STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525718	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Home Moses Hall	210 Cumberlidge Ave King, WI 54946

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not thoroughly investigate allegations of abuse for 1 member (M) (M3) of 1 sampled member.M3 made physical abuse allegations against staff on 12/15/25 and 1/3/26. The facility did not thoroughly investigate the allegations of abuse.Findings include:The facility's Prohibition and Prevention of Member Abuse, Neglect, and Exploitation policy, revised July 2024, indicates: .4. The Nursing Supervisor or Administrator immediately initiates initial reporting and conducts a thorough investigation. 1. All allegations are thoroughly investigated .8. During an investigation, staff are expected to disclose all information to investigating parties .Alleged Mistreatment.8. A list of possible witnesses is given to the Nursing Supervisor as soon as possible .Copies of daily schedules and staff statement forms .are placed on the 24-hour board; names of staff needing to provide statements are highlighted .Cross off the highlighted names after statements are obtained .Registered Nurses (RNs) follow-up with all staff who were on duty and may have provided care for the affected member at the time of the discovery and during the two previous shifts .14. A file containing .staff statements, any supporting documentation .is routed to administration for keeping .From 4/7/26 to 4/8/26, Surveyor reviewed M3's medical record. M3 was admitted to the facility on [DATE] and had diagnoses including dementia with Lewy body disorder, dementia with moderate agitation, visual hallucinations, and mood disturbance. M3's Minimum Data Set (MDS) assessment, dated 2/18/26, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated M3 had moderately impaired cognition. M3 had an activated Power of Attorney for Healthcare (POAHC). Surveyor reviewed the facility's investigations for two incidents, dated 12/15/25 and 1/3/26, in which M3 reported allegations of staff abuse. Surveyor reviewed staff schedules, dated 12/14/25 night (NOC) shift and 1/3/26, and compared staff interviews with the schedules. Surveyor noted staff who were working during the time the allegations were made were not interviewed. RN-G and Certified Nursing Assistant (CNA)-F were the only staff interviewed for the incident on 12/15/25. RN-H was the only staff interviewed for the incident on 1/3/26.On 4/7/25 at 11:43 AM, Surveyor asked Director of Nursing (DON)-B if the facility completed additional staff interviews for the incident on 12/15/25. DON-B indicated DON-B would check to see if there were other interviews.On 4/7/26 at 11:50 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-E who indicated other staff were not interviewed during the 12/15/25 NOC shift because nobody else was around. When asked if other staff were assigned to the unit besides RN-G and CNA-F, ADON-E indicated the other staff was assisting on another unit when the incident occurred. ADON-E verified the staff should have been interviewed. On 4/7/26 at 1:44 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated all staff working on the unit during the shift should have been interviewed regarding the abuse allegations.On 4/7/26 at 2:11 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and asked if the investigation for the incident on 1/3/26 contained any other staff interviews. NHA-A reviewed the file and found an Email with RN-H's statement, dated 1/6/26. The investigation did not contain any other staff statements. NHA-A indicated NHA-A would check if M3's 1:1 CNA was interviewed.On 4/8/26 at 9:22 AM, Surveyor interviewed NHA-A who verified RN-H was the only staff interviewed for the incident on 1/3/26. NHA-A verified other staff (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
	525718	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Home Moses Hall	210 Cumberlidge Ave King, WI 54946

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who were working should have been interviewed.On 4/8/26 at 12:09 PM, Surveyor interviewed DON-B who indicated no other staff were interviewed about the incident on 1/3/26. DON-B verified staff who were working at the time should have been interviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525718	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Home Moses Hall	210 Cumberlidge Ave King, WI 54946

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on staff interview and record review, the facility did not provide the necessary care and services during a choking incident for 1 member (M) (M1) of 1 sampled member. M1 had diagnoses including anoxic brain damage and dysphagia (difficulty swallowing) and was noted to be impulsive with lack of judgement. M1 and M1's family requested that M1 receive a regular texture diet for pleasure and were aware of the risks and benefits. On 2/4/26, M1 put half of a peanut butter sandwich in M1's mouth when Certified Nursing Assistant (CNA)-I stepped away to retrieve a towel. Staff noted M1 was choking but did not call 911 due to M1's Do Not Resuscitate (DNR) code status. M1 became pulseless and non-breathing and passed away due to the incident.The facility's failure to follow their policy and procedure for a member who showed signs of complete choking and was still breathing created a finding of immediate jeopardy that began on 2/4/26. