STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd Edgerton, WI 53534

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident was free from abuse from another Resident for 1 of 11 residents (R5) reviewed for abuse. R12 had witnessed R1 slap R5 when both R1 and R5's wheelchairs got hung up on each other. R12 reported the incident to staff immediately. R1 has a history of aggressive behaviors towards staff and other residents. R1 has had another known altercation with R12 in the past. Evidenced by:The facility policy entitled Abuse, Neglect and Exploitation, dated 2025, states, in part: . Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.III. Prevention of Abuse, Neglect and ExploitationThe facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: .B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified. staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; .D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect;E. Ensuring the health and safety of each resident.V. Investigation of Alleged Abuse, Neglect and ExploitationA. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.VI. Protection of the ResidentThe facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. R1 admitted to the facility on [DATE] and has diagnoses that include paranoid schizophrenia (chronic mental disorder defined by intense, irrational delusions and auditory hallucinations, often involving persecution or conspiracy) and unspecified dementia severe with mood disturbance (significant cognitive decline coupled with behavioral symptoms like agitation, depression, apathy, or aggression. It results from brain damage, making communication difficult and causing emotional instability).R1's Minimum Data Set (MDS) Significant Change Assessment, dated 2/23/26, shows that R1 has a Brief Interview of Mental Status (BIMS) score of 02 indicating R1 has severe cognitive impairment.R1's Care Plan, dated 12/06/2019, with a target date of 5/24/2026, states, in part: . Problem: Problem Start Date: 12/06/2019. Category: Cognitive Loss/Dementia. Resident has impaired decision-making R/T (related to) her diagnoses of paranoid schizophrenia, dementia, delusional disorder. BIMS score is less than 13. Resident is not her own person.Approach: .-Approach Start Date: 12/06/2019. Allow resident to make decisions although ensuring her safety and safety of others. R5 admitted to the facility on [DATE] and has diagnoses that include unspecified dementia (Cognitive decline with the specific cause unknown. It involves progressive memory loss and cognitive impairment that interferes with daily life.), major depressive disorder (a serious mental health condition characterized by persistent, intense feelings of sadness, hopelessness, and a loss of interest in activities), and down syndrome (a (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	genetic condition caused by an extra copy of chromosome 21, resulting in physical growth delays, mild to moderate intellectual disabilities, and characteristic facial features).R5's Minimum Dats Set (MDS) Quarterly Assessment, dated 1/23/26, shows that R5 has a Brief Interview of Mental Status (BIMS) score of 00, indicating R5 has severe cognitive impairment. On 3/17/26 at 11:54 AM, Surveyor interviewed LPN C (Licensed Practical Nurse) who indicated on 2/16/26 CNA D (Certified Nursing Assistant) reported to her that R1 had slapped R5 across the face. LPN C indicated the two residents were separated immediately. LPN C indicated she assessed R5 for any red marks and then reported the incident to the ADON (Assistant Director of Nursing), who is no longer employed at the facility. LPN C indicated the ADON directed LPN C to keep the two residents separated and keep an eye on them. Surveyor asked if vital signs or further follow up were completed with R5 and R1. LPN C indicated she had not completed any further assessing. LPN C indicated she had informed FM F (Family Member) of the incident as she was just arriving at that time to visit R5. LPN C indicated she then reported the incident to NHA A (Nursing Home Administrator). Surveyor asked LPN C if she documented the incident. LPN C indicated no. Surveyor asked LPN C if there were interventions put into place following this incident to prevent it from happening again. LPN C indicated she was not aware. LPN C indicated there was nothing put on the nurses 24-hour board or passed through in report when she worked her next shift. Surveyor asked LPN C if R1 has behaviors. LPN C indicated yes, paranoia, delusions, and aggressiveness with staff and residents. Surveyor asked what is meant by aggressiveness and LPN C indicated verbal aggressiveness that has been happening for a long time. Surveyor asked LPN C if she is aware of any other incidents regarding R1 and other residents. LPN C indicated yes, there was an altercation awhile back with R1 and R12. Surveyor asked LPN C what the facility's process is for a resident-to-resident altercation. LPN C indicated the staff are to separate the residents, make sure they are safe, and report it. LPN C indicated the facility would have to investigate and report it to the state.On 3/17/26 at 12:25 PM, Surveyor interviewed CNA D and asked if she was aware of an altercation between R1 and R5. CNA D indicated she had been charting in the conference room by the nurse station when R12 informed her R1 had just slapped R5's face. CNA D indicated R12 was right outside the conference room in the hallway and R1 and R5 were in front of R12. CNA D indicated she did not witness the slap. CNA D separated R1 and R5 immediately by taking R5 down the hallway. CNA D informed LPN C right away once CNA D separated the two residents and both residents were safe. Surveyor asked CNA D if R1 had ever struck another resident and CNA D indicated yes, R12. CNA D indicated R1 had slapped R12 on her face a year or so ago. Surveyor asked if R1 has behaviors. CNA D indicated yes, R1 gets combative with staff and gets verbally aggressive with staff and residents. Surveyor asked CNA D, after the incident between R1 and R5 were new interventions passed on to staff on how to prevent this from happening again. CNA D indicated no, the incident was passed on in report.On 3/17/26 at 1:30 PM, Surveyor interviewed FM F who indicated on 2/16/26 LPN C informed her that R1 had slapped R5. R1 and R5's wheelchairs somehow got hung up together and R1 got frustrated and slapped R5. FM F indicated the facility has not reached out to her regarding the incident and what has been put into place to prevent future occurrences. FM F expressed concerns with R1. R1 goes into R5's room and other resident rooms and takes things. On 3/17/26 at 3:00 PM, Surveyor interviewed R12. Surveyor asked R12 if she had witnessed a resident altercation between R1 and R5. R12 indicated yes. R12 indicated R1 and R5 were both in their wheelchairs going in opposite directions and somehow the wheelchairs got caught together. R1 then slapped R5 on the shoulder. R12 indicated there were no words exchanged. R12 indicated she informed a CNA right away and that CNA separated R1 and R5. Surveyor asked R12 if she had ever been involved in an altercation with R1. R12 indicated yes, R1 grabbed her arm a few times and pulled her. R12 indicated she has told the staff, and the staff have advised R12 to not say anything to R1 anymore. R12 indicated she has observed R1 screaming and hitting at staff.On 3/18/26 at 9:25 AM, Surveyor interviewed CNA E. Surveyor asked if R1 has behaviors and CNA E indicated yes, R1 is verbally and physically aggressive with staff and residents. CNA E indicated a while back R1 hit R12. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA E indicated she recently heard R1 had hit R5. Surveyor asked if CNA E was aware of any new interventions put into place after the incident with R1 and R5. CNA E indicated no and explained CNA E would know because she is responsible for updating the CNA cheat sheets. The cheat sheets direct the CNAs how to care for the residents. CNA E indicated if there were new interventions she would have known to add them onto those sheets. CNA E indicated she is to update the cheat sheets every week. Surveyor asked CNA E what R1's typical day is like. CNA E indicated when R1 is not sleeping, R1 tootles around the unit independently. Surveyor asked CNA E if R1 participates in activities. CNA E indicated we try but R1 will not stay in the activities. On 3/18/26 at 11:00 AM, Surveyor interviewed NHA A and asked what the facility's process is for a resident-to-resident altercation. NHA A indicated that staff report the incident to her. NHA A then reports it to the state, investigates it and provides education. Surveyor asked NHA A if she was aware of an incident between R1 and R5 on 2/16/26. NHA A indicated she does not recall. Surveyor asked NHA A if staff had informed her of R1 slapping R5 on 2/16/26. NHA A indicated on 2/16/26 LPN C or ADON at that time did report that R12 witnessed R1 slapping R5. Surveyor asked NHA A who had reported the incident to the ADON. NHA A could not recall. Surveyor asked whom R12 reported the incident. NHA A indicated she could not recall. Surveyor asked if there was any documentation on this incident. NHA A indicated no it was just conversation. Surveyor asked NHA A if there should be documentation; NHA A indicated yes. Surveyor asked what NHA A had done with the information she received from staff. NHA A indicated she talked to R12. R12 indicated that R1 did not slap R5. R12 indicated to NHA A that R1 was tapping R5 on the face. NHA A indicated R1 and R5's wheelchairs had somehow hung up together. NHA A indicated there were no words exchanged between R1 and R5. NHA A indicated she had no concerns after talking with R12 about the incident. Surveyor asked if there was any follow up with R1 and R5 after the conversation with staff and R12. NHA A indicated no. Surveyor asked if NHA A interviewed the CNA and nurse that had reported it. NHA A indicated no. Surveyor asked if the facility interviewed other residents to see if there were concerns regarding R1 and their safety in the facility. NHA A indicated no. Surveyor asked NHA A how it was determined not to investigate this resident-to-resident altercation. NHA A indicated R12 stated R1 lightly tapped R5 on the face. Surveyor asked NHA A should a resident-to-resident altercation be investigated? NHA A indicated yes. Surveyor asked NHA A if this incident could have been potentially reportable to state. NHA A indicated yes. Surveyor asked if there should have been documentation on this incident; NHA A indicated yes.