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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>525279 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>08/06/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Tudor Oaks Health Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>S77 W12929 McShane Dr<br>Muskego, WI 53150 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on record review and staff interviews, the facility did not always ensure that 3 out of 5 residents reviewed (R11, R297, R298) were free from physical and verbal abuse.</p> <p>R11 was provided cares by an agency CNA (Certified Nursing Assistant) on 6/15/25. During this time, a facility CNA was present in the room and did not intervene when she witnessed the agency CNA being rough with R11.</p> <p>R297 and R298 were allegedly both physically and verbally abused by a facility Registered Nurse on 6/18/25. The facility staff did not ensure that R297 and R298 were kept safe and free from any additional abuse by immediately reporting the allegations of abuse.</p> <p>Findings include:</p> <p>The facility's policy dated as implemented on 4/24/25 and titled, Abuse, neglect and Exploitation documents: 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.VI. Protection 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.</p> <p>1.) On 8/4/24, Surveyor conducted a review of the facility's self-reported incident involving R11 on 6/15/25. The facility's report documents that R11 made a complaint that CNA (Certified Nursing Assistant)- J was rough during cares. R11 stated that "CNA- J pulled my legs hard apart to put brief on, and also (CNA- J) was rough wiping her with the washcloths". The time of this occurrence was documented at 5:20 AM on 6/15/25.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Surveyor conducted review of the facility's investigation into R11's allegations. The investigation included a written statement from CNA- F who was present in R11's room while CNA- J was providing cares to R11. CNA- F stated that CNA-J asked her to help change R11. When CNA- J started cleaning R11 with the washcloths, she was very rough. R11 was telling CNA- J that she was hurting her. CNA- J said "sorry" but continued. When CNA- J was cleaning the backside of R11, she was rough again and R11 made another statement saying, "stop you are being so rough". CNA-J said "sorry". R11 then stated, "why do you keep saying sorry but still continuing to be rough with me". When it was time to roll R11 towards CNA- J. CNA-J pulled R11 by the arm. R11 yelled out "OW". CNA- F stated that she finished getting R11 comfortable and CNA-J walked out of the room mumbling under her breath. After the cares were completed, CNA- F did report her concerns to Nurse on the unit who then checked on R11 to make sure she felt safe. Nursing Home Administrator (NHA)- A was made aware of the situation and CNA- J was asked to leave the building and to not return until an investigation was complete.</p> <p>On 8/4/25 at 2:34 PM, Surveyor interviewed SSD (Social Services Director)- E who completed the investigation regarding the allegation of abuse/ rough treatment by CNA-J. SSD-E confirmed that CNA- F did write in her witness statement that she observed rough treatment to R11 by CNA- J. Surveyor asked SSD- E if the expectation would be that CNA- F should have intervened to keep R11 safe from further rough /abusive treatment. SSD- E state that yes, CNA- F should have tried to diffuse the situation right away saying something like "I can take over for you" or "can I help you with this". CNA- F would have been expected not to leave the room until she was sure that R11 was safe. Surveyor asked SSD- E if she was aware how long the interaction between CNA -J, CNA- F and R11 lasted. SSD- E stated that they have record that R11 placed her call light on at 5:03 AM on 6/15/25. Staff stated that they immediately went in by R11 to provide cares to her and then exited the room at approximately 5:20 AM on 6/15/25.</p> <p>On 8/5/25 at 7:35 AM, Surveyor interviewed NHA (Nursing Home Administrator)-A regarding the allegation that CNA- J was rough with R11 while providing cares and this was witnessed by CNA-F who did not intervene. NHA- A stated that yes, CNA-F should have immediately intervened to protect R11 from any potential harm. NHA- A stated that CNA-F had been previously trained on abuse prevention and that protecting the resident comes first.