

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/09/2026
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.			
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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 with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure injuries from developing for 3 (R1, R15, R16) of 4 residents reviewed for pressure injuries from a sample of 12 residents. *On 2/26/25, R1 was admitted to the facility and assessed to be at high risk for the development of pressure injuries. On 7/23/25 during wound rounds R1 was assessed to have developed a facility acquired, unstageable pressure injury to the left heel. R1's care plan did not include an intervention to wear a pressure relieving boot to the left foot until 12/05/25. R1's care plan did not address R1's preference to wear shoes. The facility did not provide R1 or their responsible party with the risks and benefits of not removing their shoes which Director of Nursing (DON-B) attributes as the root cause of the development of the unstageable pressure injury to the left heel. R1's care plan does not document interventions to address R1's refusal to remove their shoes. *R15 observed not to have the ordered treatment in place for R15's healed right hip pressure injury. R15 observed not having heel offloaded while in bed and no heel boot in place for pressure injury prevention, per physician orders. On 7/6/2026, Surveyor observed R15's stage 1, right ischial tuberosity (hip) pressure injury to be open, wound was not assessed until 7/8/2026. *R16 was admitted on [DATE] with a pressure ulcer of sacral region, stage 4. R16's pressure ulcer was not assessed with measurements and description until 3/20/26. Findings Include: The facility policy titled, Pressure Injury and Management, revised 5/27/26, documented in part, .Guideline: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure/ulcers/injuries. Explanation and Compliance Guideline: . 2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment: intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3. Assessment of Pressure Injury Risk: . c. Licensed nurses will conduct a full body skin assessment on all resident upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Findings should include type of (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Panel) Stage: Unstageable. Treatment Recommendations: The plan for the pressure ulcer is to cleanse with wound cleaner and the peri wound area with wound cleanser. Primary dressing: 1. Betadine. This treatment will be done daily by facility staff. This treatment can be changed to PRN (as needed) if soiled or dislodged. Justification for any treatment order/dressing changes: New wound to L (left) heel. Patient has not been wearing Prevalon boots-placed on patient during visits. Discussed offloading and repositioning while in bed and in wheelchair. Nutrition: Educated on food rich in protein and protein supplements in the form of a protein drink to help support wound healing. Surveyor notes R1's care plan was not revised with new interventions to promote healing, and prevent infections when R1's left heel, unstageable pressure injury was identified on 7/23/25. R1's care plan was not revised to include the intervention of Prevalon boots until 12/5/25. R1's care plan interventions included a pressure reduction mattress not an offloading mattress as recommended. Surveyor also noted that R1 was prescribed nutritional support supplements of Arginaid BID (twice daily) on 2/27/25 and no new supplements were assessed or added to ensure R1 received food rich in protein and the protein drink R1 had been receiving was adequate with this recommendation & development of an unstageable pressure injury. On 7/7/26 at 2:43 PM Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked who discovered R1's unstageable pressure injury to the left heel. DON-B stated they assumed it was discovered during wound rounds by Nurse Practitioner (NP)-P on 7/23/25 while they were assessing R1's other skin issues. DON-B stated when R1's unstageable left heel pressure injury was discovered on 7/23/25, it was very small and had dark redness on the left heel. R1's Treatment Administration Record (TAR) for July 2025, documents, Diabetic foot check: Visual check of skin condition of both feet, toes, and heels, including color and temperature. Surveyor notes the task was not documented as completed on 7/19/25 and 7/22/25. Surveyor noted R1's unstageable left heel pressure injury was not identified by staff during daily foot checks as indicated in R1's plan of care but during a weekly wound assessment completed by the Nurse Practitioner. On 7/8/26 at 2:43 PM, Surveyor asked DON-B why they think R1 originally developed an unstageable left heel pressure injury on 7/23/25. DON-B stated they believe R1 developed the unstageable left heel pressure injury because R1 would frequently refuse to take off their shoes and all of their previous health issues. DON-B stated at the time R1 developed the unstageable, left heel pressure injury, R1 was still receiving physical, occupational and speech therapy and the therapists were trying to work on R1's functional mobility. DON-B stated R1 would always want to be prepared to walk, even though R1 could not walk independently. Surveyor