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not always ensure that they implemented written procedures for screening agency staff prior to working with residents at the facility. This has the potential to affect all 51 residents residing with in the facility.On 3/4/26, the facility became aware that an agency Certified Nursing Assistant (CNA S), who had worked 12 previous shifts on various units/floors was working under a false identification as CNA T. The facility did not put new processes in place related to verifying identification of the agency staff prior to orientation and their first scheduled shift. This gave CNA S the continued ability to obtain work while posing as CNA T. This has the potential to affect the safety of all 51 residents of the facility. This is evidenced by:Policy Review: Compliance with Reporting Allegations of Abuse/Neglect/Exploitation (date implemented, revised, and reviewed is blank.)Policy: It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes.Compliance Guidelines: The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to ensure that the facility is doing all that is within its control to prevent occurrences.1.) Screening: The facility will screen employees for a history of abuse, neglect, or mistreating residents by attempting to obtain information from previous employers and/or current employers and checking with the appropriate licensing boards and registries. Policy: Abuse, Neglect and Exploitation (date implemented, revised, and reviewed is blank.): It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. 1). Screening a. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property.1.) Background reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers and consultants. 2.) Screenings may be conducted by the facility itself, third-party agency or academic institution.3.) The facility will maintain documentation of proof that the screening occurred. On 3/17/26, Surveyor initiated a complaint investigation which addressed a concern that the facility had an Agency CNA who was working under an [NAME] name (an assumed, false, or additional name used to conceal a person's true identity.) The CNA was originally identified as CNA T. According to the review of the Police Department report, on 3/3/26, a food order was delivered to the facility at approximately 7:46 PM. The [NAME] Police became aware that this food was ordered and then paid for fraudulently and began an investigation. The [NAME] Police were able to narrow down 2 females who had ordered and received the food on the evening of 3/3/26. The individual who was said to have paid for the food was CNA T, who was an agency CNA who works at multiple different facilities. CNA T was working at the facility on 3/3/26 on the third floor.On 3/4/26, [Town Name] Police returned to the facility, as they were made aware by facility management that CNA T was scheduled to start her shift at 2:00 PM. Facility Management provided the police officer with a photocopy of CNA T's (out of state) driver's license that was provided to the facility by the staffing agency. At approximately 2:00 PM on 3/4/26, the [Town name] Police made contact with CNA T at the front entrance of the facility. The police officer asked the female if she was CNA T, in which she stated she was and agreed to further speak with the police officer.The [Town name] Police continued to gather information regarding the food order and delivery from the evening of 3/3/26. The [Town name] Police established probable cause to arrest CNA T. The police officer asked CNA T for her identification so they could confirm her (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	identity, she stated she did not have her identification with her. The police officer, after further conversation, proceeded to get the photocopy of the driver's license of CNA T that was provided by the facility. The police officer noticed similarities in their facial features but did not believe the female that the officer had contact with was the same female in the driver's license photo. The police officer asked the female if she knew who the female was in the driver's license photo and asked if that was her. The female responded no. The police officer asked her if she was working for [Care Center] under a fake name, she said no.The police officer made contact with [Care Center] and asked the staff member if she knew an employee by the name of CNA T. The staff member stated she did know CNA T and was able to identify her as the female who was in the police officer's squad car. The female was transported to the [town name] Police Station where further questioning led to the female identifying herself as CNA S. CNA S informed the police officer that she is a travel nurse for a staffing agency and worked at [Care center.] The police officer asked CNA S why people at [Care center] think her name is CNA T, she responded she didn't know. Further discussion lead the police officer to believe that CNA T is CNA S's mother and that CNA S has been using her mother's identity to work at [Care Center.CNA S informed the police officer that she is a licensed CNA in multiple states, including Wisconsin. CNA S stated that her mother (CNA T) is also a licensed CNA but is no longer in the medical field. CNA S stated that she use [sic] to be employed with the staffing agency and is currently suspended for a year due to attendance issues. CNA S created her mother (CNA T) an account with the staffing agency, got hired with them, and has been working under her mother's identity. CNA S claims that she has only been working under a false identity for a couple weeks. On 3/18/26 at 10:10 AM, Surveyor conducted an interview with NHA A (Nursing Home Administrator) regarding the use of agency staff and her knowledge of CNA T not being who she identified herself as. NHA A stated she became aware of the situation when the Police arrived at the facility on 3/4/26 to arrest CNA T for potential credit card fraud. NHA A stated she tried to call the staffing agency on 2 separate occasions to report the incident and that CNA T was no longer welcome to work at the facility. NHA A stated then the situation of the false identity came about and that CNA S was posing as CNA T while working at the facility. All the staff and residents knew her as CNA T, and no one had any idea she was not who she said she was. NHA A stated that the staffing agency finally returned her phone call and told them that CNA S had previously worked for the staffing agency, but she got blocked from working there due to attendance issues. CNA S stated she needed the money so she applied under her mother's name and then could continue to work through the agency. Surveyor asked NHA A what the screening process is for new/first time agency staff who report to the facility for a shift. NHA A explained that the staffing agency obtains all of the required background information and upon hire, this information is uploaded to a shared portal that she has access to. NHA A is provided with all the information for each agency employee that is hired by the facility through this online portal. NHA A stated that upon orientation, the facility never asked her to provide identification because they never had a reason to believe that the person showing up to work was not who they said they were. NHA A stated that the facility has a contract with the staffing agency and they do all of the hiring. Once the person is hired, they put themselves out on this portal to pick up various shifts at various facilities who need to fill open shifts. Surveyor asked NHA A if she had reported this incident to the state survey agency. NHA A stated she did not because it was an active police investigation and she was charged for credit card fraud, not working at the facility under a false identification. NHA A stated CNA S has a current/valid Certified Nursing Assistant license through the state of Wisconsin and no findings on the caregiver misconduct registry. It was noted that CNA T also had a valid Wisconsin license and no misconduct findings. NHA A stated the facility continues to use the staffing agency and at this point, no changes had been made to the process when new agency personnel show up for a shift and how they verify their identity. (Of note: the facility did not report a suspicion of a crime to the state agency)On 3/18/26, Surveyor conducted a review of the contract between [Care Center] and the staffing agency. Under Agency's Responsibilities the following is (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	documented:b. Professional Credential