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	06/17/2026

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 interview and record review, the facility did not ensure the member environment was as free of accident hazards as possible when staff did not follow an intervention to prevent/reduce the impact of a fall for 1 member (M) (M121) of 6 sampled members. M121 had a history of falls. On 5/15/26, staff did not follow an intervention in M121's care plan to prevent recurrence when they did not lock M121's bed height adjustment with the bed in the lowest position. M121 fell out of bed, landed on their face, and required sutures in the left eyebrow. (This is being cited at past non-compliance.) Findings include: The facility's Prohibition and Prevention of Member Abuse, Neglect, and Exploitation policy, dated 7/2024, indicates: .The facility shall implement policies and procedures to identify, correct, and intervene in situations where abuse, neglect, exploitation, and/or misappropriation of member property is more likely to occur. M121 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, and history of falls. M121's Minimum Data Set (MDS) assessment, dated 5/6/26, stated M121 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severely impaired cognition. M121's Falls care plan (initiated 3/2/22 and revised 5/8/26) indicated they were at risk for falls related to a history of falls with debility, medication use, inpaired mobility and balance, cognitive deficits with occasional impulsive behavior, and decreased coordination with mobility. The care plan contained interventions for bed height adjustment to be locked when M121 is in bed, with bed in the lowest position (initiated 8/23/24 and revised 5/15/26) and encourage bed to be in lowest position when M121 is in bed (initiated 10/17/23 and revised 5/15/26). M121's medical record indicated M121 was found face down on the floor next to the bed and bleeding from the head on 5/15/26 at 3:20 AM. The bed was raised approximately three feet in the air and was not in a locked low position. M121 was tranferred to the hospital and received sutures in the left eyebrow. Surveyor reviewed a facility-reported incident (FRI) that indicated Certified Nursing Assistant (CNA)-C heard a thud from M121's room on 5/15/26 at 3:20 AM and observed M121 face down on the floor. CNA-C last checked on M121 at 3:00 AM. M121's bed was at the correct height at that time. M121 used the bed control to raise the height of the bed approximately three feet. It appeared M121 then sat up, attempted to exit the bed, and landed face-down on the floor. The nurse was notified and staff called 911. Emergency first-aid was provided until Emergency Medical Services (EMS) arrived. Upon review of M121's plan of care, it was noted the bed height adjustment should have been locked when M121 was in bed. CNA-C did not complete the task as instructed in M121's Kardex (an abbreviated care plan used by nursing staff). M121 sustained a laceration to the left eyebrow that required sutures. M121 was interviewed upon return from the hospital and stated they thought their bed was lower than it was. When asked if M121 raised the bed, M121 stated, I put it up, I think. M121 was educated to use the call light if they want to get out of bed. The investigation indicated M121 had many safety interventions in place to prevent harm and ensure safety due to a history of falls. After learning M121's care plan was not followed, CNA-C was removed from member care and the police were notified. M121's care plan and Kardex were updated. M121's CNA Tasks for Documentation were updated for staff to document M121's bed is in the lowest position and locked. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Members' plans of care were reviewed to ensure all fall safety measures were in their care plan, Kardex, and CNA Tasks for Documentation. All staff were educated. On 6/16/26 at 2:40 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified CNA-C did not follow M121's care plan and indicated staff should follow members' care plans. NHA-A stated CNA-C was removed from member care pending the results of the investigation and educated prior to returning to work.