asked DON-B if there is any documented refusals for R1 not wanting to take off their shoes and DON-B stated, no. Surveyor asked if there are any specific interventions to try to have R1 agree to removing shoes or addressing R1's refusals and DON-B stated, no. On 7/8/26 at 8:59 AM, Surveyor asked Registered Nurse (RN)-N if they could recall if R1 would refuse to take off his shoes. RN-N stated, yes, R1 used to sometimes refuse to take off their shoes and wanted to keep them on even while in bed as R1 stated they wanted to be able to get up and walk. RN-N stated they would always try to get R1 to remove shoes but sometimes they would not. RN-N stated now that R1 has declined, R1 does not ever wear shoes, and they remain in bed most of the (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Wound Assessment Details Report dated 10/1/25 documented, left heel pressure ulcer, facility acquired, date identified: 7/23/25. Unstageable, tissue type: bright pink or red= 10%, slough loosely adherent = 40%, necrotic soft, adherent = 50%, exudate amount: heavy, serosanguineous, peri wound: maceration. Measurements: 3.40 x 5.0 x 0.40, undermining none, tunneling, none. Current plan and comments: Bleeding from 9 to 3. The assessment is documented as performed by Licensed Practical Nurse (LPN)-T on 10/1/25 at 8:50 AM. The section for RN review Comments is blank. Surveyor noted R1's 10/1/25 left heel pressure ulcer assessment is completed by an LPN (T) and does not identify undermining or tunneling as previously identified in prior assessments and there is no documentation of the treatment to be applied. R1's Wound Assessment Details Report dated 10/8/25 documents, left heel pressure ulcer, facility acquired, date identified: 7/23/25. Unstageable, tissue type: bright beefy red = 20%, necrotic soft, adherent = 80%. Exudate amount: heavy, serosanguineous, peri wound: maceration. Measurements: 2.5 x 5.0 x 0.40, no undermining, no tunneling. Current Plan & Comments: : Medi honey to necrotic (sic) calcium alginate to follow cover with ABD and secure with roll gauze and tape. This assessment was completed by DON-B. R1's Wound Assessment Details Report dated 10/15/25 documented, left heel pressure ulcer, facility acquired, date identified: 7/23/25. Unstageable, tissue type: Bright beefy red = 20%, necrotic soft adherent = 80%. Exudate amount: heavy, serosanguineous, peri wound: maceration. Measuring 4.80 x 5.00 x 0.40 with no undermining, no tunneling. Current Plan & Comments: apply medi honey, abd and wrap with gauze. The assessment is documented as performed by Licensed Practical Nurse (LPN)-T on 10/15/25 at 10:07 AM. The section for RN review Comments is blank. Surveyor noted LPN-T completed this assessment. R1's wound has worsened with larger measurements documented. The treatment was changed, and calcium alginate is no longer being used. There is no indication an RN assessed R1's heel at this time. R1's Wound Assessment Details Report dated 10/22/25 documented, left heel pressure ulcer, facility acquired, date identified: 7/23/25. Unstageable, tissue type: Bright beefy red = 20%, necrotic soft adherent = 80%. Exudate amount: heavy, serosanguineous, peri wound: maceration. Measuring 4.45 x 3.60 x 0.40, no undermining, no tunneling. Outcome: probable improvement. Current plan & comments: Cleanse with ww (wound wash) calcium alginate F/B (followed by) ABD and kerlix. Surveyor noted LPN-T completed this assessment on 10/22/25 at 9:57 AM. The section for RN Review Comments is blank. Surveyor notes this assessment was completed by LPN-T and the treatment was changed to include calcium alginate and medi honey is no longer being used. R1's Wound Assessment Details Report dated 10/29/25 documented, left heel pressure ulcer, facility acquired, date identified: 7/23/25. Unstageable, tissue type: Bright beefy red = 20%, necrotic soft adherent = 80%. Exudate amount: heavy, serosanguineous, peri wound: maceration. Measuring 3.40 x 4.50 x 0.40, no undermining, no tunneling. Outcome: probable improvement. Current plan & comments: Cleanse with ww apply medi honey to wound bed followed by calcium alginate F/B foam bordered, (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Muskego Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE S77 W18690 Janesville Rd Muskego, WI 53150	
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F 0686 Level of Harm - Actual harm Residents Affected - Few	secure with wrap. On 10/29/25 R1's care plan for actual skin impairment was revised to now include Resident prefers to wear shoes. Encourage resident to only wear when necessary. Date initiated & created is 10/29/25 by DON-B. Surveyor noted R1's wearing of shoes was noted to be the root cause of why R1 developed an unstageable pressure injury in July of 2025, and it was only addressed on R1's care plan on 10/29/25. R1's Wound Assessment Details Report dated 11/5/25 documented, left heel pressure ulcer, facility acquired, date identified: 7/23/25. Unstageable, tissue type: Bright beefy red = 20%, necrotic soft adherent = 80%. Exudate amount: heavy, serosanguineous, peri wound: maceration. Measuring 3.0 x 4.50 x 2.00. Outcome: probable improvement. Undermining: present, location: 3 o'clock to 6 o'clock /3.00 cm. Tunneling: none. Cleanse with ww apply medi honey