref to wear dentures (upper). No obvious issues noted. Sched Tylenol. Fall 6/1 w pain to knee. Taking antidepressant, antianxiety. On Hospice. Pressure reducing devices in place. Skin and pain monitored. Monitored for changes. R25's quarterly MDS (minimum data set) with an assessment reference date of 12/25/25 is assessed as having short- & long-term memory problems and is severely impaired for cognitive skills for daily decision making. R25 is assessed as being dependent for toilet use, roll left and right, and chair/chair to bed transfers. R25 is always incontinent of bowel and bladder. R25 is assessed as not having any falls since prior assessment.R25's Visual/Bedside Kardex Report as of 1/21/26 under the safety section includes *Body pillows to be applied to right side for positioning and *Fall mat applied to right side of bed.On 1/21/26, at 7:38 a.m., Surveyor observed R25 in bed sleeping on the left side. The call light is under R25's pillow and is not in reach. Surveyor observed there is not a body pillow on the right side of R25's bed and there is not a floor mat on the right side.On 1/21/26, at 8:31 a.m., Surveyor observed R25 continues to be in bed on the left side. Surveyor observed there is still not a body pillow on the right side and there is not a floor mat on the right side.On 1/21/26, from 8:54 a.m. to 9:17 a.m., Surveyor observed Certified Nursing Assistant (CNA)-N provide morning cares for R25. At 9:17 a.m. CNA-N informed R25 she was going to get the sling and someone to help her put her in the chair. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA-N lowered the height of R25' bed down and at 9:18 a.m. CNA-N left R25's room. Surveyor observed prior to leaving R25's room, CNA-N did not place a body pillow on the right side of the bed or a fall mat on the floor.On 1/21/26, at 9:27 a.m. Surveyor observed CNA-N enter R25's room, place gripper socks on R25 and a sling under R25. CNA-N told R25 she would be right back, went into the bathroom, removed her personal protective equipment, washed her hands and left R25's room at 9:29 a.m. Surveyor observed CNA-N did not place a body pillow on the right side of the bed or a fall mat on the floor next to R25's bed.On 1/21/26, at 9:35 a.m., Surveyor observed CNA-N and CNA-CC enter R25's room, attach the sling to a Hoyer lift and R25 was transferred from the bed into the Broda chair.On 1/22/26, at 7:40 a.m., Surveyor observed R25 sleeping in bed on her back. Surveyor observed there is not a body pillow on the right side and there is not a mat on the floor next to R25's bed.On 1/22/26, at 9:55 a.m., Surveyor observed R25 sitting in a Broda chair in the hallway outside the lounge area with the soda machine, covered with a blanket.On 1/26/26, at 7:08 a.m., Surveyor observed R25 on the left side with her knees flexed. Surveyor observed there is a rolled item along the right side of R25's bed but there is not a floor mat on the right side according to R25's plan of care.On 1/27/26, at 7:20 a.m., Surveyor observed CNA-M in R25's room. R25 was sitting in a Broda chair and was dressed for the day. Surveyor asked CNA-M if she got R25 up this morning. CNA-M replied yes. Surveyor asked CNA-M when she went in R25's room was there a floor mat on the right side of R25's bed. CNA-M looked around R25's room and then stated no. Surveyor then pointed to two red rolls in the corner and asked CNA-M if these were on R25's bed. CNA-M replied yes.On 1/27/26, at 8:22 a.m., Surveyor asked Licensed Practical Nurse (LPN)-H if CNAs should follow a resident's plan of care. LPN-H replied absolutely. Surveyor asked how CNAs know what a resident plan of care is. LPN-H replied we have a Kardex and explained for extensive things she lets them know. LPN-H explained she lets them know who has weights, if their a high fall risk she tells them what interventions are in place as well as fluid restriction. Surveyor informed LPN-H of multiple observations of R25 not having a body pillow or floor mat according to R25's plan of care.On 1/27/26, at 8:48 a.m., Surveyor informed Director of Nursing (DON)-B of the multiple observations of R25 not having a body pillow or floor mat according to R25's plan of care.On 1/27/26, at 12:00 p.m., LPN-H informed Surveyor R25 didn't have the floor mat as when they moved R25's roommate to another room they moved the floor mat also.2.) R34's diagnoses includes history of traumatic brain injury (brain dysfunction caused by outside force usually a violent blow to the head), hypertension (high blood pressure), end stage renal disease (kidneys do not work to meet the body's needs), diabetes mellitus (high blood sugar), encephalopathy (general brain dysfunction characterized by alteration in brain function or structure), and conversion disorder (condition in which a mental health issue disrupts how the brain works) with seizures (sudden burst of electrical activity in brain which can cause changes in behavior, movement and level of consciousness) or convulsions. R34's fall CAA (care area assessment) with an assessment reference date of 5/13/25 under analysis of findings for nature of the problem/condition documents No recent falls. Inc. (incontinent) B & b (bowel and bladder). Toileted by staff approx. (approximately) q (every) 2 hrs. (hours). Substantial to total assist w (with) all care. Daily antidepressant, seizure med (medication), Betadine to arterial toe. Sometimes understands. Understood. Allow time to answer - Ask short questions. No glasses. Items in reach in a well-lit area. Dialysis. High back w/c (wheelchair). Skin and pain monitored. Pressure reducing devices in place. Under care plan considerations for describe impact of this problem/need on the resident and your rational for care plan decision documents Inc B & b. Toileted by staff approx. q 2 hrs. Substantial to total assist w all care. Daily antidepressant, seizure med, Betadine to arterial toe. Sometimes understands. Understood. Allow time to answer-Ask short questions. No glasses. Items in reach in a well lit area. R34's quarterly MDS (minimum data set) with an assessment reference date of 12/12/25 has a BIMS (brief interview mental status) score of 6 which indicates severe cognitive impairment. R34 is assessed as not having any behavior. R34 is assessed as requiring supervision for eating, is dependent for toileting hygiene, and requiring partial/moderate assistance for rolling left & (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right, chair/bed to chair transfer, and toilet transfer. R34 is frequently incontinent of bowel & bladder and is assessed as not having any falls since prior assessment period.R34's nurses note dated 8/12/25, at 0646 (6:46 a.m.) written by Licensed Practical Nurse (LPN)-FF documents Resident found lying on the floor on his left side. Incontinent of bowel. Resident states tried getting up and fell. Did not use call light. C/o (complained of) left knee pain. ROM (range of motion) WNL (within normal limits) to all extremities. Medicated with 650 mg (milligram) Tylenol. Hoyer lifted into bed. BP (blood pressure) 145/70, pulse 72, resp. 17, temp. (temperature) 97.2, pulse ox 96% room air. Neuro check negative. Resident denies hitting his head.On 1/27/26 at 10:15 a.m. Surveyor reviewed the facility's fall investigation provided by NHA (Nursing Home Administrator)-A. Surveyor noted the facility investigation consisted of an incident report dated 8/12/25, neuro checks, and one staff statement. The facility's investigation does not include a root