Verification. For each type of professional listed in section C of the Order Form, the agency will verify the credential(s) and/or document(s), if any, that have been selected (Credential Verification Services). The agency will only permit Professionals that satisfy the applicable credential requirements of Section C of the order form to accept shifts posted by the client [Facility name]. Notwithstanding the foregoing, Client acknowledges and agrees that Agency's Credential Verification Services will not substitute for or relieve Client of its own statutory, regulatory, and/or contractual obligations, if any, to independently verify credentials, documents, and/or information pertaining Professionals. Section C-Credentials to be Verified (includes) photo identification, criminal background check, license verification.On 3/18/26, Surveyor obtained a copy of the background information that was submitted by the staffing agency for their employee identified as CNA T. All credentials were verified and valid. CNA S also had valid credentials provided to the facility from her previous employment with the agency.CNA T (identified as CNA S) worked the following total 12 shifts at the facility:On 2/8/26, CNA S worked as CNA T on AM shift on the 3rd floor.On 2/9/26, CNA S worked as CNA T on the AM and part of the PM shift on the 3rd floor.On 2/10/26, CNA S worked as CNA T on the AM and PM shift on the 3rd floor.On 2/11/26, CNA S worked as CNA T on the NOC shift on the 2nd floor.On 2/24/26, CNA S worked as CNA T on the NOC shift on the 3rd floor.On 2/27/26, CNA S worked as CNA T on the AM shift on the 3rd floor.On 2/28/26, CNA S worked as CNA T on the NOC shift on the 3rd floor.On 3/1/26, CNA S worked as CNA T on the AM shift on the 3rd floor.On 3/2/26, CNA S worked as CNA T on the PM shift and NOC shift of the 3rd floor.On 3/3/26, CNA S worked as CNA T on the PM shift on the 3rd floor. During the investigation, Surveyor conducted a review of the facility's grievance file. It was noted that resident R2 submitted a grievance on 3/1/26. The grievance stated that on 2/27/26, a Certified Nursing Assistant left her wet and did not check and change her per the plan of care. The facility's investigation included looking over the schedules and the staff member, in question, was new. The resolution was that the Certified Nursing Assistant was educated regarding check/change of briefs and the importance of peri care. More training for check-off. It was noted that this grievance was filed against CNA T. The education provided to CNA T documents that she is new to her occupation of CNA and has been noted to be a phenomenal worker by staff and is always answering call lights and does not complain about doing anything that is asked of her. Due to the facility not implementing their policy on Abuse/Neglect and Misappropriation of property, they failed to confirm the proper identity of an agency CNA (CNA S) upon hire to work at their facility. CNA S was able to work as CNA T for a total of 12 shifts at the facility, on various units, without proper screening by both the staffing agency and the facility. Although CNA T was later identified as CNA S, Once the facility became aware that CNA T was really CNA S, they did not change their process to ensure that all employees were properly screened, including verification of identity, prior to working with the residents of the facility. This had the potential to affect all residents, as the practice remained unchanged and agency staff continued to be used to meet the facility's scheduling demands.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law though established procedures for 3 of 3 incidents involving 3 residents (R1, R5 & R6) reviewed for abuse. The facility became aware of a resident-to-resident altercation between R1 and R5 on 2/16/26. The facility failed to do an investigation and report to the state if indicated. Facility did not report a suspicion of a crime when they became aware of a staffing agency CNA (Certified Nursing Assistant) working under false identification. A staff member was alleged to have abused R6, and the facility did not report it to the State Agency. Evidenced by: The facility policy entitled Abuse, Neglect and Exploitation, dated 2025, states, in part: . Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The components of the facility abuse prohibition plan are discussed herein: . V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B Written procedures for investigations include: . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies (e.g., law enforcement when applicable) within specified timeframes: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Example 1: R1 was admitted to the facility on [DATE] and has diagnoses that include paranoid schizophrenia (chronic mental disorder defined by intense, irrational delusions and auditory hallucinations, often involving persecution or conspiracy) and unspecified dementia severe with mood disturbance (significant cognitive decline coupled with behavioral symptoms like agitation, depression, apathy, or aggression. It results from brain damage, making communication difficult and causing emotional instability). R1's Minimum Data Set (MDS) Significant Change Assessment, dated 2/23/26, shows that R1 has a Brief Interview of Mental Status (BIMS) score of 02 indicating R1 has severe cognitive impairment. R5 was admitted to the facility on [DATE] and has diagnoses that include unspecified dementia (Cognitive decline with the specific cause unknown. It involves progressive memory loss and cognitive impairment that interferes with daily life.) and down syndrome (a genetic condition caused by an extra copy of chromosome 21, resulting in physical growth delays, mild to moderate intellectual disabilities, and characteristic facial features). R5's Minimum Dats Set (MDS) Quarterly Assessment, dated 1/23/26, shows that R5 has a Brief Interview of Mental Status (BIMS) score of 00, indicating R5 has severe cognitive impairment. On 3/17/26 at 11:54 AM, Surveyor interviewed LPN C (Licensed Practical Nurse) who indicated on 2/16/26 CNA D (certified nursing assistant) reported to her that R1 had slapped R5 across the face. LPN C indicated the two residents were separated immediately. LPN C indicated she assessed R5 for any red marks and then reported the incident to the ADON (Assistant Director of Nursing), who is no longer employed at the facility. LPN C indicated the ADON directed LPN C to keep the two residents separated and keep an eye on them. Surveyor asked if vital signs or further follow up was completed with R5 and R1. LPN C indicated she had not completed any further assessing. LPN C indicated she had informed FM F (family member) of the incident as she was just arriving at that time to visit R5. LPN C indicated she then reported the incident to NHA A (Nursing Home Administrator). Surveyor asked LPN C if she documented the incident. LPN C indicated no. On 3/17/26 at 12:25 PM, Surveyor interviewed CNA D and asked if she was aware of an altercation between R1 and R5. CNA D indicated she had been charting in the conference room by the nurse station when R12 informed her R1 had just slapped R5's face. CNA D indicated R12 was right outside the conference room in the hallway and R1 and R5 were in front of R12. CNA D indicated she did not witness the slap. CNA D separated R1 and R5 immediately by taking R5 down the hallway. CNA D informed LPN C right away once CNA D separated the two residents and both residents were safe. Surveyor asked CNA D if R1 had ever struck another resident and CNA D indicated yes, R12. CNA D indicated R1 had slapped R12 on her face a year or so ago. On 3/17/26 at 3:00 PM, Surveyor interviewed R12. Surveyor asked R12 if she had witnessed a (continued on next page)

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	525241	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd Edgerton, WI 53534

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident altercation between R1 and R5. R12 indicated yes. R12 indicated R1 and R5 were both in their wheelchairs going in opposite directions and somehow the wheelchairs got hung up together in the passing. R1 then slapped R5 on the shoulder. R12 indicated there were no words exchanged. R12 indicated she informed a cna right away and that cna separated R1 and R5. On 3/18/26 at 11:00 AM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked what the facility's process is for a resident-to-resident altercation. NHA A indicated that staff report the incident to her. NHA A then reports it to the state, investigates it and provides education. Surveyor asked NHA A if she was aware of an incident between R1 and R5 on 2/16/26. NHA A indicated she does not recall. Surveyor asked NHA A if staff had informed her of R1 slapping R5 on 2/16/26. NHA A indicated on 2/16/26 LPN C or ADON at that time did report that R12 witnessed R1 slapping R5. Surveyor asked NHA A who had reported the incident to the ADON. NHA A could not recall. Surveyor asked whom R12 reported the incident. NHA A indicated she could not recall. Surveyor asked if there was any documentation on this incident. NHA A indicated no it was just conversation. Surveyor asked NHA A if there should be documentation; NHA A indicated yes. Surveyor asked what NHA A had done with the information she received from staff. NHA A indicated she talked to R12. R12 indicated that R1 did not slap R5. R12 indicated to NHA A that R1 was tapping R5 on the face. NHA A indicated R1 and R5's wheelchairs had somehow hung up together. NHA A indicated there were no words exchanged