to wound bed followed by calcium alginate F/B foam bordered, secure with wrap. This was completed by DON-B. Surveyor noted that R1's left heel pressure injury has declined with greater depth and undermining of 3.00 cm from 3-6 o'clock being assessed. On 11/8/225 R1's care plan for actual skin impairment was revised to add intervention to apply moisturizer to toes daily. R1's Wound Assessment Details Report dated 11/12/25 documents, left heel pressure ulcer, facility acquired, date identified: 7/23/25. Unstageable, tissue type: Bright beefy red = 20%, necrotic soft adherent = 80%. Exudate amount: moderate, bloody, peri wound: maceration. Measuring 3.50 x 5.0 x 1.50. Outcome: probable improvement. Undermining: none. Tunneling: none. Current plan & comments: Cleanse with ww apply medi honey to wound bed followed by calcium alginate F/B abd secure with wrap. Surveyor noted LPN-T completed this assessment on 11/12/25 at 11:58 AM. The section for RN Review Comments is blank. R1's Wound Assessment Details Report dated 11/19/25 documented, left heel pressure ulcer, facility acquired, date identified: 7/23/25. Unstageable, tissue type: Bright beefy red = 40%, necrotic soft adherent = 60%. Exudate amount: moderate, serosanguineous, peri wound: maceration. Measuring 3.50 x 5.0 x 1.50. Outcome: probable improvement. Undermining: none. Tunneling: present, location 5 o'clock / 2.00 cm. Current Plan & comments: Cleanse with ww apply medi honey to wound bed followed by calcium alginate F/B abd, secure with wrap. Surveyor noted LPN-T completed this assessment on 11/19/25 at 11:09 AM. The section for RN Review Comments is blank. R1's Wound Assessment Details Report dated 11/26/25 documented, left heel pressure ulcer, facility acquired, date identified: 7/23/25. Unstageable, tissue type: Bright beefy red = 20%, necrotic soft adherent = 80%. Exudate amount: light, serosanguineous, peri wound: maceration. Measuring 3.50 x 4.50 x 0.50. Outcome: probable improvement. Undermining: present, location 6 to 7 o'clock /1.00 cm. Tunneling: none. Current Plan & comments: Cleanse with ww apply medi honey to wound bed followed by calcium alginate F/B abd, secure with wrap. Surveyor noted LPN-T completed this assessment on 11/26/25 at 8:05 AM. The section for RN Review Comments is blank. R1's care plan for increased nutrient needs created on 3/3/25 was revised on 12/1/25 to include: (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Monitor/record/report to MD PRN s/sx (signs/symptoms) of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs. (pounds) in 1 week, > (greater than) 5% in 1 month, > 7.5% in 3 months, > 10% in 6 months. This intervention was created and initiated on 12/1/25. R1's Wound Assessment Details Report dated 12/3/25 documented, left heel pressure ulcer, facility acquired, date identified: 7/23/25. Unstageable, tissue type: Bright beefy red = 30%, necrotic soft adherent = 70%. Exudate amount: light, serosanguineous, peri wound: Maceration. Odor: Yes. Measuring 3.50 x 4.50 x 0.50. Outcome: probable improvement. Undermining: present: location 6 to 7 o'clock /1.00 cm. Tunneling: none. Current Plan & Comments: Cleanse with ww apply medi honey to wound bed followed by calcium alginate F/B abd, skin prep (sic) peri wound, secure with wrap. This assessment was completed by NP-P. Surveyor noted this is the first assessment of R1's heel pressure injury by a NP since 9/10/25. Surveyor noted R1's care plan was updated on 12/5/25 with interventions that include LAL (Low Air Loss) mattress to bed and pressure relieving boot to the left foot as ordered and as tolerated. Both interventions were created and initiated on 12/5/25. On 7/8/26 at 12:08 PM, DON-B provided Surveyor with a wound summary completed by NP-P that documented in part .due to labile blood sugars from diabetes, wound has had extremely slow progress. Sliding scale has been adjusted several times. Due to immunodeficiency and presence of foley catheter, R1 has been treated for several urinary tract infections and completed several courses of antibiotics which have had an impact on healing. Due to polyneuropathy, R1 is unable to feel sensations in left heel, making position change due to pain, difficult. R1 has little appetite and protein calorie malnutrition has made wound progress slow and difficult, even with the use of supplements such as liquid protein. Due to presence of atherosclerosis, di		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 5 of 5 Certified Nursing Assistants (CNAs) reviewed had an annual performance review completed every twelve months.CNA-E, CNA-G, CNA-H, CNA-I and CNA-J did not have an annual performance review.This deficient practice had the potential to affect all 36 residents residing in the facility as the CNAs work with residents throughout the facility.Findings include:The facility policy, entitled Competency Evaluation dated as revised 8/21/24, documents:Guideline: It is the guideline of this facility to evaluate each employee to ensure they meet appropriate competencies and skills for performing their job.Explanation and Compliance Guidelines:1.The knowledge and skills required among staff to meet residents' needs are determined through the facility assessment process.2. Evaluating competency of staff is accomplished through the facility's training program.3. Initial competency is evaluated during the orientation process.4. Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations.8. Employee competency forms are maintained in the Staff Development Coordinator's office for current training year, then forwarded to the Human Resources Director for placing into the employee's personnel file.The facility policy entitled, Nurse Aide Training Program dated as revised 12/2/25, documents:Guideline: This facility maintains an appropriate and effective nurse aide in-service training program for the purpose of ensuring the continuing competence of nurse aides.5. Additional training will be provided to each nurse aide based on areas of weakness as determined in the nurse aide's performance reviews.a. The Director of Nursing shall communicate the educational needs of the employee to the Human Resource Director upon final review of the annual performance appraisal.b. Education that is needed based on the performance appraisal will be completed within 90 days of the appraisal, unless otherwise specified in the appraisal.8.[NAME], periodic audits and/or interviews will be performed throughout the year as part of the facility's QAPI program to verify retention of information and continued competency.On 7/6/26, at 1:43 PM, Surveyor reviewed 5 randomly selected CNA's (CNA-E, CNA-G, CNA-H, CNA-I, & CNA-J) annual performance reviews.On 7/6/26, at 1:57 PM Surveyor provided CNA-E, CNA-F CNA-H, CNA-I & CNA-J's names to Administrator-A and requested their annual performance reviews.CNA-E was hired on 1/11/16.CNA-G was hired on 5/4/06.CNA-H was hired on 3/26/21.CNA-I was hired on 7/16/24.CNA-J was hired on 3/26/24.On 7/7/2026, at 7:45 AM, Surveyor noted that CNA-E, CNA-G, CNA-H, CNA-I, CNA-J had not had an annual performance review completed in the last twelve months.On 7/8/2026, at 9:23 AM, NHA-A informed Surveyor that NHA-A was unable to locate any completed annual performance for CNA-E, CNA-G, CNA-H, CNA-I, and CNA-G.NHA-A stated that CNA-E and CNA-G's performance reviews were completed this morning (7/8/26) and the reviews for CNA-H, CNA-I and CNA-J would be completed soon. NHA-A confirmed that all five CNAs had contact with residents throughout the facility.Surveyor verified with NHA-A that the annual performance reviews for CNA-E, CNA-G, CNA-H, CNA-I, and CNA-G had not been completed in the last twelve months as required.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, drugs used in the facility were not labeled in accordance with currently accepted professional principles, for 1 of 2 medication carts observed.*Surveyor observed 6 expired stock medications and 63 loose medications in the medication carts.Findings:On 07/07/2026, at 1:37 PM, Surveyor observed the side 2 medication cart with Registered Nurse (RN)-N. Surveyor observed two stock, over the counter medications labeled Calcium vitamin D and Complete Multivitamin Adult 50+, with manufacturer expiration dates of 06/2026. Surveyor also observed 35 loose pills scattered throughout the drawers of the medication cart. RN-N informed Surveyor that loose pills and two expired stock medications should be put into the drug buster, located in the medication room. The drug buster is used to remove and dispose of expired medications. RN-N informed Surveyor that all nurses are responsible for cleaning the medication carts and does not recall ever being trained on or the task being assigned to RN-N.On 07/07/2026, at 2:15 PM, Surveyor interviewed Director of Nursing (DON)-B regarding Surveyor's observations of the side 2 medication cart. DON-B indicated that pharmacy comes once a quarter to review and clean out medication carts and the medication room. DON-B informed Surveyor that the facility does not currently have a process for cleaning out medication carts to remove expired medications outside of pharmacy coming in quarterly. On 07/06/2026, at 3:15 PM, Surveyor informed the facility of the above findings.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility did not ensure each resident was treated with dignity and respect that promoted maintenance or enhancement of quality of life. This occurred for 2 (R22 and R24) of 10 residents reviewed for dignity during mealtime in the dining room.*Director of Nursing (DON)-B and Certified Nursing Assistant (CNA)-F were observed during the lunch meal standing over and feeding R22. CNA-F did not engage in conversation with R22 during the lunch meal.*Certified Nursing Assistant (CNA)-E was observed during the lunch meal standing over and feeding R24. CNA-E did not engage in conversation with R24 during the lunch meal.Findings include:The facility policy, entitled Promoting/Maintaining Resident Dignity During Mealtimes dated as revised 7/12/25, documents:Guideline: It is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident.Explanation and Compliance Guidelines:1. All staff members involved in providing feeding assistance to residents promote and maintain resident dignity during mealtimes.4. Focus on the resident while talking to him/her and addressing him/her individually.5. All staff will be seated, if possible, while feeding a resident.11. Allow adequate time for resident to complete meal. Do not rush.1.) R22 was admitted to the facility on [DATE] with diagnoses of