cause, when was R34 last seen, when was R34 last toileted and were prior interventions in place. R34's nurses note dated 10/24/25 fall at 1934 (7:34 p.m.) written by LPN-H documents During HS (hour sleep) medication administration writer heard pt (patient) yell out for help, when Nurse approached pts room pt was observed attempting to reach his w/c (wheelchair) when his gait became unsteady and fell landing on his R (right) side w/out (without) hitting his head with gripper socks and fitted. Pt stated he was okay but that he needed to get to the restroom fast for he felt a bowel movement coming. Pt was last seen coming from dinner with CNA (Certified Nursing Assistant) for nightly ADLs (activities daily living) @16:30 (4:30 p.m.). Pt able to move all extremities with no vocal or facial c/o (complaint of) pain, no new skin issues with current drainage remaining to G-tube site, VSS (vital signs stable) with no SOB (shortness of breath) or distress, eyes PERRLA (pupils are equal, round, reactive to light and accommodation) with pt A&O (alert and orientated) with clear speech. Pt was explained the importance of using the call light for assistance for transferring with UM (Unit Manager) and Nurse ambulating pt with gait belt to the restroom and then safely transferred back to bed in the lowest position. NP (Nurse Practitioner) [Name] made aware with NNO (no new orders) with close monitoring. POA (Power of Attorney) [Name] informed with no further questions or concerns.On 1/27/26, at 10:20 a.m. Surveyor reviewed the facility's investigation for R34's fall on 10/24/25 provided by NHA-A. Surveyor noted the facility's investigation included an incident report, nurses note dated 10/24/25, and four staff statements. Surveyor noted a root cause but noted the facility did not conduct a thorough investigation as staff statements document staff did not witness, were unaware of the fall or did not provide care. The investigation does not include whether prior interventions were in place, who last observed R34 and what was R34 doing to help prevent further falls.R34's nurses note dated 11/23/25 at 22:29 (10:29 p.m.) written by Registered Nurse (RN)-EE documents Nursing assistant reported to writer that resident had fallen in the bathroom. Writer entered room and noted resident sitting on buttocks next to toilet with right side against the wall. Gown and gripper socks on. Wheelchair in front of resident facing toilet and locked. Denies pain/discomfort. Denies hitting head. ROM WNL. Resident stated, I fell. Vital signs taken. Writer assisted resident to wheelchair with cna and gait belt. Updated physician, nurse manager on duty, and POA.On 1/27/26, at 10:21 a.m., Surveyor reviewed the facility investigation for R34's fall on 11/23/25 provided by NHA-A. Surveyor noted this investigation consisted of an incident report, neuro checks, and two staff statements. Surveyor noted the facility did not determine a root cause to help prevent further falls and did not conduct a thorough investigation as the staff statements indicate they didn't provide cares and did not witness R34's fall. The facility investigation did not include who last observed R34, when was R34 last toileted and were prior interventions in place. R34's nurses note dated12/13/25 at 0350 (3:50 a.m.) written by LPN-FF documents CNA found resident lying on the floor. Resident was lying on his right side. Had a BM (bowel movement) on the floor. States needed to have a BM got out of bed fell. Denies hitting head. Alert, able to make needs known. Denies pain or discomfort. ROM WNL to extremities. Skin intact, no raised or open areas to head. Neuro check negative. Cares provided. Hoyer lifted into bed. BP 114/62, pulse 72, resp. (respirations) 16, temp. (temperature) 97.6, pulse ox 96% room air. Message left for (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manager [Name].On 1/27/26, at 10:23 a.m. Surveyor reviewed the facility's fall investigation for R34's fall on 12/13/25 provided by NHA-A. Surveyor noted the facility's investigation consisted of an incident report, one staff statement, and neuro checks. Surveyor noted a root cause but the facility did not conduct a thorough investigation as the facility investigation does not include who last observed R34, when was R34 last toileted and were prior interventions in place.R34's nurses note dated 1/3/26 at 1440 (2:40 p.m.) written by LPN-H documents Pt was observed sitting on his buttocks in front of his w/c with legs straight ahead, clothes on and fitted, not incontinent, denied hitting his head, call light not on but within reach with noted tennis shoes on and laced up correctly, wheelchair locked with cushion in place. Pt stated he was attempting to get into his electric new w/c to get to the restroom. Head to Toe WNL with pt able to move all extremities without vocal and or facial pain, VSS with no SOB or distress, no changes to skin or any other noted injuries. Pt was safely transferred back to w/c via Hoyer, reminded the importance of utilization of call light for safety with pt in understanding. Pt then was sat near nurses station for comfort and safety with electric w/c removed from room as well. POA/[Name]-phone not on with message left, NP [Name] made aware as well as DON (Director of Nursing). Neuros and close monitoring to continue.On 1/27/26, at 10:25 a.m., Surveyor reviewed the facility's fall investigation for R34's fall on 1/3/26 provided by NHA-A. Surveyor noted the facility's fall investigation consists of an incident report, neuro checks, and five staff statements. Surveyor noted a root cause, but the facility did not conduct a thorough investigation as none of the staff statements included when was R34 last observed & what time was R34 toileted. The investigation doesn't include whether prior interventions were in place at the time of R34's fall.On 1/27/26, at 11:49 a.m., Surveyor interviewed Director of Nursing (DON)-B regarding the facility's process after a resident has sustained a fall. DON-B explained the resident needs to be assessed by the nurse who checks for injuries, if there is a RN in the building, we want them to do an assessment. DON-B informed Surveyor if there is not an RN in the building the floor nurse will do the assessment, and the RN will do an assessment the following day. The resident is transferred back into bed, neuro checks are started and the MD (Medical Doctor) or NP (Nurse Practitioner), POA or guardian or emergency contact, if the resident wants, are contacted. The nurse puts an intervention in place and in the morning meeting they talk about the fall, if the intervention is appropriate or if we need to find another one. Surveyor asked about the investigation into a resident's fall. DON-B replied that's where we get statements from the CNAs and the nursing statement is usually in risk management. Surveyor asked who determines the root cause. DON-B informed this is done as an IDT (interdisciplinary team). Surveyor informed DON-B Surveyor reviewed the facility's investigation for R34's five falls and was unable to consistently find the root cause. Surveyor informed DON-B R34's falls involved R34 needing to have a BM, trying to get to the bathroom or found in the bathroom. Surveyor informed DON-B the facility's investigation was not thorough as staff statements did not include who last observed R34, what was he doing, when was he toileted, etc. to help prevent further falls and whether prior interventions were in place.No additional information was provided.