</p> <p>No additional information had been provided as to why CNA- F did not keep R11 safe from further potential harm when she witnessed CNA- J being rough with R11 during cares.</p> <p>2.) R297's diagnoses includes dementia (loss of cognitive function that interferes with a person's daily life &amp; activities), paraplegia (loss or impairment of motor &amp; sensory functions in both lower legs), heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and anxiety disorder.</p> <p>R297's quarterly MDS (minimum data set) with an assessment reference date of 6/10/25 has a BIMS (brief interview mental status) score of 2 which indicates severe cognitive impairment. R297 is assessed as being dependent for toileting hygiene, requires substantial/maximal assistance for rolling left &amp; right, is frequently incontinent of urine and always incontinent of bowel.</p> <p>On 8/6/25, at 8:39 a.m., Director of Social Services (DSS)-E provided Surveyor with Facility Reported Incidents (FRI) Surveyor had requested.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 8/6/25, at 9:20 a.m. Surveyor spoke with Anonymous Staff (AS)-F on the telephone. During this conversation AS-F informed Surveyor Registered Nurse (RN)-H verbally and physically abused two residents and provided Surveyor with the names of two residents including R297. AS-F informed this abuse occurred on the same night. Certified Nursing Assistant (CNA)-I reported this abuse to Registered Nurse (RN)-C and CNA-I wrote a statement which was placed under the Director of Nursing (DON)-B's door.</p> <p>Surveyor reviewed the Facility Reported Incident for R297. Surveyor noted the date occurred is documented as 6/18/25 and date discovered documents 6/19/25. Under brief summary of incident documents while Administrator and Director of Social Services were meeting with [name of Certified Nursing Assistant (CNA)-G] for education regarding abuse reporting, we were made aware of another potential abuse incident from 6/18/25. [CNA-G's first name] told us that statements had been left under the Director of Nursing (DON's) office door. DON was not in the facility, so Administrator obtained the statements from her office. They describe an incident in which CNA [CNA-I's name] witnessed Registered Nurse (RN)-H, say to resident [R297's name], Oh stop, I can do whatever I want to you, all while wiping stool from [R297's initials] buttocks aggressively. When the cares for [R297's initials] were completed [CNA-I's name] reported the incident to RN [RN-C's name]. Once the Administrator and Dir. of SS (Director of Social Services) were made aware, an investigation was initiated and this initial self report was submitted.</p> <p>CNA-I's written statement regarding R297, which was left under the DON-B's door, dated 6/18/25 at 6:40 a.m. , documents I was changing [R297's first name] when I rolled him he got poop all over the green pad. He didn't want me to change him but I told him he had poop &amp; I should. I went to get [RN-H's first name] to help me. I was up against the wall and we rolled [R297's first name] to me. She rolled him quite aggressively. [R297's first name] was verbally upset with the roll &amp; got worse when she started wiping him. She was very aggressive when whipping (sic) him. He was grabbing me because of this, pushing on me trying to roll back to stop her, yelling at her to stop &amp; this is when [RN-H's first name] said Oh stop I can do whatever I want to you. Whipping (sic) very aggressive on his butt.</p> <p>The facility's investigation summary written by Director of Social Services (DSS)-E includes documentation of this writer called [RN-C's name] and [RN-C's first name] stated [CNA-I's first name] reported the incident to me, and I told [CNA-I's first name] to go back and check on the residents. If the residents were not okay, I told her I would go and check on the residents. I didn't want to go into Team 1 because I was afraid [RN-H's name] would get suspicious as to why I would be in Team 1. [CNA-I's first name] reported back to me that [R297's first name] and [R298's first name] were okay. [RN-C's first name] instructed [CNA-I's first name] to write out a statement of what happened, and [RN-C's first name] put their statements under the office door of the DON.