STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525686	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muskego Health and Rehabilitation Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy, the facility failed to document in the medical record family notification for two out of four falls for one resident (Resident (R) 1) in a total sample of five residents. This failure placed the resident at risk of his family not being notified or the resident consented to the notification.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with diagnoses that included Osteomyelitis (bone infection) of the left foot, diabetic foot ulcers, and Parkinson's disease (a neurological disease).Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 10/22/25 revealed R1 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15 which indicated R1 was moderately impaired in cognition.Review of the 10/16/25 Fall Care Plan revealed, The resident is at risk for falls, accidents and incidents r/t [related to] Parkinson's disease, weakness, NWB LLE [non weight bearing left lower extremity], forgetfulness.Review of the 12/02/25 IDT [interdisciplinary team] FALL located in the Progress Notes tab of the EMR revealed, Resident stated that he rolled from bed .no injuries noted. Root cause revealed that the resident was repositioning in bed and rolled from the bed .There was no documentation in the IDT FALL note that indicated R1 was asked if he wanted his family updated regarding the fall or not.Review of the 12/15/25 IDT FALL located in the Progress Notes tab of the EMR revealed, Resident was found on [sic] holding onto the bar in the bathroom squatting against the wall. Resident stated, 'I was trying to get on the toilet .' Assessment and neuro check completed WNL [within normal limits]. VSS [vital signs stable]. No injuries noted.There was no documentation in the IDT FALL note that indicated R1 was asked if he wanted his family updated regarding the fall or not.During an interview on 01/27/26 at 12:47 PM, the Director of Nursing (DON) stated, R1 did not have a POA [power of attorney] and he was his own person. I see in the record that his son was notified of one of the four falls, and his daughter was here for one of the falls, but staff did not document that he wanted his family notified or not for the other two falls.Review of the facility policy titled, Notification of Changes, dated 01/3/31/25 revealed, .The purpose of this guideline is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification .Competent individuals .The facility must still contact the resident's physician and notify resident's representative, if known When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure the medical record was complete and accurate for three residents (Residents (R)1, R2, and R3 in a total sample of five residents. The facility failed to ensure weekly weights, meals, incontinent care, and skin assessments were documented for R1, failed to ensure weekly skin assessments, and incontinent care was documented for R2, and failed to ensure incontinent care was documented for R3. These failures placed residents at risk for unmet care needs and a diminished quality of life.Findings include:1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed that R1 was admitted to the facility on [DATE] with diagnoses that included diabetic foot wounds, diabetes, and Parkinson's disease (a neurologic disease).Review of the admission Minimum Data Set (MDS) located in the MDS tab of the electronic medical record (EMR) with an assessment reference date (ARD) of 10/22/25 revealed R1 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15 which indicated R1 was moderately impaired in cognition, was independent with eating, had a foot infection and diabetic foot ulcers, was frequently incontinent of bladder and was always incontinent of bowel, and weighed 175 pounds (lbs.) without any swallowing difficulties.Review of the Weekly Skin Assessments located in the Evaluations tab of the EMR revealed the following missing skin assessments from admission to discharge on [DATE] revealed the following:October 2025: 10/23/25; 10/30/25.November 2025: 11/20/25; 11/27/25.December 2025: 12/04/25; 12/11/25; 12/28/25; 12/25/25,January 2026: 01/01/26 and 01/08/26.Review of the Weekly Weights located in the Weights and Vitals tab of the EMR revealed the following missing weights from admission to discharge.October 2025: 10/24/25; 10/31/25.November: 11/07/25; 11/14/25; 11/21/25; 11/28/25.December: 12/26/25.January 2026: 01/02/26. Review of Meal Percentage Eaten located in the Tasks tab of the EMR revealed the following with no documentation that a meal was served or refused:October 2025: 10/18/25; 10/21/25; 10/24/25; 10/25/25; 10/26/25; 10/27/25; and 10/31/25.November 2025: 11/1/25; 11/07/25; 11/08/25; 11/09/25; 11/10/25; 11/11/25; 11/13/25; 11/14/25; 11/15/25; 11/16/25; 11/17/25; 11/22/25; 11/23/25; 11/24/25; 11/26/25; 11/28/25; 11/29/25 and 11/30/25.December 2025: 12/02/25; 12/04/25; 12/07/25; 12/08/25; 12/12/25.January 2026: 01/01/26; 01/02/26; 01/03/26; 01/04/26; 01/05/26 and 01/10/26.Review of the Incontinent Care located in the Tasks tab of the EMR revealed the following days in which incontinent care was not documented:December 2025: 12/02/25; 12/04/25; 12/07/25; 12/08/25; 12/12/25; 12/13/25; 12/26/25; 12/28/25.January 2026: 01/01/26; 01/02/26; and on 01/11/26 in which the documentation showed it was not applicable as R1 had an indwelling urinary catheter.2. Review of the admission Record located in the Profile tab of the EMR revealed that R2 was admitted to the facility on [DATE] with a diagnosis of a brain injury.Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 11/20/25 revealed that R2 had a staff assessed BIMS score of three out of 15 which indicated R2 was severely impaired in cognition, was always incontinent of bowel and bladder, and had no skin issues.Review of the Weekly Skin Assessments located in the Evaluations tab of the EMR revealed the following missing assessments from October 2025 to January 2026:October 2025: 10/03/25; 10/10/25; 10/17/25; 10/24/25; 10/31/25.November 2025: 11/14/25; 11/28/25.December 2025: 12/05/25; 12/13/25; 12/19/25; and 12/26/25.January 2026: 01/09/26.Review of the Incontinent Care located in the Tasks tab of the EMR revealed the following dates in which no incontinent care was documented as having been provided in the last 14 days:01/16/26; 01/26/26.Documentation that showed R2 was only provided with incontinent care one time per day:01/17/26; 01/18/26; 01/19/26; 01/22/26 and 01/23/26.3. Review of the admission Record located in the Profile tab of the EMR revealed R3 was admitted to the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE] with a diagnosis of multiple sclerosis (a neurological disease).Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 12/29/25 revealed R3 had a BIMS score of 14 out of 15 which indicated R3 was cognitively intact, was always incontinent of bowel and bladder and had no pressure ulcers.Review of the Incontinent Care located in the Tasks tab of the EMR had the following days in which no incontinent care was provided:November 2025: 11/01/25; 11/07/25; 11/08/25; 11/09/25; 11/10/25; 11/13/25; 11/15/25; 11/16/25; 11/17/25; 11/21/25; 11/22/25; 11/23/25; 11/24/25; 11/26/25; 11/28/25; 11/29/25.In addition, the Incontinent Care documentation revealed the following days in which incontinent care was only provided once on the 7:00 AM to 3:00 PM shift:11/2/25; 11/04/25; 11/05/25; 11/06/25; 1/11/25; 11/14/25; 11/19/25; 11/27/25.During an interview on 01/28/26 at 11:06 AM, Certified Nurse Aide (CNA)1 stated, The documentation needs to be accurate, but we have a lot of CNAs who are agency and they may not do it [documentation.]During an interview on 01/28/26 at 2:00 PM, the Administrator and the Director of Nursing (DON) confirmed that there was missing documentation in resident records.Review of the facility policy titled, Documentation in Medical Record, dated 05/01/25 revealed, .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation .Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service provided .