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure ongoing communication with the dialysis center and monitoring for complications before and after dialysis treatment for 2 (R34 & R11) of 2 residents reviewed for hemodialysis. Findings include: The facility's undated policy, titled Hemodialysis documents: The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: *The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. *Safe administration of hemodialysis at the bedside in the nursing home provided by qualified trained staff/caregivers, in accordance with State and Federal laws and regulations: (see home dialysis treatment policy). *Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices: and *Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. 1.) R34's diagnoses includes a history of traumatic brain injury (brain dysfunction caused by outside force usually a violent blow to the head), hypertension (high blood pressure), end stage renal disease (kidneys do not work to meet the body's needs), diabetes mellitus (high blood sugar), encephalopathy (general brain dysfunction characterized by alteration in brain function or structure), and conversion disorder (condition in which a mental health issue disrupts how the brain works) with seizures (sudden burst of electrical activity in brain which can cause changes in behavior, movement and level of consciousness) or convulsions. R34's alteration in kidney function care plan initiated 10/6/25 documents the following interventions: *Labs per Physician order and PRN (as needed) for change in condition/manifestation of clinical signs or symptoms. Initiated 10/6/25. *Monitor for edema in extremities and report any increase to Physician, pre-dialysis and post dialysis weights at dialysis center. Initiated 10/6/25. *Monitor thrill and bruit daily and document findings; report abnormal findings to Physician. Initiated 10/6/25. *Observe for signs and symptoms of bleeding, i.e. hematuria, bleeding gums, tarry stools, increase in bruising. Initiated 10/6/25. R34's quarterly MDS (minimum data set) with an assessment reference date of 12/12/25 has a BIMS (brief interview mental status) of 6, which indicates severe cognitive impairment. On 1/21/26, at 9:26 a.m., Licensed Practical Nurse (LPN)-H asked Surveyor if Surveyor wanted R34's dialysis binder as he is going to dialysis today. LPN-H explained R34 goes to dialysis on Monday, Wednesday, and Friday. Surveyor informed LPN-H Surveyor would review R34's dialysis binder at (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another time. On 1/21/26, at 12:57 p.m., Surveyor went to R34's room and noted R34 has not returned from dialysis. On 1/22/26, at 10:44 a.m., Surveyor observed R34 sitting in a high back wheelchair in R34's room. Surveyor asked R34 how his dialysis was yesterday. R34 replied good I think depending on who the instructor is. On 1/22/26, at 10:49 a.m., Surveyor heard R34 yelling out for Surveyor. Surveyor spoke with R34 who started to talk to Surveyor about his tube leaking. Surveyor asked R34 if his G-tube was leaking. R34 was unsure then showed Surveyor his dialysis port located on R34's right upper chest. Surveyor informed R34 Surveyor would ask LPN-H to see him. R34 stated oh first name of LPN-H is here? Surveyor spoke with LPN-H who then went to R34's room. On 1/26/26, at 8:12 a.m., Surveyor asked LPN-H where Surveyor could find R34's dialysis book. LPN-H showed Surveyor a thin white binder stating this is his little one, he had a thick binder. Surveyor asked LPN-H what happened to R34's thick binder. LPN-H explained R34 went to the hospital from dialysis and the hospital lost R34's binder. LPN-H informed Surveyor they called the hospital and they said they couldn't find it. On 1/26/26, starting at 8:14 a.m., Surveyor reviewed R34's dialysis binder and R34's medical record regarding dialysis communication and monitoring. Surveyor noted R34 was hospitalized on [DATE] and returned to the facility on [DATE]. Surveyor noted the following: *On 12/12/25 the bottom portion of the dialysis communication report sheet is not completed by the dialysis center and there is no post dialysis assessment. *On 12/15/25 the bottom portion of the dialysis communication report sheet is not completed by the dialysis center and there is no post dialysis assessment. *On 12/17/25 the bottom portion of the dialysis communication report sheet is not completed by the dialysis center and there is no post dialysis assessment. *On 12/19/25 there is no pre dialysis assessment, communication from dialysis center, and no post dialysis assessment. *On 12/21/25 the bottom portion of the dialysis communication report is not completed by the dialysis center and there is no post dialysis assessment. *On 12/24/25 there is no pre dialysis assessment, no communication from dialysis center, and no post dialysis assessment. *On 12/26/25 there is no pre dialysis assessment, no communication from the dialysis center, and no post dialysis assessment. *On 12/29/25 the bottom portion of the dialysis communication sheet is not completed by the dialysis center and there is no post dialysis assessment. *On 12/31/25 there is no pre dialysis assessment, no communication from the dialysis center, and no (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	post dialysis assessment. *On 1/2/26 there is no pre dialysis assessment, no communication from the dialysis center, and no post dialysis assessment. *On 1/5/26 there is no pre or post dialysis assessment. *On 1/7/26 the bottom portion of the dialysis communication sheet is not completed by the dialysis center and there is no post dialysis assessment. *On 1/9/26 there is no pre or post dialysis assessment. *On 1/12/26 there is no post dialysis assessment. *On 1/16/26 there is no pre dialysis assessment, no communication from the dialysis center, and no post dialysis assessment. *On 1/19/26 there is no post dialysis assessment. On 1/26/26, at 9:41 a.m., Surveyor interviewed LPN-H to inquire about the facility's dialysis communication and monitoring for R34. LPN-H explained they do a pre and post dialysis assessment form. The pre assessment goes to the dialysis center then dialysis reads it and sometimes they send the form back. Surveyor informed LPN-H Surveyor