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 8/6/25, at 12:50 p.m., Surveyor asked DSS-E how she became aware of the verbal &amp; physical abuse allegation involving RN-H with R297. DSS-E explained she and Nursing Home Administrator (NHA)-A were educating [first name of CNA-G] on abuse. Surveyor asked what day was this. DSS-E informed Surveyor the 18th. Surveyor asked why was the date of discovery on the facility reported incident 6/19/25. DSS-E informed Surveyor she would have to double check the date. At 1:12 p.m. DSS-E informed Surveyor she did not speak with CNA-G until the 19th (6/19/25). DSS-E explained while they were educating CNA-G about abuse, CNA-G said what about [CNA-I's first name] and they asked CNA-G what about CNA-I. DSS-E informed Surveyor this is when they were informed CNA-I witnessed RN-H's allegation of abuse with R297. The nurse &amp; CNA-I put statements under DON's door. The DON was not here so NHA-A went to the DON's office and they were under the door. Surveyor asked whose statement was under the DON's door. DSS-E replied at that time only [first name of CNA-I] and the nurse, the one who she reported it to, [RN-C's first name]. Surveyor asked DSS-E if they notified the police. DSS-E replied we did not. Surveyor asked DSS-E why they didn't contact the police. DSS-E replied I didn't see any harm.</p> <p>On 8/6/25, at 1:54 p.m. Surveyor asked NHA-A how she became aware of the allegation of verbal and physical abuse involving RN-H with R297. NHA-A informed Surveyor she and [name of DSS-E] were meeting with [name of CNA-G] on 6/19/25 about the abuse policy and [first name of CNA-G] said what about the other night with [first name of CNA-I]. [First name of CNA-I] and nurse left statements. NHA-A informed Surveyor they asked where were the statements left. CNA-G informed them under the DON's door. NHA-A informed Surveyor this is the first they were hearing about it and the DON was on vacation. Surveyor asked NHA-A if she asked RN-C why she didn't report the allegation of verbal and physical abuse immediately &amp; why RN-C didn't go to the unit where RN-C was working. NHA-A informed Surveyor RN-C didn't know the DON was off. NHA-A informed Surveyor RN-C was being snippy to co-workers, acting passive aggressive. RN-C was hesitate. Surveyor asked NHA-A why RN-C didn't report the allegation of abuse to her. NHA-A replied I don't know and explained RN-C went to report to the DON and didn't realize she was off.</p> <p>Surveyor reviewed RN-H's employee time sheet and noted RN-H worked until 6:46 a.m. on 6/18/25. RN-H returned to work on 6/18/25 at 10:20 p.m. and worked until 6:48 a.m. on 6/19/25. This allegation was not reported immediately to Nursing Home Administrator (NHA)-A as CNA-I's statement was slid under the DON's door. Residents were not protected from further potential abuse.</p> <p>3.) R298's diagnoses includes hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side) following cerebral infarction (type of stroke) affecting left non dominate side, heart failure (chronic condition in which the heart doesn't pump enough blood as well as it should), diabetes mellitus (high blood sugar), and dementia (loss of cognitive function that interferes with a person's daily life &amp; activities).</p> <p>On 8/6/25, at 9:20 a.m. Surveyor spoke with Anonymous Staff (AS)-F on the telephone. During this conversation AS-F informed Surveyor Registered Nurse (RN)-H verbally and physically abused two residents and provided Surveyor with the names of two residents including R298. AS-F informed this abuse occurred on the same night. Certified Nursing Assistant (CNA)-I reported this abuse to Registered Nurse (RN)-C and CNA-I wrote a statement which was placed under the Director of Nursing (DON) door.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Certified Nursing Assistant (CNA)-I's statement dated 6/18/25 at 6:40 a.m. for R298 documents [Name of ] Registered Nurse-H said she wanted to see [first name of R298] butt so I asked if she just wanted to come in when I changed him. She said yes. [First name] call light went off so I answered it &amp; she wanted her remote. After I went to [R298's first name] room she was in the middle of changing him. She rolled rolled him aggressively onto his bad side &amp; wiping him aggressively also to the point where he was showing he was in pain.</p> <p>On 8/6/25, at 12:50 p.m., Surveyor asked DSS-E if she is involved when there is an allegation of abuse. DSS-E replied yes. Surveyor inquired what DSS-E's role is. DSS-E informed Surveyor when an allegation is brought to her attention she will initiate an investigation, reports the allegation to the State, interviews residents and staff if needed and does the investigation summary. DSS-E informed Surveyor she and Nursing Home Administrator (NHA)-A became aware of CNA-I's statement when they were providing abuse education to CNA-G on 6/19/25.