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 4/8/26 at 2:30 PM. The immediate jeopardy was removed and corrected on 2/5/26. This is being cited at past non-compliance. Findings include: The facility's Choking Incident WVH (Wisconsin Veterans Home) 123-00-10 document, dated February 2025, indicates: Applies to: Members, visitors, volunteers, contracted parties, facility staff .Medical conditions that impact chewing or swallowing increase a person's chance of experiencing choking episodes. Partial choking is when the airway is not fully blocked, still allowing some air to pass. Complete choking is when the airway is fully blocked, and the person cannot breathe .All staff shall be aware of the signs and symptoms of choking .If the person is showing signs of complete choking, call 911 and prepare for cardiopulmonary resuscitation (CPR). Try to dislodge the object by alternating abdominal thrusts and chest thrusts. Continue until the person begins to breathe or becomes unresponsive.The facility's Choking Incident WVH (Wisconsin Veterans Home) 123-00-10, dated 2/10/26, indicates: Applies to:Employees, members, visitors .Partial choking is when the airway is not fully blocked, still allowing some air to pass. Complete choking is when the airway is fully blocked, and the person cannot breathe. Resuscitation does not include the Heimlich Maneuver or similar procedure used to expel an obstruction from the throat S 154.17 .All staff shall be aware of the signs and symptoms of choking .3. If the person is showing signs of complete choking, call 911 and prepare for CPR. Try to dislodge the object by alternating back blows and abdominal thrusts. Continue until the person begins to breathe or becomes unresponsive .On 4/9/26, Surveyor reviewed M1's medical record. M1 was admitted to the facility in 2012 and had diagnoses including anoxic brain damage, dysphagia, dementia with mood disturbance and anxiety, impulse disorder, unspecified psychosis, personality change due to known physiological condition, and aphasia (impaired ability to understand or produce speech). M1's Quarterly Minimum Data Set (MDS) assessment, dated 1/25/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated M1 had intact cognition. M1 had an activated Power of Attorney for Healthcare (POAHC) who was a family member and actively involved in M1's care. M1 had a diet order, dated 1/28/25, for a general diet (no skins/hulls, nuts/seeds, rice) Texture: Regular, Consistency: HoneyM1's care plan, dated 11/18/25, indicated M1 received dysphagia therapy. The care plan contained goals to advance PO (by mouth) diet plan to include sandwiches and hamburgers and hot dogs buns.The care plan also indicated M1 required assistance with eating meals and had an altered texture diet. M1 could eat snacks from store orders independently. M1's POAHC was aware of the risks of eating items not within M1's diet order and accepted the risks for M1's pleasure and quality of life (date initiated: 12/14/16).A Patient Referral for Speech Therapy and History doument, dated 11/18/25, indicated M1 had a consistent cough during the meal which was baseline for M1 and recently lodged a piece of peach that potentially penetrated M1's airway. The document indicated M1 had an up/down versus rotary chewing pattern, but had controlled regular textures for years. M1 and M1's family desired regular texture foods. M1 was fed by staff. Moderately thick liquids were recommended and a regular diet with no modifications. Speech Pathologist (SP)-N verified the assessment.On 4/9/26, Surveyor reviewed a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525718	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Home Moses Hall	210 Cumberlidge Ave King, WI 54946

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility-reported incident (FRI) that indicated Certified Nursing Assistant (CNA)-I assisted M1 with eating supper in the dining room on 2/4/26. M1's meal consisted of beverages, diced pears cut in bite-size pieces, and a peanut butter sandwich cut in half. CNA-I offered M1 a drink which M1 refused. M1 grabbed half of the sandwich, shoved it in M1's mouth, and asked CNA-I for a towel for M1's lap. CNA-I retrieved a towel from the linen cart which was steps from where M1 was seated. When CNA-I returned, CNA-I noted M1 was having trouble breathing. CNA-I aked CNA-J to get the nurse while CNA-I pushed the emergency button in the dining room and the code blue button in M1's room. Registered Nurse Supervisor (RNS)-K and Registered Nurse (RN)-L responded. RNS-K initiated the Heimlich Maneuver. M1 became unresponsive but still had a pulse. Staff moved M1 from a wheelchair to the floor. Staff continued the Heimlich Maneuver until M1 was pulseless and non-breathing. Staff did not call 911 or initiate CPR because M1's code status was DNR. M1 was pronounced dead at 5:33 PM by the on-call physician.On 2/5/26, Medical Examiner (ME)-M called the facility and asked whether 911 was called at the time of the choking incident. RNS-K stated 911 was not called because M1's code status was DNR. (Of note: The facility's policy indicates to call 911 if a member shows signs of complete choking.)On 4/9/26 at 8:52 AM, Surveyor interviewed ME-M who confired M1's cause of death was choking. On 4/8/26 at 9:31 AM, Surveyor interviewed SP-N who had a history of caring for M1. SP-N stated SP-N tried a pureed diet for M1 multiple