other specified intracranial injury and unspecified dementia, severe with anxiety.R22's Annual Minimum Data Set (MDS) completed 4/16/26 documented that both R22's short and long-term memory was impaired and R22 demonstrated severely impaired skills for daily decision making. R22's MDS also documented that R22 was assessed to be dependent for eating.R22's activities of daily living (ADL) self-care performance deficit due to confusion, limited mobility care plan revised on 2/17/26 documents: Interventions: Eating: Assist of 1; Eating: DependentR22's Swallowing difficulty due to motor causes as evidenced by need for altered texture diet, and potential for inadequate oral intake due to mood disorders, diagnosis of dementia as evidenced by variable oral intakes (PO) at times care plan dated as revised 6/8/26 documents under the Interventions section: Monitor/document/report as needed (PRN) any signs/symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, holding food in mouth, several attempts at swallowing, Refusing to eat, Appears concerned during meals; Initiated 3/2/26 Provide and serve diet as ordered - regular, puree, thin liquids; Initiated 10/9/24 Provide set up and assistance with all intake.On 7/6/2026, at 12:20 PM, Surveyor observed DON-B standing over R22 attempting to encourage R22 to eat with a spoon of pureed food and encouraging R22 to drink from a straw in a milk carton. R22 was in a reclining wheelchair during mealtime. On 7/6/2026, at 12:25 PM, CNA-F took over assisting R22. Surveyor observed CNA-F standing over the left side of R22 while feeding R22. Surveyor observed that CNA-F did not engage in conversation with R22 while feeding R22.On 7/8/2026, at 9:35 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A confirmed that standing over residents while feeding them was not the policy of the facility. NHA-A stated it mostly likely occurred because space was challenged in the dining room.NHA-A understood that standing over R22 while feeding them was not dignified. 2.) R24 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebrovascular disease (CVA) affecting right side, and vascular dementia.R24's Quarterly Minimum Data Set (MDS) completed 6/14/26 documented both R24's short-and long-term memory was impaired and that R24 demonstrated severely impaired skills for daily decision making. R24's MDS also documented that R24 (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed as dependent on staff for eating:R24's activities of daily living (ADL) self-care performance deficit due to hemiplegia status post CVA (cerebrovascular accident), impaired cognition care plan dated as revised 3/25/25 documents the following interventions:Eating: Assist x; revised 12/19/25R24 also had a care plan dated as revised 6/10/26 that stated the potential for inadequate oral intake due to dementia, unable to make needs known at times,variable by mouth (PO) intakes at times, dependance on staff for feeding/drinking, self-feeding difficulty due to cva bilateral upper extremity contractures as evidenced by need for assistance and/or cueing with meals/intake, and swallowing difficulty due to cva status post dysphagia as evidence by need for mechanically altered diet per speech therapy, history of pocketing/holding boluses.Under the Interventions section it documented: Provide and serve diet as ordered - regular, ground texture, thin liquids; Initiated 1/5/26 Provide assistance for all meals/intakes; Initiated 9/17/25 Provide assistance with feeding as needed and ensure resident is in the dining room for 2 out of 3 meals every day.; Initiated 3/3/26R24's Nutritional Evaluation dated 6/10/26 and completed by Registered Dietitian (RD)-M documented that R24 required assistance at all meals.On 7/6/2026, at 12:25 PM, Surveyor observed CNA-E assisting R24 with the lunch meal. Surveyor observed CNA-E holding R24's plate in left hand, while using a spoon with CNA-E's right hand to feed R24. Surveyor observed CNA-E standing over the left side of R24 while assisting R24 with eating. Surveyor observed CNA-E not conversing with R24 during the lunch meal. Surveyor observed CNA-E put R24's plate down and stand over R24 while CNA-E hand rested on CNA-E's left hip.On 7/7/2026, at 2:02 PM, Surveyor interviewed CNA-E. Surveyor asked CNA-E what the proper way was to feed residents. CNA-E stated the proper way to feed a resident was to be sitting while assisting a resident. Surveyor asked CNA-E why CNA-E was standing when feeding R24. CNA-E stated CNA-E did not know why CNA-E was standing while feeding R24.On 7/8/2026, at 9:35 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A confirmed that standing over residents to feed was not the policy of the facility. NHA-A stated it mostly likely occurred because space was challenged in the dining room.NHA-A understood that CNA-E standing over R24 while feeding them was not dignified.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure 1 (R15) of 12 sampled residents , received necessary care and treatment based on an assessment.