</p> <p>On 8/6/25, at 1:46 p.m., Surveyor telephoned RN-C. Surveyor left a messaging asking RN-C to return Surveyor's call. Surveyor did not receive a return call from RN-C.</p> <p>Surveyor reviewed RN-H's employee time sheet and noted RN-H worked until 6:46 a.m. on 6/18/25. RN-H returned to work on 6/18/25 at 10:20 p.m. and worked until 6:48 a.m. on 6/19/25. This allegation was not reported immediately to Nursing Home Administrator (NHA)-A as CNA-I's statement was slid under the DON's door. Residents were not protected from further potential abuse.</p> <p>No additional information was provided.</p> |   |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and staff interviews, the facility did not ensure that allegations of potential verbal and physical abuse involving 3 out of 5 residents (R11,R297, R298) reviewed were reported to the Nursing Home Administrator (NHA) or Designee and Law Enforcement.</p> <p>The facility did not contact the local law enforcement after they became aware that an agency CNA was witnessed to be rough with R11 when providing cares on 6/15/25.</p> <p>R297 was allegedly physically and verbally abused by a facility Registered Nurse (RN-H) on 6/18/25. This allegation was not immediately reported to the NHA . This allegation was not reported to Law Enforcement as a possible crime of abuse.</p> <p>R298 was allegedly physically abused by a facility Registered Nurse (RN-H) on 6/18/25. This allegation was not immediately reported to the NHA. This allegation was not reported to Law Enforcement as a possible crime of abuse.</p> <p>Findings include:</p> <p>The facility's policy dated as implemented on 4/24/25 and titled Abuse, Neglect and Exploitation documents:</p> <p>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.</p> <p>VII. Reporting/ Response</p> <p>1. Reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies ( e.g., law enforcement when applicable) within specified timeframes:</p> <p>a.) Immediately, but not 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</p> <p>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.</p> <p>1.) On 8/4/24, Surveyor conducted a review of the facility's self-reported incident involving R11 dated 6/15/25. The facility's report documents that R11 made a complaint that CNA (Certified Nursing Assistant)- J was rough during cares. R11 stated that &amp;ldquo;(CNA- J) pulled my legs hard apart to put brief on, and also (CNA- J) was rough wiping her with the washcloths&amp;rdquo;. The time of this occurrence was documented at 5:20 AM on 6/15/25.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Surveyor conducted review of the facility's investigation into R11's allegations. The investigation included a written statement from CNA- F who was present in R11's room while CNA- J was providing cares to R11. CNA- F stated that CNA-J asked her to help change R11. When CNA- J started cleaning R11 with the washcloths, she was very rough. R11 was telling CNA- J that she was hurting her. CNA- J said "sorry" but continued. When CNA- J was cleaning the backside of R11, she was rough again and R11 made another statement saying, "stop you are being so rough". CNA-J said "sorry".</p> <p>R11 then stated, "why do you keep saying sorry but still continuing to be rough with me". When it was time to roll R11 towards CNA- J. CNA-J pulled R11 by the arm. R11 yelled out "OW". CNA- F stated that she finished getting R11 comfortable and CNA-J walked out of the room mumbling under her breath. After the cares were completed, CNA- F did report her concerns to the Nurse on the unit who then checked on R11 to make sure she felt safe. NHA- A was made aware of the situation and CNA- J was asked to leave the building and to not return until an investigation was complete.</p> <p>Surveyor conducted a review of Form F- 62447 "Misconduct Incident Report" that is required to be completed by the facility and submitted to the state survey agency within 5 working days of the date the facility knew of the incident. The form indicates that law enforcement was not involved or contacted by the facility, per policy and regulation.