noted in R34's binder dialysis communication forms where the facility completes the top portion and the bottom portion is completed by the dialysis center. Surveyor inquired about the top portion. LPN-H explained if they don't complete the dialysis pre assessment on the computer and print it out then they complete the top portion of the dialysis communication form. Surveyor inquired who is responsible for the post dialysis assessment. LPN-H replied the PM (evening) nurse for [R34's first name]. On 1/26/25, at 11:04 a.m., Surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM)-U to explain the facility's communication process with the dialysis center. LPN/UM-U explained there is a communication book, the nurses fill out pre and post assessment in the computer and they are supposed to send the pre assessment with the patient to dialysis so the dialysis center knows if there is any medication taken and also has a set of vitals. LPN/UM-U explained the pre assessment is completed by the nurse on the unit and then the post is completed by the floor nurse when they return. Surveyor informed LPN/UM-U Surveyor noted in R34's dialysis binder there is a communication form which has the facility completing the top portion and dialysis center the bottom section. Surveyor asked if the nurses complete this top portion. LPN/UM-U replied I've seen some of the forms and explained the form in the computer system has everything on the top portion. LPN/UM-U informed Surveyor she believes they have been doing the assessments on the computer. Surveyor asked LPN/UM-U who ensures the dialysis center is completing their section to communicate back to the facility. LPN/UM-U replied the nurse should because the binder should be coming back. LPN/UM-U explained the nurse should be looking at what dialysis says and then complete the post dialysis assessment in PCC. Surveyor informed LPN/UM-U there are multiple dates when the facility has not completed R34's pre or post dialysis assessment and there is no communication from the dialysis center. Surveyor asked LPN/UM-U to look into this, and Surveyor would meet with her the next day. On 1/26/26, at 2:59 p.m., during the end day meeting with Nursing Home Administrator (NHA)-A and (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON)-B, facility staff were informed of the multiple days when the facility did not complete R34's pre or post dialysis assessment and there is no communication from the dialysis center. On 1/27/26, at 8:53 a.m., Surveyor asked DON-B if there is any additional information regarding R34's pre & post dialysis assessment and communication with the dialysis center. DON-B replied no. On 1/27/26, at 12:05 p.m., Surveyor asked LPN/UM-U if she has any information for Surveyor regarding R34's pre/post dialysis assessments and communication with the dialysis center. LPN/UM-U replied I was looking and think we might of dropped the ball, I'm not finding anything else. No additional information was provided. 2.) R11 admitted to the facility on [DATE] and has diagnoses that include non-displaced condyle fracture of lower end of right femur, Type 1 Diabetes Mellitus and End Stage Renal Disease dependence on renal dialysis. R11's admission Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R11 is cognitively intact. R11's Care Plan documents: Alteration in Kidney Function evidenced by hemodialysis; date initiated 12/22/25. Interventions include: Written communication form with review of weights and any changes in condition between dialysis provider and living center. On 1/20/26 at 9:27 AM, Surveyor spoke with R11 who reported she goes to dialysis every Monday, Wednesday and Friday. R11 showed Surveyor the access port in her right chest and reported the facility does not do anything with the access site and that the dressing is changed at dialysis. 01/26/2026 9:02 AM Surveyor asked Director of Nursing (DON)-B how the facility communicates with the dialysis center. Surveyor was advised residents on dialysis have a binder with facility and dialysis communication sheets. Surveyor was unable to locate R11's dialysis binder. Surveyor was advised by the unit nurse (unknown name) the dialysis communication book goes with the resident to dialysis, and that R11 leaves at 5:30 am and should return around 11:00 am. Surveyor was unable to locate any facility/dialysis communication forms and reviewed R11's progress notes which included the following facility pre or post dialysis evaluations completed: 1/26/26 pre-dialysis, 1/19/26 post-dialysis, 1/14/26 post-dialysis, 1/12/26 post-dialysis, 1/9/26 pre-dialysis, 1/8/26 pre and post dialysis, 1/7/26 pre and post dialysis, 1/2/26 pre and post dialysis, 12/31/25 pre and post dialysis, 12/26/25 post-dialysis and 12/23/25 post-dialysis. Surveyor noted there was no assessment/evaluation for R11 documented before or after dialysis on 12/22/25, 12/24/25, 12/29/25, 1/5/26, 1/16/26, 1/21/26 or 1/23/26. In addition, facility documentation on 1/19/26, 1/14/26, 1/7/26, 1/2/26, 12/26/25 and 12/23/25 documented: Bruit – positive. Thrill – yes. R11 does not have a dialysis shunt to assess bruit and thrill. On 1/26/26 at 12:09 PM, Surveyor spoke with R11 while R11 was eating lunch in the dining room. Surveyor asked if she had the dialysis communication book she takes to dialysis. R11 stated, No, I don't have, and I've never had a book that I take with me. It depends on who's working, but I've only (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taken a piece of paper with me two time to dialysis. Someone here filled it out and then someone there wrote on it too. That has only happened twice. Surveyor confirmed R11 has a dialysis access port in her chest and no access shunt in either arm. R11 stated, They tried an access in my arm like 5 years ago, but it didn't take. On 1/26/26 at 3:11 PM, during the daily exit meeting with Nursing Home Administrator (NHA)-A and DON-B, Surveyor shared concern regarding the lack of communication between the facility and the dialysis center, and the facility not consistently assessing R11 before and after dialysis. Surveyor advised DON-B of documentation indicating assessment of bruit/thrill, though R11 does not have a shunt to assess bruit/thrill. No additional information was provided.