*Surveyor observed a border gauze dressing in place to R15's right knee. There was no assessment of the wound and no order for treatment.Findings include: R15 was admitted to the facility on [DATE] and has diagnoses including multiple sclerosis, contractures, urine retention, need for assistance with personal cares and non-pressure chronic ulcer of skin.R15's Annual Minimum Data Set (MDS), dated [DATE] indicates a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition, no behaviors or rejection of care, has impairment on both sides of upper and lower extremities, dependent on staff to roll left to right, is at risk for pressure injuries and has an indwelling urinary catheter.On 07/06/2026, at 8:45 AM, Surveyor observed Certified Nursing Assistant (CNA)-F providing cares for R15. Surveyor observed a dressing in place to R15 right knee.Surveyor reviewed R15's physician orders and noted there is no treatment order for R15's right knee.Surveyor reviewed wound notes and weekly skin checks for R15 and noted no assessment of R15's right knee wound.R15's last skin assessment, dated 7/1/2026, indicates R15 has intact skin.On 07/06/2026, at 12:40 PM, Surveyor interviewed Registered Nurse-O regarding R15's right knee. RN-O indicated that R15's right knee is currently covered with a foam border dressing but there is no order in R15's electronic health record. RN-O informed Surveyor that RN-O will notify Director of Nursing (DON)-B and Nurse Practitioner (NP)-P and they will complete wound rounds later today. On 07/06/2026, at 1:17 PM, DON-B informed Surveyor that R15 is not currently being seen by the wound team for any wounds and only has preventative treatment to the right hip and offloading heels. Nurses provide the treatment and complete weekly skin checks. Surveyor reviewed Nurse Practitioner (NP)-P's note, dated 7/6/2026, which indicated the following: R15has neurogenic bladder from multiple sclerosis and has suprapubic catheter in place. Catheter site does not show signs/symptoms of infection, urine yellow, denies pain or spasm.R15's right knee wound check:- Staff noted today right knee wound - Partial thickness wound abrasion/shear 1.0 centimeters (cm) x 1.5cm x 0.1 cm (length x width x depth)- Wound is pink, no drainage, peri wound is normal, no erythema or maceration- Site covered today with xeroform gauze and border gauzeOn 07/07/2026, at 8:53 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B informed Surveyor that Nurse Practitioner (NP)-P assessed R15's right knee wound yesterday and determined it to be an abrasion. DON-B's expectation is that any new open wounds identified should be reported to the provider and DON-B to ensure proper and timely assessment.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility did not ensure 1 (R29) 1 sampled resident with hearing impairment received proper treatment and assistive devices including arrangements for an audiology (ear doctor) evaluation. The facility did not follow up on an audiology consult dated 10/25/25 after recommending wax in both ears be removed to complete a hearing evaluation. Findings Include: The facility policy, entitled Hearing and Vision Services reviewed/revised 7/12/25, documents: Guideline: It is the guideline of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. Explanation and Compliance Guidelines: 2. Staff should refer any identified need for hearing or vision services/appliances to the social worker/social service designee. 3. The social worker/social service designee is responsible for assisting residents, and their families, in locating and utilizing any available resources, for the provision of the vision and hearing services the resident needs. 4. Once vision or hearing services have been identified, the social worker/social service designee will assist the resident by making appointments and arranging for transportation. 6. Assistive devices to maintain hearing include, but not limited to, hearing aids and amplifiers. R29 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side, depression, major depressive disorder, and anxiety disorder. R29's Quarterly Minimum Data Set (MDS) assessment, dated 5/18/26, indicated that R29's Brief Interview for Mental Status (BIMS) score was 14, which indicated R29 was cognitively intact. R29's MDS documented that R29 was assessed as having no concerns with hearing. On 7/6/2026, at 9:49 AM, R29 informed Surveyor that R29 was to have R29's hearing tested, but it could not be done because R29 had extreme wax build-up in both ears. R29 informed Surveyor that R29 was to receive treatment to clear the wax and then have R29's hearing re-tested. R29 stated there had been no follow-up from the facility. R29 informed Surveyor that R29 had informed Social Worker (SW)-C that R29 had noticed a decrease in R29's hearing ability. R29 stated that R29 believed the wax had been removed but had no follow-up audiology assessment after the ear wax removal. Surveyor was unable to locate a care plan for R29's hearing/audiology in R29's medical record. Surveyor noted that on 10/22/25, it is documented that an audiology referral for R29 was made due to a complaint of decreased hearing. R29's audiology exam dated 10/25/25 could not be completed due to wax being so deep that it needed to be removed from both ears before the exam could occur. On 6/5/26, Nurse Practitioner (NP)-P documented that R29 was complaining of cerumen impaction in bilateral ears and NP-P used debrox to soften the wax. NP-P documented R29 had ear discomfort occasionally. Surveyor noted that NP-P had not