

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525686	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Muskego Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE S77 W18690 Janesville Rd Muskego, WI 53150	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540</p> <p>Based on interview, document review and record review, the facility failed to ensure professional standards of care were provided when transferring physician wound care orders. The failure to ensure physician orders for antibiotics were transcribed and administered for one of three residents (Resident (R)2) reviewed for antibiotic administration. The facility failed to have documentation of skin conditions during nursing assessments for one of three residents (R1) reviewed for skin assessments and treatment. Specifically, the wound physician wrote treatment orders for R1's skin wounds. However, nursing staff failed to review the wound physician's notes and receive clarification of the orders if necessary, prior to documenting the orders in the record. As a result of this deficient practice, residents receiving care for healing of wounds had the potential to decrease healing potential and harm for lack of treatment and administering antibiotics as ordered for treatment of infection.</p> <p>Findings include:</p> <p>Review of R1's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed an admitted [DATE] and a readmitted [DATE] with medical diagnoses that included moderate protein-calorie malnutrition and quadriplegia.</p> <p>Review of R1's Evaluations tab in the EMR revealed an Admission/Readmission Head-to-toe Evaluation dated 08/08/24. The section for skin integrity documented areas of skin alterations as bilateral lower legs with no description of the skin alteration.</p> <p>Review of R1's Evaluations tab in the EMR revealed an Admission/Readmission Head-to-toe Evaluation dated 08/27/24. The section for skin integrity documented areas of skin alterations as bilateral lower legs with no description of the skin alteration.</p> <p>Review of R1's EMR under the Misc tab revealed an Initial Wound Evaluation dated 08/14/24, documented by the wound care physician, indicated wounds on right lateral ankle and left lateral shin, measurements for the size of the wounds and orders for treatment of wounds including dressing changes three times a week for 30 days.</p> <p>Review of R1's physician orders under the Orders tab in the EMR lacked documentation of physician orders for the care of the skin wounds to the bilateral lower extremities.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2024 and September 2024 lacked documentation of dressing changes to the lower bilateral limbs.</p> <p>Review of R1's Evaluations tab in the EMR revealed Weekly Nursing Notes dated 08/16/24, 8/23/24, 08/30/24, and 09/7/24 revealed that each of the assessments documented the same thing under the Integumentary section, site of skin alteration Other (specify): has outbreak with scar tissue and tunneling with no specific site documented and Other (specify): small open area to bony prominences of ankles.</p> <p>Review of R1's Care Plan tab in the EMR revealed an area of focus Resident has pressure ulcers [related to] immobility, malnutrition, and quadriplegia, dated 8/12/24 with interventions to administer treatments as ordered and monitor for effectiveness and assess/record/monitor wound healing. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the Medical Doctor (MD).</p> <p>Review of R1's Prog Note tab in the EMR lacked documentation of wound assessments, measuring, wound healing status or reports to the physician of improvement or decline.</p> <p>During an interview on 10/23/24 at 11:05 AM, the Director of Nursing (DON) explained the process when the wound physician makes recommendations and orders for wound care, the information is uploaded to the EMR under the Misc section by the end of day or the next day. The wound physician did assess and treat the wounds for R1 and the recommendations for care and orders for dressing changes were uploaded to the EMR. The orders were not documented in the orders section of EMR and therefore nursing staff did not have the information to apply dressings to R1's lower legs. The DON confirmed this was missing and wound treatments not done and should have been. The DON was not aware of the orders for wound care until this interview and confirmed there was a break in the system for transcribing orders from the wound care provider and the EMR system the nurses use. The DON stated that the nursing assessments done both upon admission and readmission and the weekly nursing note should be documenting the skin alterations in detail and the skin assessments for R1 did not reflect detail about R1's leg wounds and the documentation should have been more specific and descriptive.</p> <p>2. Review of R2's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] with medical diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side.</p> <p>Review of R2's Prog Note in the EMR revealed a nursing progress note dated 09/05/24 documenting Writer notified POA [Power of Attorney], DON, and physician of missed antibiotic doses. The physician ordered to start the course today for seven days. Resident is on Amoxicillin/clavulanic 875mg (milligrams)-125mg BID (twice a day) x seven days for aspiration pneumonia.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the grievance log provided by the facility revealed a summary of the grievance which stated, The Administrator received an email on 09/06/24 from [R2's name] POA that stated the following: [POA] had spoken with DON on 09/03/24 at 12:12 pm, regarding the medication [R2] was prescribed for pneumonia diagnosed at the acute hospital on 09/02/24. DON assured me that [R2] was going to be put on the medication they prescribed, into her chart. As of yesterday, it was not in her chart, and she had not received any medication since 09/02/24. When asked the staff yesterday about [R2] getting the medication, the medication was not on R2 chart. Summary of the investigation revealed POA was concerned that antibiotic order was not transcribed when resident returned from hospital and the summary of findings revealed a transcription error did occur when resident was readmitted from the hospital. DON attempted to enter order in PCC [Point Click Care] the order was never completed.</p> <p>During an interview on 10/21/24 at 1:00 PM, the DON confirmed a transcription error had occurred.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540</p> <p>Based on observation, interview, record review, and policy review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for five of five residents (Resident (R)4, R5, R6, R7, R8) reviewed for EBP due to presence of a wound requiring care, indwelling urinary catheter, or gastrostomy tube. The facility failed to ensure that when a resident's incontinence brief change occurred, staff's gloves were changed between cleaning the urine or stool and placing a clean incontinence brief on the resident for one of one residents (R9) observed for incontinence care. As a result of this deficient practice the residents had the potential for harm of cross contamination (from one resident to another) by transmission of multidrug-resistant organisms (MDRO).