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility did not ensure residents received the necessary behavioral health care and services to maintain the highest practical mental and psychosocial well being in accordance with a comprehensive assessment and plan of care for 1 (R69) of 1 resident received for mood concerns.R69 has a long history of suicidal ideations. On 9/3/25 and 1/19/26, R69 voiced suicidal ideations while in the dining room. R69 was not placed on a one to one according to R69's plan of care, R69's physician and/or psychological services were not notified, and social service staff was unaware of these suicidal ideations.Findings include:The facility's undated policy titled, Suicide Prevention documents: It is the policy of this facility to act quickly and appropriately if a resident expresses thoughts of suicide. Under policy explanation and compliance guidelines documents 1. All staff members will immediately report any suicidal ideation to the resident's charge nurse and facility social worker. 2. Immediately notify the resident's physician if the resident presents with suicidal ideation, even if he or she isn't specific about a plan or intent. 3. If applicable, notify the resident's responsible party of the resident's suicidal ideation and any orders received from the resident's physician. 4. The resident will not be left alone. One on one care will be provided until arrangements can be made for the resident to receive emergency psychiatric care, or until the resident's physician determines that the risk of suicide is no longer present. 5. Objectively and thoroughly document the resident's mood and behaviors, as well as all actions taken, in the medical record. 6. If the resident requires inpatient psychiatric services, State specific guidelines and requirements will be followed. 7. All staff will be trained annually on risk factors and warning signs of suicide, as well as how to respond to a resident with suicidal ideation.R69's diagnoses include bipolar disorder (mental disorder characterized by periods of depression and periods of abnormally elevated mood), hypertension (high blood pressure), diabetes mellitus (high blood sugar), major depressive disorder (serious mood disorder that causes a persistent feeling of sadness and a loss of interest in activities interfering with daily life), generalized anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear and nervousness that can interfere with daily life), and obsessive-compulsive personality disorder (excessive thoughts that lead to repetitive behaviors).R69's PASRR (Pre-admission Screening and Resident Review) level II (2) dated 10/17/24 under reason for referral documents [R69's name] was referred to [Name] due to his diagnosis of bipolar disorder, major depressive disorder, generalized anxiety disorder, and obsessive-compulsive disorder. Claustrophobia (extreme or irrational fear of confined spaces) is also noted in his records. He was originally diagnosed in the late 1970's and early 80's. Symptoms in the past have included fluctuation in mood, periods of depression, feelings of frustration, feeling overwhelmed, and suicidal ideation. He has had 2 psychiatric hospitalizations and suicide attempts in the 1980's. He has taken psychotropic medications since around that time. He continues to see a psychiatrist in the community.R69's at risk for alteration in psychosocial well-being related to bipolar disorder, depressive disorder, generalized anxiety disorder. I have episodes of increased irritability and aggressive verbalizations. I have a history of suicide attempt many years ago, related to a breakup with girlfriend. I sometimes have behaviors which include yelling, attention seeking. I sometimes refuse showers. I am taking Buspirone for my anxiety. I am taking Depakote for my anxiety. I am taking Seroquel for my Bipolar. 4/10/25 I am currently having episodes of increased anxiety that become overwhelming. I will make statements of not wanting to live anymore. 4/30/25 Voice suicidal thoughts, no plan care plan. Initiated 9/14/24 documents the following interventions:*Encourage me to openly express my feelings. Initiated 9/14/24.*Observe for and report any changes in my mental status to nursing and/or social services. Initiated 9/14/24 & revised 4/11/25.*Refer to social services PRN (as needed) for additional emotional support. Initiated 9/14/24.*Update me regularly to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525549	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	help put my mind at ease. Initiated 9/14/24.*If I am having increased anxiety or irritability, allow me to express my feeling, provide me validation and reassurance. Encourage me to socialize, offer things I enjoy; favorite music station, Sci-Fi tv shows, phone calls to family/friends. Initiated 4/10/25 & revised 10/23/25.*Approach me from the front and address me by name. Initiated & revised 4/11/25.*Don't leave me alone if I express any suicide ideation, initiate 1:1, inform nurse and call 911. Initiated & revised 4/11/25.*Please avoid things that make me more anxious. Initiated 4/11/25.*Please give me my medication that help me with my anxiety. Initiated 4/11/25.*Please refer me to my psychologist/psychiatrist as needed. Initiated 4/11/25.*Please tell me what you are going to do before you begin. Initiated 4/11/25.*Monitor me for any changes in my mood. Initiated 9/2/25.*Monitor me for medication side effects. Initiated 9/2/25.R69's physician orders include Buspirone HCl 5 mg (milligrams) three times a day for anxiety related to bipolar disorder, current episode depression, moderate with an order date of 8/21/25. Depakote Delayed Release 125 mg, 4 tablets four times a day related to generalized anxiety disorder with an order date of 11/18/24. Seroquel 300 mg, give 2 tablets in the evening related to bipolar disorder, current episode depressed moderate with an order date of 4/11/25 and Seroquel 50 mg in the evening related to bipolar disorder, current episode depressed, moderate with an order date of 9/19/25.Surveyor reviewed R69's August 2025, September,2025, & January 2026 MAR (medication administration record) and noted the following Order date 11/18/24 Monitor - Behavior Symptoms: 0=none noted, 1=frequent crying, 2=repeats verbalization, 3=repeats movement, 4=yelling/screaming, 5=kicking/hitting, 6=pinching/scratching/spitting, 7=biting, 8=wandering, 9=abusive language, 10=threatening behavior, 11=sexually inappropriate, 12=rejection of care, 13=other (describe in progress note) every shift. Surveyor noted there are only check marks with licensed nurse's initials.Surveyor reviewed R69's August 2025, September 2025 , & January 2026TAR (treatment administration record) and noted the following: Order date 11/18/24 Resident is prescribed an antianxiety medication. Document number of times per shift that resident