between R1 and R5. NHA A indicated she had no concerns after talking with R12 about the incident. Surveyor asked if there was any follow up with R1 and R5 after the conversation with staff and R12. NHA A indicated no. Surveyor asked if NHA A interviewed the cna and nurse that had reported it. NHA A indicated no. Surveyor asked if the facility interviewed other residents to see if there were concerns regarding R1 and their safety in the facility. NHA A indicated no. Surveyor asked NHA A how it was determined not to investigate this resident-to-resident altercation. NHA A indicated R12 stated R1 lightly tapped R5 on the face. Surveyor asked NHA A should a resident-to-resident altercation be investigated? NHA A indicated yes. Surveyor asked NHA A if this incident could have been potentially reportable to state. NHA A indicated yes. Surveyor asked if there should have been documentation on this incident; NHA A indicated yes. Example 2: Surveyor initiated a complaint investigation which addressed a concern that the facility had an Agency CNA (Certified Nursing Assistant) who was working under an [NAME] name (an assumed, false or additional name used to conceal a person's true identity). The CNA was originally identified as CNA T. On 3/18/26 at 10:10 Am, Surveyor conducted an interview with NHA A (Nursing Home Administrator) regarding the use of agency staff and her knowledge of CNA T, not being who she identified herself as. NHA A stated she became aware of the situation when the Police arrived at the facility on 3/4/26 to arrest CNA- T for potential credit card fraud. NHA A stated she tried to call the staffing agency, on 2 separate occasions, to report the incident and that CNA T was no longer welcome to work at the facility. NHA A stated that then the situation of the false identity came about and that CNA S was posing to be CNA T while working at the facility. All the staff and residents knew her as CNA T, and no one had any idea she was not who she said she was. NHA A stated that the staffing agency finally returned her phone call and told them that CNA S had previously worked for the staffing agency, but she got blocked from working there due to attendance issues. CNA S stated she needed the money so she applied under her mother's name (CNA T) and then could continue to work through the agency. Surveyor asked NHA A what the screening process is for new /first time agency staff who report to the facility for a shift. NHA A explained that the staffing agency obtains all the required background (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information and upon hire, this information is uploaded to a shared portal that she has access to. NHA A is provided with all the information for each agency employee that is hired by the facility through this online portal. NHA A stated that upon orientation, the facility never asked the agency personnel to provide identification because they never had a reason to believe that the person showing up to work was not who they said they were. NHA A stated that the facility has a contract with the staffing agency and they do all the hiring. Once the person is hired, they put themselves out on this portal to pick up various shifts at various facilities who need to fill open shifts. Surveyor asked NHA A if she had reported this incident to the state survey agency. NHA A stated she did not because it was an active police investigation and she was charged for credit card fraud, not working at the facility under a false identification. NHA A stated the facility continues to use the staffing agency and at this point, no changes had been made to the process when new agency personnel show up for a shift how they verify their identity. As of exit, the facility was unable to provide additional information as to why they did not report the suspicion of a crime when they became aware that a staffing agency CNA (CNA S) was working under false identification. Example 3: R6 was admitted to the facility on [DATE]. On 2/21/26, CNA Q (Certified Nursing Assistant) alleged that another staff member had forced R6 out of his bed, despite R6 stating he did not want to get up. In an interview with Surveyors on 3/18/26, CNA Q stated that R6 stated to her in the morning of 2/21/26 that he did not want to get up for breakfast because he was in so much pain and wanted to wait for the nurse to deliver his morning medications before getting out of bed. CNA Q stated that she communicated this to another CNA who then indicated that R6 could not do that and went into R6's room and started yelling at R6 and forced R6 out of bed, while calling him racist. CNA Q stated to Surveyors that she felt this was abusive and reported it to the nurse, who then reported it to NHA A (Nursing Home Administrator). The facility conducted a thorough investigation into the allegation; however, the State Agency has no record of this being reported. On 3/18/26 at 10:57 AM, Surveyor interviewed NHA A who stated that she believed the allegation to sound of abuse and NHA A should have reported the incident to the state agency. NHA A stated that by the time she realized that the incident should have been reported to the facility, it was past due and then decided to not report it at all.

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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 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 interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, that all alleged violations are thoroughly investigated, and that steps were taken to prevent further abuse for 2 of 3 residents (R1) reviewed. The facility became aware of a resident-to-resident altercation between R1 and R5 on 2/16/26. The facility failed to do a thorough investigation and put interventions into place to prevent future occurrences. Evidenced by:The facility policy entitled Abuse, Neglect and Exploitation, dated 2025, states, in part: . Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.The components of the facility abuse prohibition plan are discussed herein: . The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: .B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified. staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; .D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect;E. Ensuring the health and safety of each resident.V. Investigation of Alleged Abuse, Neglect and ExploitationA. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B Written procedures for investigations include: .4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. VI. Protecting of ResidentThe facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:A. Responding immediately to protect the alleged victim and integrity of the investigation;B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed;C. Increased supervision of the alleged victim and residents.F. Providing emotional support and counseling to the resident during and after the investigation, as needed;G. Revision of the resident's care plan. R1 was admitted to the facility on [DATE] and has diagnoses that include paranoid schizophrenia (chronic mental disorder defined by intense, irrational delusions and auditory hallucinations, often involving persecution or conspiracy) and unspecified dementia severe with mood disturbance (significant cognitive decline coupled with behavioral symptoms like agitation, depression, apathy, or aggression. It results from brain damage, making communication difficult and causing emotional instability).R1's Minimum Data Set (MDS) Significant Change Assessment, dated 2/23/26, shows that R1 has a Brief Interview of Mental Status (BIMS) score of 02 indicating R1 has severe cognitive impairment.On 3/17/26 at 11:54 AM, Surveyor interviewed LPN C (Licensed Practical Nurse) who indicated on 2/16/26 CNA D (Certified Nursing Assistant) reported to her that R1 had slapped R5 across the face. LPN C indicated the two residents were separated immediately. LPN C indicated she assessed R5 for any red marks and then reported the incident to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the ADON (Assistant Director of Nursing), who is no longer employed at the facility. LPN C indicated the ADON directed LPN C to keep the two residents separated and keep an eye on them. Surveyor asked if vital signs or further follow up were completed with R5 and R1. LPN C indicated she had not completed any further assessing. LPN C indicated she had informed FM F (Family Member) of the incident as she was just arriving at that time to visit R5. LPN C indicated she then reported the incident to NHA A (Nursing Home Administrator). Surveyor asked LPN C if she documented the incident. LPN C indicated no. Surveyor asked LPN C if there were interventions put into place following this incident to prevent it from happening again. LPN C indicated she was not aware. LPN C indicated there was nothing put on the nurses 24-hour board or passed through in report when she worked her next shift. Surveyor asked LPN C if R1 has behaviors. LPN C indicated yes, paranoia, delusions, and aggressiveness with staff and residents. Surveyor asked what is meant by aggressiveness and LPN C indicated verbal aggressiveness that has been happening for a long time. Surveyor asked LPN C if she is aware of any other incidents regarding R1 and other residents. LPN C indicated yes, there was an altercation awhile back with R1 and R12. Surveyor asked LPN C what the facility's process is for a resident-to-resident altercation. LPN C indicated the staff are to separate the residents, make sure they are safe, and report it. LPN C indicated