addressed the wax build-up in R29's bilateral ears prior to 6/5/26. On 7/7/2026, at 9:38 AM, Surveyor interviewed Social Worker (SW)-C regarding R29's hearing concern. SW-C stated SW-C was responsible for making the referral for audiology services for residents as SW-C would contact the company and make a referral. SW-C informed Surveyor that when a resident is examined by audiology, the documented report is sent to SW-C, Director of Nursing (DON)-B, Medical Record/Receptionist (MR)-K, and Nursing Home Administrator (NHA)-A just got added. SW-C stated that if there were any recommendations, they would be discussed as an Interdisciplinary Team (IDT). SW-C stated that nursing would receive any recommendations and follow-up. SW-C informed Surveyor that SW-C believed that MR-K follows-up on any audiology recommendations. SW-C was unable to answer why R29 had not received an audiology consult after 10/25/25. On 7/7/2026, at 9:51 AM, Surveyor informed NHA-A and SW-C that Surveyor was unable to locate any documentation that (continued on next page)		

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 07/09/2026
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)		
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's audiology consult recommendations regarding R29's ear wax were followed up on. NHA-A stated the facility would look for the documentation of follow-up to the initial audiology consult on 10/25/25. On 7/8/2026, at 8:21 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E who was very familiar with R29. CNA-E confirmed that R29 was hard of hearing. On 7/8/2026, at 11:31 AM, Surveyor interviewed R29 again. R29 confirmed R29 still has hearing loss and would like to be tested. On 7/8/2026, at 10:26 AM, Surveyor interviewed Minimum Data Set Nurse (MDSN)-D via telephone. MDSN-D explained that MDSN-D completed all resident assessments out of the facility. MDSN-D was not aware of R29 having difficulty hearing as MDSN-D would be provided with the information of R29 having difficulty hearing from SW-C. On 7/8/26, at 8:26 AM, Surveyor interviewed MR-K. MR-K stated MR-K was responsible for setting up medical appointments. MR-K explained that MR-K reviewed resident hospital summaries and recorded the appointments, confirmed appointments and arranged transportation. MR-K confirmed that MR-K received audiology consultations. MR-K explained that MR-K would glance at the audiology consults but did not really read the whole consult. MR-K stated: I am not a nurse to understand everything. I would scan the consults into the resident electronic medical record (EMR). SW-C was part of the clinical review that completed audiology consult recommendations. MR-K stated the interdisciplinary team formalized a process yesterday (7/7/26) and that it was decided that MR-K will review consults carefully for clinical information, send it to the physician's office if needed and get outside orders for consultation if required. On 7/8/2026, at 9:03 AM, NHA-A informed Surveyor the facility did not have documentation of any audiology assessment follow-up for R29. NHA-A stated that MR-K would be getting an audiology consult scheduled. NHA-A stated that an audiology follow-up should have been initiated and completed for R29 after the initial consult on 10/25/25 and after R29's ears were cleaned of wax on 6/5/26.		

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure a resident received routine dental services for 1 (R29) of 1 resident reviewed for dental services. On 11/11/25 a dental referral for R29 was initiated due to cracked teeth and jaw pain. R29 was not evaluated until 6/15/26 by the dentist. Findings Include: The facility policy, entitled Dental Services reviewed/ revised 11/12/24, stated: Policy: It is the policy of this facility to assist residents in obtaining routine and emergency dental care. Policy Explanation and Compliance Guidelines: 1. The dental needs of each resident are identified through the physical assessment and MDS assessment processes and are addressed in each resident's plan of care. a. Oral/dental status shall be documented according to assessment findings. c. Referrals to dietitian, speech therapist, physician, or dental provider shall be made as appropriate. 2. Residents and/or resident representatives, during the admission process, are notified of dental services available under the State plan, and of the potential charges that may apply in the case of routine or emergency dental care provided by outside resources. a. The facility will assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. 3. The Social Services Director maintains contact information for providers of dental services that are available to facility residents at a nominal cost. 4. The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location. 7. In the case of an acute dental condition, the facility will take measures to ensure residents are still able to eat and drink while awaiting dental services. Interventions include, but are not limited to: a. Notifying physician of pain or other needs. b. Modifying diet consistency. c. Providing room temperature liquids for heat/cold sensitivity. d. Referring to dietitian for food preferences during the interim. Referral to speech therapist for chewing or swallowing problems. 9. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record. R29 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side, depression, major depressive disorder, and anxiety disorder. On 11/11/25 a dental referral was completed for R29's cracked teeth and jaw pain. On 7/6/2026, at 9:47 AM, R29 informed Surveyor that prior to admission to the facility, a dentist had informed R29 that R29 had 4 cracked crowns, 2 on the left and 2 on the right. R29 stated that R29 was also missing 2 teeth. In the hospital, speech was working with R29 on chewing food completely, but R29 was not able to, due to the dental issue. R29 stated they had some pain depending on if it was the wrong food or wrong spot when eating. R29 stated they did have difficulty chewing. R29 informed Surveyor that they had been telling Social Worker (SW)-C for several months that they needed to be seen by a dentist for the issue of pain associated with the cracked crowns. R29 stated that they have had no follow-up. R29's nutritional evaluation dated 4/27/26 documented R29 was on a regular, thin liquid diet. R29's nutritional evaluation did not address R29's dental status or difficulty chewing. R29's Quarterly Minimum Data Set (MDS) assessment, dated 5/18/26, indicated that R29's Brief Interview for Mental Status (BIMS) score was 14, which indicated R29 did not have cognitive concerns. R29's MDS documented R29 had no dental concerns. On 7/8/2026, at 10:26 AM, Surveyor interviewed Minimum Data Set Nurse (MDSN)-D via telephone. MDSN-D explained that MDSN-D completed all resident assessments out of the facility. MDSN-D was not aware of R29 having dental concerns. MDSN-D would be provided with the information of R29 having dental issues from SW-C. On 6/5/26, Nurse Practitioner (NP)-P documented R29 reported 4 cracked caps. On 6/12/26, (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Speech Therapist (ST)-R documented R29 had stated they broke another crown or tooth yesterday when eating an egg roll. R29 unable to reliably state which tooth it was, pointing generally to upper left side of mouth. Per Social Worker (SW-C), dentist would be coming 6/15/26. R29's dental consult dated 6/15/26 documented R29 was evaluated and R29 had 2 missing teeth along with multiple fractures of their teeth. Surveyor noted R29 was not evaluated from the initial dental referral on 11/11/25 until 6/15/26. On 7/7/2026, at 9:38 AM, Surveyor interviewed SW-C. SW-C confirmed that SW-C was responsible for making dental referrals for residents. SW-C would contact the company and make a referral. SW-C explained when a resident is examined by the dentist, the documented report is sent to SW-C, Director of Nursing (DON)-B, Medical Record/Receptionist (MR)-K, and Nursing Home Administrator (NHA)-A just got added. If there was a recommendation it would be discussed as an Interdisciplinary Team (IDT). Nursing would receive any recommendations and follow-up. SW-C informed Surveyor that SW-C believes MR-K follows-up on any recommendations. SW-C was unable to answer why it took so long for R29 to receive dental services. On 7/7/2026, at 9:51 AM, Surveyor shared the concern with NHA-A and SW-C that there had been no follow-up with a dental consultation after the initial 11/11/25 until 6/15/26. NHA-A stated the facility would look for the documentation of follow-up to the initial 11/11/25 dental referral. On 7/7/26, at 1:11 PM, Director of Nursing (DON)-B documented that R29 complains of pain to molars when chewing due to having cracked crowns that occurred prior to admission from his dog sitting on his jaw. The dentist noted this and suggested that R29 brush their teeth more often. On 7/8/2026, at 8:21 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E who was very familiar with R29. CNA-E was never informed of R29 having dental concerns. On 7/8/2026, at 11:31 AM, Surveyor interviewed R29 again. R29 stated they remained very frustrated that R29 had not been seen by the dentist. R29 informed Surveyor that it was hard to chew some food items and sometimes it could be painful depending on what eating and where it hits. On 7/8/26, at 8:26 AM, Surveyor interviewed MR-K. MR-K stated MR-K was responsible for appointments. MR-K explained that MR-K reviewed resident hospital summaries and recorded the appointments, confirm the appointments and arrange transportation. MR-K confirmed that MR-K did receive the dental consultations. MR-K explained that MR-K would glance at the dental consults but did not really read the whole consult. I am not a nurse to understand everything. I would scan the consults into the resident electronic medical record (EMR). SW-C was part of the clinical review that was being completed of the dental consults. MR-K confirmed that SW-C completes the initial referral. MR-K stated the interdisciplinary team formalized the process yesterday. It was decided that MR-K will review carefully for clinical information, send it to the physician's office if needed and get outside orders for consultation if required. On 7/8/2026, at 9:03 AM, NHA-A informed Surveyor the facility did not have documentation as to why it took so long for dental follow-up for R29. NHA-A understood the concern that the dental follow-up should have been initiated after the 11/11/25 referral but was not completed until 6/15/26.		