times; however, M1 and M1's family did not want that type of diet. SP-N stated staff regularly fed and supervised M1 who had disorganized eating and swallowing. SP-N stated the facility, M1, and M1's family worked together over the years. M1 and M1's family chose quality of life and food preferences over a prescribed diet. SP-N stated M1 had a brain injury, was impulsive, had a lack of judgement, and lacked insight into how much food M1 put in M1's mouth. SP-N verified M1 grabbed half of the peanut butter sandwich and put it in M1's mouth. SP-N stated M1 got mad if sandwiches were cut in pieces and staff had to hold the sandwich to feed M1. SP-N stated M1 required the assistance of one staff for supervision and verified M1's care plan did not contain an intervention to keep meal trays out of M1's reach. SP-N also stated M1 became agitated and kicked staff if M1 did not like the food that was served. SP-N stated M1's last speech therapy evaluation was completed on 11/18/25 and was done because M1 did not want to trial pureed fruit or a modified diet. SP-N stated SP-N requested modifications previously, however, M1 and M1's family did not want diet modifications and requested a general diet to assist with M1's quality of life. On 4/8/26 at 12:00 PM, Surveyor interviewed NHA-A who verified staff did not follow the facility's choking incident policy and procedure and did not call 911 when M1 showed signs of complete choking. NHA-A confirmed staff should have called 911. The facility's failure to follow their policy and procedure for a member who was showing signs of complete choking and was still breathing created a reasonable likelihood for serious harm thus leading a finding of immediate jeopardy. The facility removed and corrected the jeopardy on 2/5/26 when it completed the following:1. Educated staff in-person and through Relias (the facility's online training program) training on unsafe eating behaviors, notifying the nurse if a member refuses to the follow their plan of care, and the facility's choking policy and procedure.2. Completed diet and meal settings audits for all members.3. Reviewed/revised members' diet care plans.4. Completed mock CPR/Automatic Defibrillatorr (AED) drills.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525718	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Home Moses Hall	210 Cumberlidge Ave King, WI 54946

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 - 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 observation, staff and member interview, and record review, the facility did not ensure adaptive eating/drinking equipment was used during meal time to prevent burns for 2 Members (M2 and M6) of 3 sampled members. M2 did not receive coffee in a covered mug during supper on 3/1/26. M2 attempted to transfer the coffee from the uncovered mug to an insulated mug with a cover. The coffee spilled in M2's lap and resulted in burns to M2's bilateral thighs. (This example is being cited at a level G.)M6 did not receive coffee in a covered mug during lunch on 4/8/26.Findings include:The facility's Adaptive Equipment policy, dated May 2023, indicates: Adaptive equipment shall be available to assist members in maintaining or achieving their highest level of independent functioning possible. 5. The equipment is provided at the needed meal times on the meal cart. The facility's Member Meals and Snacks policy, dated 3/13/26, indicates: Meal Distribution - Retherm Carts - Review care plans for adaptive equipment needs and eating/swallowing programs, provide as ordered. Between 4/7/26 and 4/8/26, Surveyor reviewed M2's medical record. M2 was admitted to the facility on [DATE] and had diagnoses including Multiple Sclerosis (MS), generalized muscle weakness, early onset Alzheimer's disease, and dysphagia (difficulty swallowing), oropharyngeal phase. M2's Minimum Data Set (MDS) assessment, dated 2/4/26, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated M2 had moderate cognitive impairment.M2's Activities of Daily Living (ADL) self-care deficit care plan, revised 2/7/24, indicated M2 was at risk for ADL self-care deficit related to limited mobility, MS with progressive declines, and early onset Alzheimer's disease. M2's nutrition care plan, revised 2/5/26, indicated M2 was at increased risk for altered nutritional status and had swallowing difficulty related to dysphagia, oropharyngeal phase as evidenced by a Speech Therapy review and recommendations for a modified texture/consistency diet. The care plan contained an intervention for an insulated coffee mug with lid and indicated M2 had a general ground with nectar thick consistency liquids diet order (dated 3/2/26). Surveyor reviewed a facility-reported incident (FRI) that indicated M2 spilled hot coffee on 3/1/26 which resulted in burns that blistered on M2's bilateral thighs. The investigation included a statement from Certified Nursing Assistant (CNA)-O who provided M2's supper tray on 3/1/26 at approximately 5:00 PM. CNA-O put the tray in front of M2, removed a coffee cup from the tray, and put the coffee cup on the table. CNA-O removed the cover of the coffee cup to allow it to cool. CNA-O left to retrieve M2's adaptive equipment which included a covered mug. While CNA-O was obtaining the equipment, M2 attempted to pour the coffee into M2's personal thermal mug. When M2 missed the mug, the thickened coffee spilled into M2's lap. M2 called for