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Enhanced Barrier Precautions implemented 12/23/22, revealed, Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high contact resident care activities that require the use of gown and gloves. Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders. An order for enhanced barrier precautions will be obtained for residents with any of the following: . indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, . even if the resident is not known to be infected or colonized with a MDRO.</p> <p>1. Review of R4's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with medical diagnoses that included pressure ulcer of the sacral region, stage four, and neuromuscular dysfunction of bladder.</p> <p>Observation on 10/21/24 at 11:53 AM, R4 was in bed and urinary catheter collection bag was hanging below the level of the bed. The room lacked signs indicating the type of PPE to be used when providing direct care to the residents.</p> <p>Review of R4's physician's orders dated 10/14/24 under the Orders tab in the EMR, revealed, right Ischium: Cleanse with Dakin's, apply calcium alginate and cover with ABD [abdominal pad] and secure. Change daily and PRN [as needed] one time a day and an order for Urostomy Care every shift and PRN Change Weekly and PRN with 2 1/4 inch wafer and drainable pouch as needed. R4's physician's orders lacked an order for EBP.</p> <p>2. Review of R5's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] with medical diagnosis that included neuromuscular dysfunction of bladder.</p> <p>Observation on 10/21/24 at 4:10 PM, R5 had a urinary catheter collection bag hanging below the level of the bed. The room lacked signs indicating the type of PPE to be used when providing direct care to the resident.</p> <p>Review of R5's physician's orders dated 09/30/24 under the Orders tab in the EMR, revealed, Catheter privacy bag to gravity drainage below level of bladder. Ensure tubing is not kinked. Verify catheter secure in place. every shift. R5's physician's orders lacked an order for EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of R6's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] with medical diagnosis that included neurogenic bladder.</p> <p>Observation on 10/21/24 at 4:10 PM revealed R6 had a urinary catheter collection bag hanging below the level of the bed. The room lacked signs indicating the type of PPE to be used when providing direct care to the residents.</p> <p>Review of R6's physician's orders dated 06/23/23 under the Orders tab in the EMR, revealed, Suprapubic Foley Catheter Size: 18FR Diagnosis: Neurogenic bladder. R6's physician's orders lacked an order for EBP.</p> <p>4. Review of R7's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] with medical diagnosis that included encounter for attention to gastrostomy [feeding tube].</p> <p>Observation on 10/21/24 at 4:20 PM, R7 had a kangaroo pump [used to infuse fluids and formula through a gastrostomy tube was on a pole next to the bed. The room lacked signs indicating the type of PPE to be used when providing direct care to the residents.</p> <p>Review of R7's physician's orders dated 04/04/24 under the Orders tab in the EMR revealed, Enteral Feed Order three times a day related to dysphagia following cerebral infarction. R7's physician's orders lacked an order for EBP.</p> <p>5. Review of R8's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] and readmission on 10/21/24, with medical diagnosis that included neuromuscular dysfunction of bladder.</p> <p>Observation on 10/21/24 at 4:10 PM, R8 had a urinary catheter collection bag hanging below the level of the bed. The room lacked signs indicating the type of PPE to be used when providing direct care to the residents.</p> <p>Review of R8's physician's orders dated 08/14/24 under the Orders tab in the EMR revealed, Catheter privacy bag to gravity drainage below level of bladder. Ensure tubing is not kinked. Verify catheter secure in place. every shift. R8's physician's orders lacked an order for EBP.</p> <p>During an interview on 10/21/24 at 4:42 PM, Licensed Practical Nurse (LPN)1 verbalized that EBP were not being applied, no signs on the doors and staff were not using PPE when providing direct care to the residents with catheters, wounds, or gastrostomy tubes.</p> <p>During an interview on 10/22/24 at 10:05 AM, the Director of Nursing (DON) confirmed the signs indicating EBP were not in place and should have been to give staff the needed information about PPE to use when providing direct care.</p> <p>During an interview on 10/22/24 at 10:10 AM, the Administrator confirmed there were no signs on the resident rooms to indicate EBP were in place and identifying the PPE staff were to use when providing direct resident care.</p> <p>6. Review of R9's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] and readmission on 06/12/22, with medical diagnosis that included cerebellar stroke syndrome.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R9's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 08/09/24, revealed under functional abilities for toileting the resident was dependent on staff to provide the care and that the resident does none of the effort to complete the task.</p> <p>Observation on 10/23/24 at 9:20 AM, Certified Nursing Assistant (CNA)1 gathered needed supplies, washed hands, applied gloves, and proceeded to remove R9's soiled incontinence brief. CNA1 wore the same gloves and cleaned the resident's perineal area. Upon completion of the cleaning, CNA1 applied a clean incontinence brief and did not wash hands or change gloves after removing the soiled incontinence brief and before applying the clean incontinence brief.</p> <p>During an interview on 10/23/24 at 10:20 AM, CNA 1 verbalized should have changed gloves after removing the soiled brief before applying the clean brief and did not change gloves when providing R9's incontinence care.</p> <p>During an interview on 10/23/24 at 11:15 AM, the DON confirmed proper infection control practice would have been to change gloves once the soiled incontinence brief was removed prior to placing the clean incontinence brief. The expectation of staff while providing brief changes was to follow the infection control practice of changing gloves once a soiled brief or dressing was removed prior to applying a clean incontinence brief or dressing.</p> <p>During an interview on 10/23/24 at 11:20 AM, the Administrator verbalized the expectation that staff should follow infection control practices when providing brief changes and change gloves, hand hygiene after removing a soiled incontinence brief and applying new gloves when applying clean incontinence brief.</p>