the facility would have to investigate and report it to the state.On 3/17/26 at 12:25 PM, Surveyor interviewed CNA D and asked if she was aware of an altercation between R1 and R5. CNA D indicated she had been charting in the conference room by the nurse station when R12 informed her R1 had just slapped R5's face. CNA D indicated R12 was right outside the conference room in the hallway and R1 and R5 were in front of R12. CNA D indicated she did not witness the slap. CNA D separated R1 and R5 immediately by taking R5 down the hallway. CNA D informed LPN C right away once CNA D separated the two residents and both residents were safe. Surveyor asked CNA D if R1 had ever struck another resident and CNA D indicated yes, R12. CNA D indicated R1 had slapped R12 on her face a year or so ago. Surveyor asked if R1 has behaviors. CNA D indicated yes, R1 gets combative with staff and gets verbally aggressive with staff and residents. Surveyor asked CNA D, after the incident between R1 and R5 were new interventions passed on to staff on how to prevent this from happening again. CNA D indicated no, the incident was passed on in report.On 3/18/26 at 9:25 AM, Surveyor interviewed CNA E. Surveyor asked if R1 has behaviors and CNA E indicated yes, R1 is verbally and physically aggressive with staff and residents. CNA E indicated a while back R1 hit R12. CNA E indicated she recently heard R1 had hit R5. Surveyor asked if CNA E was aware of any new interventions put into place after the incident with R1 and R5. CNA E indicated no and explained CNA E would know because she is responsible for updating the CNA cheat sheets. The cheat sheets direct the CNAs how to care for the residents. CNA E indicated if there were new interventions she would have known to add them onto those sheets. CNA E indicated she is to update the cheat sheets every week. Surveyor asked CNA E what R1's typical day is like. CNA E indicated when R1 is not sleeping, R1 tootles around the unit independently. Surveyor asked CNA E if R1 participates in activities. CNA E indicated we try but R1 will not stay in the activities. On 3/18/26 at 11:00 AM, Surveyor interviewed NHA A and asked what the facility's process is for a resident-to-resident altercation. NHA A indicated that staff report the incident to her. NHA A then reports it to the state, investigates it and provides education. Surveyor asked NHA A if she was aware of an incident between R1 and R5 on 2/16/26. NHA A indicated she does not recall. Surveyor asked NHA A if staff had informed her of R1 slapping R5 on 2/16/26. NHA A indicated on 2/16/26 LPN C or ADON at that time did report that R12 witnessed R1 slapping R5. Surveyor asked NHA A who had reported the incident to the ADON. NHA A could not recall. Surveyor asked whom R12 reported the incident. NHA A indicated she could not recall. Surveyor asked if there was any documentation on this incident. NHA A indicated no it was just conversation. Surveyor asked NHA A if there should be documentation; NHA A indicated yes. Surveyor asked what NHA A had done with the information she received from staff. NHA A indicated she talked to R12. R12 indicated that R1 did not slap R5. R12 indicated to NHA A that R1 was tapping R5 on the face. NHA A indicated R1 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and R5's wheelchairs had somehow hung up together. NHA A indicated there were no words exchanged between R1 and R5. NHA A indicated nothing more was done with the incident or documented; she had no concerns after talking with R12 about the incident. Surveyor asked if there was any follow up with R1 and R5 after the conversation with staff and R12. NHA A indicated no. Surveyor asked if NHA A interviewed the CNA and nurse that had reported it. NHA A indicated no. Surveyor asked if the facility interviewed other residents to see if there were concerns regarding R1 and their safety in the facility. NHA A indicated no. Surveyor asked NHA A how it was determined not to investigate this resident-to-resident altercation. NHA A indicated R12 stated R1 lightly tapped R5 on the face. Surveyor asked NHA A should a resident-to-resident altercation be investigated? NHA A indicated yes. Surveyor asked NHA A if this incident could have been potentially reportable to state. NHA A indicated yes. Surveyor asked if there should have been documentation on this incident; NHA A indicated yes.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal hygiene for 6 (R6, R7, R8, R9, R10, R11) of 12 residents reviewed for Activities of Daily Living (ADLs). R6, R7, R8, R9, R10, and R11 expressed long call light wait times. Facility documentation shows residents waited an hour or more for ADL care when prompted with their call lights. Findings includeThe facility uses a call light system that alarms mini mobile devices on each of the facility's 2 resident floors (2nd floor and 3rd floor). When a resident uses their call light to notify staff of a need, the devices for that floor sound an alarm. The devices are meant to be carried so that nursing staff can hear the alarms while they are on the floor providing cares and services on behalf of the residents. There is no central hub that alarms, nor are their any indicators outside of each room (light above door, sound near door, etc.). On 3/18/26 at 9:20 AM, Surveyor interviewed CNA G (Certified Nursing Assistant) who stated that there are supposed to be 4 mobile devices on each floor for each of the scheduled CNAs, but some have gone missing so there are currently only 2 on the third floor. CNA G stated that staff usually leave one in the central nursing area and check on it when they have time in passing. CNA G stated that she believes many call lights do not get answered timely or at all due to not hearing the tone because there are not enough mobile devices and often CNAs are too busy to stop by the central nursing station to check the devices for alerts. CNA G showed Surveyor the mobile device that was laying on the table in a closed off room at the nursing station. The device showed active alarms and resolved alarms and the length of time that each took to be resolved. On 3/18/26 at 9:34 AM, Surveyor interviewed CNA H who stated that she gets complaints daily of long call light wait times from residents. When asked if she believed the lack of mobile devices has anything to do with these complaints, CNA H stated, Absolutely.Example 1R6 was admitted to the facility on [DATE]. His most recent Minimum Data Set (MDS), dated [DATE], shows a Brief Interview for Mental Status (BIMS) score of 13, indicating R6 is cognitively intact.On 3/18/26 at 3:40 PM, R6 indicated that he has waited, at times, for up to 45 minutes for care when using his call light.The call light log that was presented to Surveyor by CNA G indicated that on 3/18/26, R6 waited 1 hour and 32 minutes (time stamped at 8:51 AM) for cares to be given. Example 2R7 was admitted to the facility on [DATE]. Her most recent MDS, dated [DATE], shows a BIMS score of 15, indicating R7 is cognitively intact.On 3/17/26 at 10:25 AM, R7 indicated to Surveyors that she has waited, at times, for up to 45 minutes for care when using his call light.Example 3R8 was admitted to the facility on [DATE]. His most recent MDS, dated [DATE], shows a BIMS score of 15, indicating R8 is cognitively intact.On 3/18/26 at 2:27 PM, R8 indicated that he has waited, at times, for over an hour and a half for care when using his call light.The call light log that was presented to Surveyor by CNA G indicated that on 3/18/26, R8 waited 1 hour and 34 minutes (time stamped at 7:47 AM) for cares to given. Example 4R9 was admitted to the facility on [DATE]. His most recent MDS, dated [DATE], shows a BIMS score of 15, indicating R9 is cognitively intact.On 3/18/26 at 2:31 PM, R9 indicated that he has waited, at times, for up to 4 hours for care when using his call light and, on multiple occasions, has not gotten a response at all. R9 stated the response time is, Horrible.The call light log that was presented to Surveyor by CNA G indicated that on 3/18/26, R9 waited 1 hour and 10 minutes (time stamped at 5:11 AM) for cares to given. Example 5R10 stated to Surveyors on 3/18/26 at 1:19 PM that she frequently waits over an hour when using her call light.The call light log that was presented to Surveyor by CNA G indicated that on 3/18/26, R10 waited 2 hours and 36 minutes (time stamped at 7:37 AM) for cares to given. Example 6R11 was admitted to the facility on [DATE]. Her most recent MDS, dated [DATE], shows a BIMS score of 15, indicating R11 is cognitively intact.On 3/18/26 at 2:15 PM, R11 indicated that she was waited over 2 hours lately for care when using her call light.The call light log that was presented to Surveyor by CNA G indicated that on 3/18/26, R11 waited 50 minutes (time stamped at (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:40 AM) for cares to given. On 3/18/26 at 10:57 AM, Surveyor interviewed NHA A (Nursing Home Administrator) who stated that the facility has had some trouble with their call light system, which is new to the facility. NHA A stated that there have been some problems with the wireless internet in the building, which is a requirement for the mobile devices to work properly. NHA A stated that this is now fixed. When asked if each of the 4 CNAs scheduled on each floor should have a device to answer call lights, NHA A stated yes. Surveyor asked NHA A if she was aware that some of the mobile devices were missing, NHA A indicated she was unaware. NHA A indicated that call lights could possibly go unanswered if CNAs are not properly notified.