</p> <p>On 8/5/25 at 7:35 AM, Surveyor interviewed NHA-A regarding the allegation that CNA- J was rough with R11 while providing cares and this was witnessed by CNA-J . Surveyor asked NHA- A why law enforcement was not contacted. NHA- A stated that since R11 didn't really say that she was abused by CNA-J, law enforcement was not contacted.</p> <p>As of the time of exit on 8/6/25, no additional information has been provided as to why the facility did not contact law enforcement when they became aware of an allegation that R11 was treated roughly/abused by CNA- J during cares on 6/15/25.</p> <p>2.) R297's diagnoses includes dementia (loss of cognitive function that interferes with a person's daily life &amp; activities), paraplegia (loss or impairment of motor &amp; sensory functions in both lower legs), heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and anxiety disorder.</p> <p>R297's quarterly MDS (minimum data set) with an assessment reference date of 6/10/25 has a BIMS (brief interview mental status) score of 2 which indicates severe cognitive impairment. R297 is assessed as being dependent for toileting hygiene, requires substantial/maximal assistance for rolling left &amp; right, is frequently incontinent of urine and always incontinent of bowel.</p> <p>On 8/6/25, at 8:39 a.m., Director of Social Services (DSS)-E provided Surveyor with Facility Reported Incidents (FRI) Surveyor had requested.</p> <p>On 8/6/25, at 9:20 a.m. Surveyor spoke with Anonymous Staff (AS)-F on the telephone. During this conversation AS-F informed Surveyor Registered Nurse (RN)-H verbally and physically abused two residents and provided Surveyor with the names of two residents including R297. AS-F informed this abuse occurred on the same night. Certified Nursing Assistant (CNA)-I reported this abuse to Registered Nurse (RN)-C and CNA-I wrote a statement which was placed under the Director of Nursing (DON) door.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Surveyor reviewed the Facility Reported Incident for R297. Surveyor noted the date incident occurred is documented as 6/18/25 and date discovered documents 6/19/25. Under brief summary of incident documents: While Administrator and Director of Social Services were meeting with [name of Certified Nursing Assistant (CNA)-G] for education regarding abuse reporting, we were made aware of another potential abuse incident from 6/18/25. [CNA-G's first name] told us that statements had been left under the Director of Nursing (DON's) office door. DON was not in the facility, so Administrator obtained the statements from her office. They describe an incident in which CNA [CNA-I's name] witnessed Registered Nurse (RN)-H, say to resident [R297's name], Oh stop, I can do whatever I want to you, all while wiping stool from [R297's initials] buttocks aggressively. When the cares for [R297's initials] were completed [CNA-I's name] reported the incident to RN [RN-C's name]. Once the Administrator and Dir. of SS (Director of Social Services) were made aware, an investigation was initiated and this initial self report was submitted.</p> <p>CNA-I's written statement dated 6/18/25 at 6:40 a.m., left under the DON office door, documents I was changing [R297's first name] when I rolled him he got poop all over the green pad. He didn't want me to change him but I told him he had poop &amp; I should. I went to get [RN-H's first name] to help me. I was up against the wall and we rolled [R297's first name] to me. She rolled him quite aggressively. [R297's first name] was verbally upset with the roll &amp; got worse when she started wiping him. She was very aggressive when whipping (sic) him. He was grabbing me because of this, pushing on me trying to roll back to stop her, yelling at her to stop &amp; this is when [RN-H's first name] said Oh stop I can do whatever I want to you. Whipping (sic) very aggressive on his butt.</p> <p>The facility's investigation summary written by Director of Social Services (DSS)-E documents: This writer called [RN-C's name] and [RN-C's first name] stated [CNA-I's first name] reported the incident to me, and I told [CNA-I's first name] to go back and check on the residents. If the residents were not okay, I told her I would go and check on the residents. I didn't want to go into Team 1 because I was afraid [RN-H's name] would get suspicious as to why I would be in Team 1. [CNA-I's first name] reported back to me that [R297's first name] and [R298's first name] were okay. [RN-C's first name] instructed [CNA-I's first name] to write out a statement of what happened, and [RN-C's first name] put their statements under the office door of the DON.