help. CNA-O and a nurse cleaned up and assessed M2. M2 had a reddened area on the right upper thigh. A statement from Registered Nurse (RN)-P indicated a CNA informed RN-P at approximately 9:00 PM that the reddened area was starting to become fluid-filled. A wound assessment, dated 3/2/26, indicated M2's left thigh had an intact blister that measured 2.6 centimeters (cm) x 1.5 cm. M2's right thigh had a 60% intact blister with 40% granulation tissue and scant exudate that measured 4 cm x 2.8 cm.On 4/7/26 at 12:26 PM, Surveyor interviewed CNA-C regarding education related to the incident. CNA-C indicated CNA-C was educated and a new process was implemented for serving meals. CNA-C indicated staff now prepare meal trays behind the counter and ensure adaptive equipment is on the tray before delivering trays to members.On 4/7/26, Surveyor reviewed M6's medical record. M6 was admitted to the facility on [DATE] and had diagnoses including gastroesophageal reflux disease (GERD,) legal blindness, vascular dementia, dysphagia oral phase, and esophageal obstruction. M6's MDS assessment, dated 1/7/26, had a BIMS score of 12 out of 15 which indicated M6 had moderate cognitive impairment. M6's ADL self-care deficit care plan, dated 12/9/19, indicated M6 was at risk for ADL self-care deficits related to poor vision and dementia. A revised approach (dated 1/12/26) indicated: Vision: Legally blind. M6's nutrition care plan, 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
	525718	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Home Moses Hall	210 Cumberlidge Ave King, WI 54946

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 - Actual harm Residents Affected - Few	1/9/26, indicated M6 was at increased risk for altered nutritional status and had difficulty swallowing related to dysphagia oral phase with esophageal stricture, history of need for dilation per Speech Therapy review, and recommendations for a modified texture diet. The care plan contained an intervention that indicated: Adaptive Equipment: Coffee cup with lid and white deep dish divided plate (dated 1/25/22).On 4/7/26 at 11:33 AM, Surveyor observed lunch on M2 and M6's unit. Staff prepared meal trays behind a counter and delivered the trays to residents. M2 received coffee in a covered mug. Surveyor started observing M6 shortly after M6's meal was delivered and observed M6 feel around for silverware. After M6 had searched for approximately one minute, staff approached and explained what food was on M6's plate and its location. Staff helped M6 find the utensils so M6 could eat. Surveyor observed an open cup of coffee to the left of M6's tray with a blue plate. Surveyor did not observe M6 drink coffee during the meal. On 4/7/26 at 12:26 PM, Surveyor interviewed CNA-D who helped serve and assist members during the meal. When Surveyor asked about adaptive equipment and M6's uncovered coffee mug and blue plate, CNA-D indicated M6 had a blue covered mug. When CNA-D and Surveyor approached M6, CNA-D verified M6 had a blue covered mug but also had a red uncovered coffee mug within reach. When Surveyor indicated M6's plate was blue but M6's care plan indicated M6 should have a white plate, CNA-D stated CNA-D was not sure. CNA-D stated meal carts contain bins with adaptive equipment which staff spread on the counter. If a member has adaptive equipment, it is indicated on a green meal tray ticket and staff check the pile on the counter for the member's equipment. CNA-C then approached Surveyor and CNA-D. CNA-C stated each member has a dysphagia card which tells staff if they need help eating. Surveyor reviewed M6's dysphagia card which did not indicate what adaptive equipment M6 needed. When Surveyor informed CNA-C that M6's meal tray contained an uncovered coffee mug and did not contain a white divided plate, CNA-C stated new staff do not always know what members need. When Surveyor asked if there is a list of what adaptive equipment members should have, CNA-C and CNA-D indicated adaptive equipment is listed on a member's Kardex (an abbreviated care plan used by nursing staff) in the binder at the nurses' station. CNA-C took Surveyor to the nurses' station. After paging through the binder for approximately one minute, CNA-C found M6's Kardex. On 4/7/26 at 1:35 PM, Surveyor interviewed CNA-D who stated the unit has two bins of adaptive equipment. CNA-D stated the bin with M6's adaptive equipment arrived late to the unit. M6 was already served when the bin arrived. Surveyor looked in the bin and observed a small coffee mug with a cover labeled with M6's name. On 4/8/26 at 11:39 AM, Surveyor observed lunch on M6's unit and noted M6's white divided plate and covered coffee mug were available to use during the meal. Surveyor tested the temperature of a cup of coffee from the same cart that held M6's meal tray. The temperature was 146.6 degrees Fahrenheit (F.) Per time and temperature tables for third degree burns, a third degree burn can occur at a liquid temperature of 140 degrees F in 5 seconds; and 148 degrees F in 2 seconds. On 4/7/26 at 2:02 PM, Surveyor informed Assistant Director of Nursing (ADON)-E of Surveyor's observations. ADON-E verified the only place to find what adaptive equipment a member should have is the member's care plan/Kardex. ADON-E confirmed if a member's adaptive equipment is not on the unit, staff should not serve the member until the adaptive equipment is available.