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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, interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 1 of 4 residents (R1) reviewed for falls.R1 had a history of falls including one that resulted in multiple rib fractures. The facility did not complete a thorough root cause analysis on the falls or ensure that care planned interventions were in place for R1.As evidenced by:Facility policy, titled Falls - Clinical Protocol, with last revision date of March 2018, states, in part: Assessment and Recognition: 1. The physician will help identify individuals with a history of falls and risk factors for falling. c. While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause. 2. In addition, the nurse shall assess and document/report the following: . c. Musculoskeletal function, observing for change in normal range of motion. g. Frequency and number of falls since last physician visit; h. Precipitating factors, details on how fall occurred. Cause Identification: 1. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. a. Often multiple factors contribute to a falling problem. 3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. Treatment/Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on assessment of the nature or category of falling, until falling reduces or stops. Monitoring and Follow-Up:. 2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls. 4. If the individual continues to fall, the staff and physician will reevaluate the situation and reconsider possible reasons for the resident's falling. and also reconsider the current interventions.R1 was readmitted to the facility on [DATE] with diagnoses that include, in part: paranoid schizophrenia (mental health illness where paranoia and delusions are prominent), unspecified dementia severe with mood disturbance, unsteadiness on feet, pain in right hip post fall, muscle wasting and atrophy (wasting away as a result of degeneration of cells), delusional disorder, post-traumatic stress disorder, altered mental status, pain in right and left shoulder, chronic kidney disease and Type 2 diabetes mellitus.R1's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/23/26, indicates R1 has a Brief Interview of Mental Status (BIMS) of 2 out of 15, indicating R1 is severely cognitively impaired. Section GG of R1's MDS indicates R1 uses a wheelchair and requires partial/moderate to substantial/maximum assistance for all Activities of Daily Living (ADLs). Section H of R1's MDS indicates that R1 is frequently incontinent of bladder.R1's electronic medical record includes multiple John Hopkins Fall Assessment Tools with scores of 18-21, which indicate R1 is a high fall risk. R1's comprehensive care plan, includes, in part:-Focus: Resident on a scheduled toileting plan every 2-4-hour checks for safety awareness, fall prevention, continued education to resident, and toileting as needed. Date Initiated: 4/20/25.-Approach: Adapt environment to maximize fall prevention with safety awareness, prevention of falls with staff intervention and monitoring, interventions in place with every 2-3-hour toileting checks. Date Initiated: 4/20/25-Focus: Interventions in place to decrease risk of falls. Resident has cognition issues that hinder safety awareness with removal of safety precautions. Date Initiated: 4/14/25.--Approach: Pool noodle on outer side of bed to remind resident where edge of bed is to prevent rolling out of bed. Replace noodle as needed and gently remind resident that noodle is placed for safety. Date Initiated: 4/14/25. Staff to check that resident has cushion in chair and replace when removed. Date Initiated: 4/14/25. Staff to gently remind (continued on next page)

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	525241	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd Edgerton, WI 53534

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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 0689 Level of Harm - Actual harm Residents Affected - Few	resident to have grippy socks on feet and assist with placement. Date Initiated: 4/14/25.--Focus: Basic CNA (Certified Nursing Assistant) Care Plan. Date Initiated: 9/13/24.--Approach: Devices: WC (wheelchair) with auto lock brakes.Grip socks on at all times. (Does remove herself and needs monitoring to ensure placement) . May use EZ stand and 2 assist for toileting and weakness. Scoop mattress. Broda chair. Transfers: 2 assist squat pivot transfer. Date Initiated: 9/13/24.--Focus: Resident at risk for falling r/t_____ (blank). Date Initiated: 9/14/17.--Approach: Call, don't fall signage placed in room as reminder to call for assistance. Date Initiated: 2/12/26. Scoop mattress. Date Initiated: 1/26/26. Staff to make bed after resident is up in am. Will try to make on own. Date Initiated: 11/24/25. When assisting resident with pm cares help her into her pajamas. If resident refuses to change clothes, reapproach at a later time to assist her. Date Initiated: 10/7/25. Gripper strips on floor in BRM (bedroom). Gripper strips next to bed on floor. Ensure that gripper strips are changed as needed when frayed or worn down. Date Initiated: 7/17/25. With increased restlessness E/B (evidenced by) wheeling self in hallway, offer distraction activities and bring to nursing area for increased supervision. Date Initiated: 6/16/25. New low WC delivered. Auto lock brakes used for safety. Date Initiated: 5/27/25. Bed in low position when [Resident Name] is in bed, keep at knee level when out of bed for easier transfers. Date Initiated: 5/24/25. Resident tends to remove fall interventions and needs reminders to keep in place and staff to reimplement interventions when resident has removed. Staff to reapproach patient as needed when [Resident Name] is unable to redirect. Date Initiated: 3/31/25. Keep WC (wheelchair) close to bed. Date Initiated: 3/12/25. Frequent rounds with change of shift, am/pm cares, meals, scheduled activities, routine toileting and NOC (overnight) rounds. Ensure that feet have grippy socks in place. Date Initiated: 7/3/24. Resident is to wear gripper socks at all times. Will frequently remove. Staff to monitor and assist with placement. Explain to [Resident Name] that foot covering should be worn for safety to prevent falls. Date Initiated: 7/3/24.On 9/5/25 at 7:10 PM, R1 had an unwitnessed fall in her room. The fall incident report indicates, in part: 5 Whys: Resident found on floor. Stated she slid out of bed. Grippy socks on floor next to her. Getting ready for bed. Was previously laid down without jammies. Combative while providing cares. Care planned to reapproach if combative or agitated with cares. Resident was to be reapproached. Skin check revealed bruising on top of right and right buttock. Intervention: gripper socks, analgesics, low bed and floor mat. Root cause: resident was to be reapproached. No injury noted.On 10/12/25 at 7:51 PM, R1 had an unwitnessed fall in her room. The fall incident report indicates, in part: Patient was heard falling out of bed. This RN was walking past her room [ROOM NUMBER] minutes prior and she was in bed. Patient stated she was trying to get up. Intervention: Maintenance to review resident's wheelchair. No injury noted. No root cause identified.(Of note: this is the 2nd time R1 has fallen out of bed.) On 10/22/25 at 7:03 PM, R1 had an unwitnessed fall in a peer's room. The fall incident report indicates, in part: Writer heard resident say ?help me' and observed to be sitting on floor with left leg bent inward, in door frame of bathroom, in front of her w/c (wheelchair) at the end of [Resident Room Number] bed. Wearing non-skid tennis shoes. Resident had paper towel in her hand and urine observed on the floor. When asked what happened she stated ?I don't know' and ?I went down'. abrasion to inner right thigh observed from left shoe rubbing inner right thigh.Intervention: gripper socks, rest, and low bed. No injury noted. No root cause identified.On 10/27/25 at 9:20 AM, R1 had an unwitnessed fall in her room. The fall incident report indicates, in part: Resident found on floor next to her bed. Last time she was seen at 0800 (8:00 AM) she was laying in bed. W/c was in bathroom doorway when found turned outward. Resident stated she went to the bathroom, fell, and crawled back to bedside. No injury noted.No root cause identified. No new intervention was put in place.(Of note: this is the 3rd time R1 has fallen out of bed/near the bed and the 2nd of R1's falls related to going to the bathroom).On 11/1/25 at 9:30 PM, R1 had an unwitnessed fall in her bathroom. The fall incident report indicates, in part: . Writer was in hallway and heard ?help me someone'. Resident observed to be sitting on buttocks, on floor of bathroom, with knees bent and legs spread out, barefoot. Gripper socks observed on floor next to her. W/c in door frame. When asked (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	what happened she told writer ?I don't know'.No root cause identified. No new intervention was put in place.(Of note: this is the 3rd time R1 has fallen related to going to the bathroom.)On 11/1/25 at 9:40 PM, a nursing progress note was entered into R1's electronic medical record which states, in part: This writer assessed resident after she was found on the floor of the bathroom. This fall was unwitnessed. She states she went to turn around to get onto the toilet when she lost her balance and fell. Bathroom pull cord was activated and one of the wheelchair brakes were locked. No physical injury noted. she complains of moderate left rib and left ankle pain. resident's pj (Pajamas) and entire bedding were soaked with urine. Bedding and clothing changed. Pain appears to subside with rest.