exhibits any of these behavior: anxiety, restlessness, agitation. Non-Pharm interventions A=food/fluids, B=toileting, C=Massage, D=repositioning, E=soft music, F=quiet environment, G=deep breathing, H=reassurance, I=exercise/ambulating, J=relaxation no/visualization, K=dim lighting, L=cold compress, M=diversional activity, N=other. Place code in box when used, place N/A (non-applicable) every shift.Surveyor noted there are only check marks with the licensed nurse's initials and/or is blank and doesn't indicate if R69 has exhibited any of these behaviors listed.Order date 11/18/24 Resident receives an antidepressant. Document number of times per shift that any of these behaviors occur: states feeling sad or depressed, crying, tearfulness, social isolation. Non-Pharm interventions A=food/fluids, B=toileting, C=Massage, D=repositioning, E=soft music, F=quiet environment, G=deep breathing, H=reassurance, I=exercise/ambulating, J=relaxation no/visualization, K=dim lighting, L=cold compress, M=diversional activity, N=other. Place code in every shift. Surveyor noted there are only check marks with the licensed nurses' s initials and/or is blank and does not indicate if R69 has exhibited any of these behaviors. Order date 11/18/24 Resident receives antipsychotic medication. Document number of times resident exhibits any of these behaviors: suspiciousness, suicidal ideations, hallucinations, paranoia, or verbal/physical aggression. Non-Pharm interventions A=food/fluids, B=toileting, C=Massage, D=repositioning, E=soft music, F=quiet environment, G=deep breathing, H=reassurance, I=exercise/ambulating, J=relaxation no/visualization, K=dim lighting, L=cold compress, M=diversional activity, N=other. Every shift. Surveyor noted there are only check marks with the licensed nurses' s initials and/or is blank and does not indicate if R69 has exhibited any of these behaviors. R69's late entry nurses note dated 9/3/25, at 1900 (7:00 p.m.), and created on 9/4/25 at 11:37 a.m. written by Licensed Practical Nurse/Unit Manager (LPN/UM)-U documents Writer was informed by the nurse on the unit that the patient was talking in the dining room to the other residents and had mentioned that he wanted to slit his wrist. The nurse on duty reported that she had talked to the patient and asked him what was going on the patient replied to the nurse I was feeling a little depressed and needed to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525549	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	talk it out. Writer informed [NAME] (Director of Nursing) and Adon (Assistant Director of Nursing) about the situation. Writer also had the patient come in to talk with us regarding his remarks. the patient stated I did say that I want to slit my wrist which I have done in the past, but I was feeling a little depressed and just needed to talk it out and now I feel better and there is no need to worry.R69's social service note dated 9/4/25, at 1400 (2:00 p.m.), written by Social Worker (SW)-S documents Care conference held today. SW, SSD (Social Service Director), Resident were present. SSD discussed with the resident about the ADRC (Aging and Disability Resource Center). Resident shared his thoughts on it and agreed to enroll into a Family Care Program. SSD called the ADRC and shared this information with them after the meeting. Resident shared that he has been having some ups and downs with his mood. Resident shared at the end that he feels better talking with the SW and SSD. Resident shared that talking with others have always helped express his feelings and calm himself down. Resident denied any suicidal ideations. SW will continue to follow and provide support.R69's social service note dated 9/19/25, at 1430 (2:30 p.m.), written by Social Services Director (SSD)-R documents Behavior/GDR (gradual dose reduction) meeting held today. IDT (Interdisciplinary team) reviewed resident medications, mood and behavior. Resident is stable at this time. psych continues to follow. No changes recommended at this time.Advanced Practice Nurse Prescriber (APNP) Psych-KK's psychiatry follow up progress note dated 9/19/25 under review of systems for psychiatric documents no suicidal ideation, no homicidal ideation, no plan, fixating on rejections from females he is looking to be involved romantically with, no hallucinations, thought process organize, associations normal, judgment intact, insight intact, impulse control intact, no acute behavioral concerns, no apparent agitation, no aggression, no combativeness, cooperative demeanor, good eye contact, interacting with peers and staff, goes to activities sometimes. Under risk assessment for comments documents Patient reports having thoughts of suicide over the last 2 days but denies any plan or intent at this time. Patient will contract for safety. Patient reported talking to an RN (Registered Nurse) last night when having suicidal thoughts. Denies homicidal ideation, plans, intent, or access. Surveyor did not note any documentation from an RN regarding R69 having suicidal thoughts the night prior.R69's quarterly MDS (minimum data set) with an assessment reference date of 11/21/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R25's PHQ-9 (patient depression questionnaire) has a score of 11 which indicates moderate depression. Yes was answered for feeling down, trouble falling or staying asleep, feeling tired, poor appetite, and feeling bad about self. R69 is assessed as being independent for his ADLs (activities daily living) and is continent of bowel and bladder.There are psychiatry follow up progress notes written by APNP Psych-KK on 11/21/25 & 12/19/25.R69's nurses note dated 1/19/26, at 18:46 (6:46 p.m.), written by Nursing-LL documents: Resident said to a CNA (Certified Nursing Assistant) @ (at) 1730 (5:30 p.m.) in the dining room that he was having suicidal thoughts, and that he wouldn't harm himself, he needed to say it out loud. Resident also said he did not want to go to the hospital. Writer called on- call and resident spoke with nurse and verbalized not being happy with 3rd shift staff and was feeling defeated. On call nurse made sure no plan was in place to harm himself and there was not. On- call is to help investigate the issue and resident was feeling better and thanked the CNA for telling writer and not being upset. Resident reassured and now feeling fine. Writer told resident she was working tonight and to feel free to be in Complex area if he wanted too.On 1/20/26, at 9:53 a.m., Surveyor observed R69 lying in bed. Surveyor asked R69 how he is doing and if staff help with cares. R69 informed Surveyor he does all his own cares except he can't shower by himself because of safety. Surveyor observed multiple items around and in R69's bed. Surveyor inquired about these items. R69 informed Surveyor it makes him feel like he's home. R69 then stated to Surveyor he wanted