(Of note: this is the 4th time R1 has fallen related to going to the bathroom).On 11/2/25 at 9:02 PM, R1 had an unwitnessed fall in her room. The fall incident report indicates, in part: Resident was unable to state what happened. Walked in and resident was sitting with back against bed and butt on floor. Bed was in lowest position. All she stated was ?help me. No injury noted. No root cause identified. Intervention: gripper socks and rest.(Of note: this is the 4th time R1 has fallen out of bed or near the bed).On 11/22/25 at 8:51 AM, R1 had an unwitnessed fall in her room. The fall incident report indicates, in part: Resident was found laying on her right side next to her bet. She admits to falling stating ?I was trying to make my bed'. She notes some right shoulder and hip pain. Grimacing and increased complaints of pain noted with right shoulder and right hip movement. provider notified. POA (power of attorney) notified and requested that resident was evaluated at [Hospital Name] . New intervention added to care plan for staff to make resident bed in the AM when resident is out of bed.(Of note: this is the 5th time R1 has fallen out of bed or near the bed.)R1's ER notes, dated 11/22/25, indicate, in part: . presented to ED (emergency department) via EMS for evaluation of fall and left rib cage pain. She fell from wheelchair this morning. currently she reports right shoulder pain and pain in left rib cage.her fall was unwitnessed. in ED she was found to have multiple anterior (front of body) and anterolateral (anterior and lateral (side)) acute left rib fractures. traumatic/due to trauma from fall. was admitted as observation for pain control.On 11/23/25 at 4:14 PM, Nurse progress note states the following, in part: Res(ident) returned from her 24-hour hospital observation, around 2 pm. Received report prior to discharge. right hip x-ray negative, 5 rib fractures noted on her left side.On 1/23/26 at 8:47 PM. R1 had an unwitnessed fall in her room. The fall incident report indicates, in part: . Resident slid off edge of her bed on to the floor, the bed was in the lowest position, she had nothing on her feet, was dressed in a night gown, no injuries. No root cause identified.(Of note: this is the 6th time R1 fell out of bed/near the bed).On 1/31/26 at 2:25 PM, R1 had an unwitnessed fall in peer's room. The fall incident report indicates, in part: .Resident found sitting on the floor of [Room Number]. Appeared to be organizing blankets/stuffed animals in another resident's room. No injury noted.No root cause identified. No new intervention in place.(Of note: this is the 2nd unwitnessed fall for R1 in another Residents room)On 2/12/26 at 12:30 AM, R1 had an unwitnessed fall in her room. The fall incident report indicates, in part: Resident was found by CNA sitting on the floor next to her bed in low position. W/c a few feet away from bed and locked. Resident attempted to self-transfer from her bed to her w/c. Resident noted to have been incontinent of urine at the time of the fall. Interventions: gripper socks.No root cause identified. New care plan intervention added of a call don't fall sign.(Of note: this is the 7th time R1 had a fall out of bed/near the bed and the 5th fall R1 had while incontinent or relating to going to the bathroom).On 3/12/26 at 1:04 PM, R1 had a witnessed fall in her room. The fall incident report indicates, in part: Responded to resident's room post fall. Resident was found laying face down on the floor. Housekeeper was in the room at the time of the fall. Per housekeeper and resident, resident was attempting to tie her shoes. Redness noted to left knee and small abrasion noted to right knee. some minor complaints of pain but nothing specific. hospice notified of fall and hospice to send nurse out.No root cause identified. No new interventions were put in place.On 3/18/26 at 9:40 AM, Surveyor observed R1 in a wide low wheelchair in the hallway attempting to self-propel herself. Surveyor observed that R1 was wearing gripper socks, and that she had slid down in the wheelchair seat. On 3/18/26 at 9:45 AM, Surveyor (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	observed R1's room and observed that R1's bed was stripped and not made.On 3/18/26 at 10:04 AM, Surveyor interviewed agency LPN I (Licensed Practical Nurse) about R1's fall interventions. LPN I stated that today was her first time working with R1, and she would have to look up her fall interventions on her care plan.On 3/18/26 at 10:07 AM, Surveyor interviewed CNA G (Certified Nursing Assistant) about R1's fall interventions. CNA G stated that R1's fall interventions included to make sure she has shoes on and that they are tied, a fall mat, low bed, Dycem on her wheelchair, keeping her close to the nurse's station. CNA G indicated that everyone keeps an eye on R1, because she is a big fall risk. Surveyor asked CNA G if she had received any recent education on fall interventions. CNA G stated that she couldn't think of anything recent, but that they had a skills fair a year ago that included using the mechanical lifts safely.On 3/18/26 at 10:14, CNA G and CNA H stood R1 up and confirmed that R1 did not have dycem or anything else in her chair. Surveyor observed CNA G and CNA H go to R1's room to look for her Dycem and were unable to locate any. CNA G stated that she would ask therapy for more Dycem to put in R1's wheelchair. CNA H stated that R1 should have Dycem in her wheelchair to keep from sliding down, but that she had not gotten R1 up that morning. On 3/18/26 at 10:19 AM, Surveyor interviewed agency CNA J who indicated that she had gotten R1 up and ready this morning. Surveyor asked CNA J what R1's fall interventions were. CNA J stated R1's fall interventions included bed all the way down and to have her wheelchair nearby, since R1 does try to transfer herself. Surveyor asked if R1 had Dycem for her wheelchair. CNA J stated that no, R1 did not have any dycem that she was aware of. Surveyor asked CNA J where she would find R1's fall interventions. CNA J stated that she would look on the charting system in her care plan. Surveyor asked CNA J if R1 had ever slid out of her wheelchair. CNA J stated that R1 slides down in her wheelchair all the time and they have to boost her up. CNA J stated that 9 times out of 10 that is how R1 has fallen, by sliding out of her wheelchair. CNA J indicated that she had not received any education or training on fall interventions because she was agency.On 3/18/26 at 10:40 AM, Surveyor interviewed DOR K (Director of Rehab) about R1's fall interventions. DOR K stated that R1 has poor cognition and that she can't retain safety information. DOR K stated that they have assessed R1 after several of her falls and will make recommendations for her care plan and get orders as necessary, like for a gel wheelchair cushion, which R1 ripped apart. Surveyor asked if any of R1's falls were a result of sliding out of her wheelchair. DOR K stated that yes, R1 had slid out of her wheelchair, and that she is supposed to have Dycem under her wheelchair cushion so that the cushion doesn't slide out. DOR K stated that R1 will often remove the cushion and the Dycem, and that her Dycem needs to be replaced weekly.On 3/18/26 at 1:54 PM, Surveyor interviewed DON B (Director of Nursing) about R1's multiple falls. DON B stated that she had only been working at the facility since February. Surveyor asked DON B if root cause analysis had been completed for R1's falls. DON B stated that the IDT (interdisciplinary team) does the 5 Whys but that she was not sure when they started doing that. DON B stated that R1 has decreased safety awareness and decreased cognition, and she doesn't remember that she is declining in abilities and mobility. Surveyor asked DON B how often R1's fall interventions were reviewed by the IDT for effectiveness. DON B stated that usually when a resident has a fall the IDT tries to look at them. DON B indicated that she has been going through the care plans to review them, but she hadn't gotten to R1's yet. Surveyor asked DON B if a call don't fall sign would be an effective intervention for R1 given her decreased cognition. DON B stated no, that would not be a good intervention for R1. Surveyor asked DON B if an intervention of Dycem should be on R1's care plan, given her falls out of her wheelchair, so that all staff, even agency would know about it. DON B stated yes, Dycem should be on R1's care plan. Surveyor asked DON B if there had been any staff education recently about fall prevention. DON B stated that she would have to look, and indicated that yes, there should be staff education about fall prevention. Surveyor asked DON B if she would expect R1's care plan to be updated with effective fall interventions, and if she would expect R1's care planned interventions to be followed. DON B stated yes, that was her expectation.The facility failed to identify a true root cause for R1's repeated falls and failed to ensure that the fall (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	interventions on R1's care plan were appropriate and adequately enforced. R1 had multiple falls, including one that resulted in major injury.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility did not complete a performance review of every nurse aide at least once every 12 months for 2 of 5 Certified Nursing Assistants (CNA) reviewed.CNA U did not have an annual performance review.CNA H did not have an annual performance review.Evidenced by:The facility's Performance Evaluations policy, dated 9/2020, states, in part: The job performance of each employee shall be reviewed and evaluated at least annually. 