to go on record and informed Surveyor he's having problems with one of Certified Nursing Assistants (CNAs). Surveyor asked R69 what's the problem. R69 explained he goes over to the other side's living room and watches a movie or listens to music. R69 informed Surveyor a CNA told him to keep the door closed because it was too loud. R69 explained he opened the door because he was (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	getting warm and she got smart with him asking why he opened the door as she told him to keep it closed. Surveyor asked R69 if he reported this to anyone. R69 replied I sure did. Reported it to name of SW-S, name of SSD-R and the admissions clerk, kind of high up the totem pole people. Surveyor asked R69 if he knew the CNA's name. R69 replied no and then explained what the CNA looked at. R69 informed Surveyor another time, two or three nights ago he was watching a science fiction movie Aliens, asking Surveyor if Surveyor knew this movie. R69 stated I talk to the screen, I get into things. R69 informed Surveyor the CNA pounded on the glass of the living room. R69 stated he disregarded her. The CNA said to him when you get back to the 21st century, shut up. Surveyor asked R69 if he reported this. R69 replied yes but was unable to tell Surveyor who he reported this incident to. Surveyor asked if there is anything else he'd like to tell Surveyor. R69 informed Surveyor he's been depressed and yesterday he had thoughts of suicide. Surveyor asked R69 if he was still having thoughts about suicide. R69 no and then explained he doesn't like someone from the outside telling him what to do.R69's nurses note dated 1/20/26, at 10:19 a.m. created on 1/26/26 at 1655 (4:55 p.m.), written by Infection Preventionist/Assistant Director of Nursing (IP/ADON)-E documents: Note for conversation with resident on 1/19/26 @ (at) approx. (approximately)1800 (6:00 p.m.). Writer received phone call from nurse at facility d/t (due to) resident had expressed suicidal thoughts and was present with her at the time of the call. Writer received permission from resident to have discussion with him. Resident stated, you know that when I feel this way that if I say it out loud, put it out of me then I feel better. I am not going to hurt myself and I do not have a plan. And I refuse to go to the hospital. This is what I am allowed to say when I am feeling like this. Resident stated that he would stay with nurse. Resident stated that what 'got him going' was being told his phone was too loud, that people were sleeping. Writer told resident I would follow up with him this morning. Resident stated he is still upset but thanked writer for checking up on him.On 1/21/26, at 8:50 a.m., Surveyor observed R69 propelling his wheelchair down the hallway by moving his feet. R69 went into his room, sat in the doorway for a few seconds and then wheeled back down the hallway.On 1/21/26, at 1:02 p.m., Surveyor entered R69's room. Surveyor informed R69's roommate Surveyor was just going to check R69. The roommate informed Surveyor he's sleeping. Surveyor observed R69 in bed on his left side with his arms crossed and eyes closed.On 1/22/26, at 1:56 p.m., Surveyor met with SW-S and SSD-R. Surveyor asked if SW-S could tell Surveyor about R69. SW-S replied he's been fine; we have conversations in the morning. Surveyor asked if R69 has ever voiced suicidal ideations. SW-S informed Surveyor he had a couple but not recently; they are just thoughts. R69 doesn't have any plan or intent, when R69 is in a lower mood he expresses them. Surveyor asked SW-S what she does for R69. SW-S replied I talk with him about any plans, if he has a plan, any intent. SW-S indicated they go through why R69 is having these thoughts. Surveyor asked SW-S what nursing does. SW-S informed they assess him and if they feel he may harm himself they would send him out. SSD-R informed Surveyor in R69's care plan there are a lot of problem statements and interventions used. R69 is followed by psych, and he comes to their office pretty regularly about his thoughts, his past thoughts, things that have happened in the past. We talk with him, and he's followed by our psych team. SSD-R informed Surveyor they have a new psychologist who saw him on 12/19/25 and yesterday (1/21/26) but they may not have received these notes. Surveyor asked if R69 has voiced any concerns regarding staff. SSD-R informed Surveyor she knows R69 recently had episodes with staying up late at night and will go over to the family room on the other side. They have been addressing the tv's volume. R69 complained about staff telling him to turn the tv down. SSD-R informed Surveyor she has an open grievance. Surveyor asked if there were any other issues. SSD-R informed Surveyor the only thing R69 mentioned was staff telling him he can't go behind the nurse's station. SSD-R informed Surveyor she told R69 that is correct. SSD-R informed Surveyor they are going to do education on resident's rights, R69 has the right to be over in the lounge, and review interventions with behavior. SSD-R explained R69 becomes verbally aggressive, swears at staff when situations like that arise. Surveyor then informed SW-S and SSD-R what R69 had said to Surveyor regarding the Alien movie. (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor informed SW-S and SSD-R, R69 had stated to Surveyor he told a staff member and asked if they were aware. SW-S stated to Surveyor no one has reported that to us. Surveyor then informed SW-S and SSD-R R69 had informed Surveyor after the incident with the alien movie R69 said he had suicidal thoughts which according to the nurse's notes R69 did on January 19th. SSD-R informed Surveyor she just saw the note. Surveyor asked SW-S and SSD-R if they were aware of R69's suicidal ideations on 1/19/26. SW-S informed Surveyor R69 didn't talk to them, and no one reported it. SSD-R informed Surveyor R69 has a history of suicidal thoughts, they talk to him, ask him about going to the hospital but he doesn't want to go. SSD-R informed Surveyor they will speak with R69 and R69 said someone knocked on the window. SSD-R stated I want to reinterview him in case I'm missing anything. Surveyor asked SW-S and SSD-R to get back to Surveyor tomorrow after they have spoken with R69.R69's social services note dated 1/22/26, at 15:37 (3:37 p.m.), written by Social Service Director (SSD)-R documents: SW (Social Worker) and SSD made aware of resident recently voicing thoughts of suicide. Resident has a history of voicing thoughts of suicide without any plan or intent. SW and SSD met with resident 1:1to further discuss and provide psychosocial support. When asked what he is feeling when he is having these thoughts, resident states, ?I just don't feel right when I have those thoughts. SS asked what it feels like overall, and he stated he feels like he is just existing and depressed. Reviewed interventions that were discussed with resident in the past such as talking with other staff, writing things down/journaling, listening to music or watching movies. Resident states he still does these interventions. When asked if he had any plan to harm himself or if he currently has any plan to harm himself, resident sated, no and in the sixteen months I have been here I have not had a plan or looked for anything to harm myself with. Resident is happy with the plan in place for when he has these thoughts. Resident is followed by psych at facility and has declined the last two visit attempts by psychologist for two weeks in a row, 1/14/26 and 1/21/26. SS encouraged resident to accept visits from psychologist to help him with depression and negative thoughts. SS to continue to follow and provide support.On 1/26/26, at 2:59 p.m., during the daily exit conference with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B Surveyor informed staff R69 has two documented episodes of suicidal ideation on 9/3/25 & 1/19/26 and Surveyor was unable to locate evidence R69's physician, psych services were notified and unable to locate what interventions were implemented. On 1/27/26, at 8:58 a.m., Surveyor asked DON-B if she had any additional information regarding R69's documented suicidal ideations. DON-B informed Surveyor she was not here on 9/3/25 as she started working at the facility in November. DON-B informed Surveyor she became aware of R69's 1/19/26 suicidal ideations on 1/22/26. Surveyor asked DON-B how she became aware. DON-B replied I was told by social services. DON-B informed Surveyor she believes the nurse on 1/19/26 is an agency nurse. DON-B informed Surveyor that the plan is for social service to follow up, they were doing one on one after with him. Surveyor asked what nursing did after R69 voiced the suicidal ideations. DON-B informed Surveyor she would have to check with first name of Licensed Practical Nurse/Unit Manger (LPN/UM)-U as that's her unit.On 1/27/26, at 9:09 a.m., Surveyors met with SW-S and SSD-R. SSD-R informed Surveyor they were not aware of R69's September suicidal thoughts. They became aware of R69's suicidal thoughts on 1/19/26 when Surveyor spoke to them on 1/22/26. Surveyor asked after they became aware of what they did. SSD-R informed Surveyor they went and met with R69, and they have been checking on him daily. SSD-R informed Surveyor she was at the facility over the weekend and R69 didn't have any suicidal ideations. SSD-R informed Surveyor they should have initiated one on one, called the doctor, and R69 wouldn't want any family called but they should have asked him when this happened. SSD-R informed Surveyor they have tried to send him to the hospital, but he has refused anytime it is brought up. A Surveyor asked if they would have called the crisis team. SSD-R indicated in the past they have called them and R69 has also called the crisis team. Surveyor asked after they became aware by the Surveyor of R69's suicidal ideations did they call psychiatric services. SSD-R replied no. SSD-R informed Surveyors that the psychologist has tried to see R69 for the past two weeks, but he has (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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused. A Surveyor asked if there is a contact in place for R69's suicidal ideation/behavior. SSD-R replied no. On 1/27/26, at 12:06 p.m., Surveyor informed LPN/UM-U she had written R69's nurses note on 9/3/25 regarding R69's suicidal ideations and inquired what was implemented after. LPN/UM-U informed Surveyor R69 was placed on the 24-hour board. Surveyor asked LPN/UM-U if R69 was placed on one-to-one observation. LPN/UM-U informed Surveyor she thought 15-minute checks. Surveyor informed LPN/UM-U R69's care plan intervention is to place R69 on one to one. LPN/UM-U replied oh. Surveyor asked LPN/UM-U for R69's fifteen-minute checks. Surveyor was not provided with these checks.No additional information was provided.

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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greendale Park Nursing and Rehab	5404 W Loomis Rd Greendale, WI 53129

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 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 interview and record review, the facility did not ensure that each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period and each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized for 2 of 5 (R9 and R35) residents reviewed for immunizations. Findings include:The facility policy titled Influenza Vaccination (which is not dated) 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 workers annual immunization against influenza.2. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine.7. Individuals receiving the influenza vaccine or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. The completed signed and dated record will be filed in the individual's medical record.9. The resident's medical record will include documentation that the resident and/or 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.On 1/22/26 at 11:52 AM, Surveyor asked Infection Preventionist/Assistant Director of Nursing (IP/ADON)-E about the vaccination protocol. IP/ADON-E stated, Upon admit, there is a document nurses fill out asking about immunizations. If they want or consent, they are supposed to get an order, then normally I will see the order during morning meeting.R9 admitted to the facility on [DATE] with diagnoses that include muscle wasting and atrophy, protein-calorie malnutrition, immunodeficiency, chronic obstructive pulmonary disease, malignant neoplasm of sigmoid colon and chronic congestive heart failure.Review of R9's medical record revealed a consent for the influenza and pneumonia vaccine signed 7/2/25. Per WIR (Wisconsin Immunization Records) pneumonia vaccine was completed. Surveyor could not locate evidence the influenza vaccine was offered or given.R35 admitted to the facility on [DATE] and has diagnoses that include chronic obstructive pulmonary disease, asthma and chronic respiratory failure with hypoxia.Review of R35's medical record revealed a consent for the influenza vaccine signed 12/18/25. Surveyor could not locate evidence the influenza vaccine was offered or given.On 1/26/26 at 10:25 AM, Surveyor spoke with IP/ADON-E about the above immunizations. IP/ADON-B reported she spoke with R9 today about receiving the flu vaccine and he refused. IP/ADON-E reported R35's flu vaccine was not given and will be given today. Surveyor advised IP/ADON of concern consents were signed in 2025 and there was no follow up until after Surveyor identified concern. IP/ADON-E stated, I understand the concern.On 1/26/26 at 3:11 PM, Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were advised of the concerns regarding the above immunizations. No additional information was provided.