1. A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter.CNA U was hired 1/28/15. CNA U did not have an annual performance evaluation completed for 2025.CNA H was hired 8/21/19. CNA H did not have an annual performance evaluation completed for 2025.On 3/26/26 at 2:31 PM, Surveyor interviewed CNA H about performance evaluations. CNA H stated I don't recall having one. I have received paperwork about whether or not there was a raise, but no information about my performance.On 3/26/26 at 2:16 PM, Surveyor interviewed HRM W (Human Resources Manager) about performance evaluations. HRM W stated the evaluations for 2025 for CNA U and CNA H had been started by the past DON (Director of Nursing) but were not completed. HRM W stated that an annual evaluation is required.On 3/26/26 at 2:18 PM, Surveyor interviewed NHA A (Nursing Home Administrator) who stated she would expect staff to have an annual performance evaluation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 1 of 3 Residents (R2) were free from significant medication errors. R2's medication was given late per documentation from 1/14/26 to 2/15/26. Findings Include: A policy titled Administering Medications Revised April 2019 documented:Medications are administered in a safe and timely manner, and as prescribed.Policy interpretation and implementation. Medications are administered in accordance with prescriber orders, including any required time frame.Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:enhancing optimal therapeutic effect of the medication;preventing potential medication or food interactions; andhonoring resident choices and preferences, consistent with his or her care plan.Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff trainingmedications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). R2 was admitted on [DATE] with diagnoses that include Parkinsonism (an umbrella term for neurological disorders causing movement problems, including slowness, rigidity, tremor, and balance issues with symptoms worsening over time). R2's Physician orders indicate: Carbidopa-Levodopa 25-100 mg (milligrams), 1 tablet, 3 times a day, 1/14/26 -1/16/26. Scheduled 8:00 AM, 3:00 PM, 8:00 PMThe following dates and times were administered late:1/14/26 at 4:41 PM, scheduled 3:00 PM, given 41 minutes late.1/15/26 at 9:06 AM, scheduled 8:00 AM, given 6 minutes late. Carbidopa-Levodopa 25-100 mg, 1 tablet, 3 times a day, special instructions: Take 1 tab TID (3 times a day). Resident is requesting administration 1 hour prior to meals per home routine. 1/16/26 -2/13/26. Scheduled 7:00 AM, 11:00 AM, 4:00 PM.The following dates and times were administered late:1/16/26 8:45 AM, scheduled 7:00 AM, given 45 minutes late.1/16/26 12:23 PM, scheduled 11:00 AM, given 23 minutes late.1/16/26 5:35 PM, scheduled 4:00 PM, given 35 minutes late.1/17/26 5:38 PM, scheduled 4:00 PM, given 38 minutes late.1/18/26 12:22 PM, scheduled 11:00 AM, given 22 minutes late.1/19/26 12:08 PM, scheduled 11:00 AM, given 8 minutes late.1/21/26 12:19 PM, scheduled 11:00 AM, given 19 minutes late.1/21/26 5:38 PM, scheduled 4:00 PM, given 38 minutes late.1/22/26 12:45 PM, scheduled 11:00 AM, given 45 minutes late.1/23/26 6:57 PM, scheduled 4:00 PM, given 2 hours and 57 minutes late.1/24/26 8:30 AM, scheduled 7:00 AM, given 30 minutes late.1/24/26 5:20 PM, scheduled 4:00 PM, given 20 minutes late.1/25/26 8:58 AM, scheduled 7:00 AM, given 58 minutes late.1/25/26 2:07 PM, scheduled 11:00 AM, given 3 hours and 7 minutes late.1/25/26 7:57 PM, scheduled 4:00 PM, given 3 hours and 57 minutes late.1/28/26 8:10 AM, scheduled, 7:00 AM, given 10 minutes late.1/28/26 12:01 PM, scheduled 11:00 AM, given 1 minute late.1/28/26 5:12 PM, scheduled 4:00 PM, given 12 minutes late.1/29/26 12:18 PM, scheduled 11:00 AM, given 18 minutes late.2/1/26 8:34 AM, scheduled 7:00 AM, given 34 minutes late.2/2/26 6:48 PM, scheduled 4:00 PM, given 2 hours and 48 minutes late.2/4/26 1:13 PM, scheduled 11:00 AM, given 2 hours and 13 minutes late.2/4/26 10:43 PM, scheduled 4 PM, given 6 hours and 43 minutes late.2/5/26 8:58 AM, scheduled 7:00 AM, given 58 minutes late.2/7/26 12:04 PM, scheduled 11:00 AM, given 4 minutes late.2/9/26 12:15 PM, scheduled 11:00 AM, given 15 minutes late.2/9/26 9:53 PM, scheduled 4:00 PM, given 5 hours and 53 minutes late.2/10/26 8:08 AM, scheduled 7:00 AM, given 8 minutes late.2/11/26 12:05 AM, scheduled 11:00 AM, given 5 minutes late. Carbidopa-Levodopa 25-100 mg, 1 tablet, 3 times a day, special instructions: Take 1 tab TID (3 times a day). Resident is requesting administration 1 hour prior to meals per home routine. {PLEASE GIVE ON TIME! } 1/16/26 -2/13/26. Scheduled 7:00 AM, 11:00 AM, 4:15 PM.The following dates and times were administered late:2/15/26 8:29 AM, scheduled 7:00 AM, given 29 minutes late.2/15/26 2:10 AM, scheduled 11:00 AM, given 3 hours and 10 minutes late. On 3/17/26 at 10:17 AM, Surveyor interviewed R2. R2 stated she had concerns of getting medications on time and now self-administers medications as R2 does at home. R2 stated R2 has no other concerns (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with medications currently.On 3/18/26 at 11:08 AM, Surveyor interviewed DON B (Director of Nursing). DON B stated she started the role at the end of February 2026. DON B expects medications to be given 1 hour before or after the medication time listed in the Electronic Medical Record (EMR). DON B stated if a medication is late, DON B expects nursing staff to fill out a medication error report, notify the resident's physician, and notify the resident or responsible party. DON B informed Surveyor that DON B does not think staff fill out medication error reports. DON B informed Surveyor that DON B is aware of the medication administration times as an issue and is currently working on fixing the issue. DON B stated the facility has hired more staff and have the Medication Technicians work a longer shift instead of a partial shift. Surveyor shared the concern with DON B of R2's medications not being given on time resulting in a significant medication error. No further information has been provided by the facility at this time. R2's Carbidopa-Levodopa was not administered per physician orders for at least 32 different administration times as evidence by being administered late.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd Edgerton, WI 53534

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility did not dispose of garbage and refuse properly. This has the potential to affect all 54 residents. The facility did not ensure that lids on the dumpster were shut and secured to prevent pests.This is evidenced by: The facility policy titled, Sanitization, states in part: . 14. Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters with lids. On 3/26/26 at 10:25 AM Surveyor observed one lid open on recycling dumpster, and one lid open on regular trash dumpster.On 3/26/26 at 11:10 AM Surveyor interviewed DM V (Dietary Manager). Surveyor asked DM V if she knew why the dumpster lids would be open. DM V stated that sometimes the wind will catch them or when the truck comes to dump the trash the lid will remain open. Surveyor asked DM V what days they pick up trash. DM V stated Monday, Wednesday, and Friday for regular trash, and only Fridays for recycling dumpster. DM V stated that her staff tries to remember to shut the lids when the trash is taken out. Surveyor asked DM V how often her staff takes the trash out. DMV stated that each position in the kitchen is responsible for different stations, trash cans and everything is emptied daily. Surveyor asked would you expect one of your staff to see the trash lid open and close it, DM V stated yes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	03/26/2026

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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 0948 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that paid feeding assistants have the training they need. Based on interview and record review, the facility did not assure that the Feeding Assistant Program included annual training and skills review for 2 of 4 feeding assistants reviewed.The facility did not provide annual training or skills monitoring, per state regulations for two Feeding Assistants.This is evidenced by:Wisconsin's State requirements for Feeding Assistants, specified in 42 CFR 483.60(h), includes, in part: . Feeding Assistants must receive an annual in-service on relevant feeding assistant topics (any topic area included in the curriculum is appropriate). In addition, Feeding Assistants must be evaluated on a yearly basis to document that their skill performance and feeding competence is satisfactory .Surveyor reviewed DOR K's (Director of Rehabilitation) Feeding Assistant Training Program documents and noted that the facility developed a state approved Feeding Assistant Program and identified DOR K as a Feeding Assistant. DOR K successfully completed training and skills review on 4/17/24 for this program. Surveyor did not see any annual training for DOR K since completing the program on 4/17/24.Surveyor reviewed [NAME] V's Feeding Assistant Training Program documents and noted that the facility developed a state approved Feeding Assistant Program and identified [NAME] V as a Feeding Assistant. [NAME] V successfully completed training and skills review on 4/17/24 for this program. Surveyor did not see any annual training for [NAME] V since completing the program on 4/17/24.On 3/26/26 at 11:00 AM, Surveyor interviewed [NAME] V who stated there had been no additional training following completion of the Feeding Assistant Program.On 3/26/26 at 11:31 AM, Surveyor interviewed HR W (Human Resources) about the Feeding Assistant Program. HR W stated that no additional training had been done for feeding assistants as HR W was not aware of the requirement for annual training and skills review for feeding assistants.On 3/26/26 at 1:56 PM, Surveyor interviewed NHA A (Nursing Home Administrator) who stated she would expect that refresher training would be completed per state regulation.