</p> <p>On 8/6/25, at 12:50 p.m., Surveyor asked DSS-E how she became aware of the verbal &amp; physical abuse allegation involving RN-H with R297. DSS-E explained she and Nursing Home Administrator (NHA)-A were educating [first name of CNA-G] on abuse. Surveyor asked what day was this. DSS-E informed Surveyor the 18th. Surveyor asked why was the date of discovery on the facility reported incident 6/19/25. DSS-E informed Surveyor she would have to double check the date. At 1:12 p.m. DSS-E informed Surveyor she did not speak with CNA-G until the 19th (6/19/25). DSS-E explained while they were educating CNA-G about abuse, CNA-G said what about [CNA-I's first name] and they asked CNA-G what about CNA-I. DSS-E informed Surveyor this is when they were informed CNA-I witnessed RN-H's allegation of abuse with R297. The nurse &amp; CNA-I put statements under DON's door. The DON was not here so NHA-A went to the DON's office and they were under the door. Surveyor asked whose statement was under the DON's door. DSS-E replied at that time only [first name of CNA-I] and the nurse, the one who she reported it to, [RN-C's first name]. Surveyor asked DSS-E if they notified the police. DSS-E replied we did not. Surveyor asked DSS-E why they didn't contact the police. DSS-E replied I didn't see any harm.</p> <p>(continued on next page)</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>525279  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>08/06/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Tudor Oaks Health Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>S77 W12929 McShane Dr<br>Muskego, WI 53150 |  |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |   |   |  |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 8/6/25, at 1:54 p.m. Surveyor asked NHA-A how she became aware of the allegation of verbal and physical abuse involving RN-H with R297. NHA-A informed Surveyor she and [name of DSS-E] were meeting with [name of CNA-G] on 6/19/25 about the abuse policy and [first name of CNA-G] said what about the other night with [first name of CNA-I]. [First name of CNA-I] and nurse left statements. NHA-A informed Surveyor they asked where were the statements left. CNA-G informed them under the DON's door. NHA-A informed Surveyor this is the first they were hearing about it and the DON was on vacation. Surveyor asked NHA-A if she asked RN-C why she didn't report the allegation of verbal and physical abuse immediately &amp; why RN-C didn't go to the unit where RN-C was working. NHA-A informed Surveyor RN-C didn't know the DON was off. NHA-A informed Surveyor RN-C was being snippy to co-workers, acting passive aggressive. RN-C was hesitate. Surveyor asked NHA-A why RN-C didn't report the allegation of abuse to her. NHA-A replied I don't know and explained RN-C went to report to the DON and didn't realize she was off. Surveyor asked NHA-A if she knew why the police weren't called. NHA-A replied I do not.</p> <p>Surveyor noted that the allegation of verbal and physical abuse involving R297 were not reported immediately to NHA-A and the police were not contacted.</p> <p>3.) On 8/6/25, at 8:39 a.m., Director of Social Services (DSS)-E provided Surveyor with Facility Reported Incidents (FRI) Surveyor had requested.</p> <p>On 8/6/25, at 9:20 a.m. Surveyor spoke with Anonymous Staff (AS)-F on the telephone. During this conversation AS-F informed Surveyor Registered Nurse (RN)-H verbally and physically abused two residents and provided Surveyor with the names of two residents including R298. AS-F informed this abuse occurred on the same night. Certified Nursing Assistant (CNA)-I reported this abuse to Registered Nurse (RN)-C and CNA-I wrote a statement which was placed under the Director of Nursing (DON) door.</p> <p>On 8/6/25, at 10:30 a.m., Surveyor reviewed the facility's self reported incidents that DSS-E had provided to Surveyor. Surveyor noted there was not an investigation for R298.</p> <p>R298's diagnoses includes hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side) following cerebral infarction (type of stroke) affecting left non dominate side, heart failure (chronic condition in which the heart doesn't pump blood as well as it should), diabetes mellitus (high blood sugar), and dementia (loss of cognitive function that interferes with a person's daily life &amp; activities).</p> <p>Certified Nursing Assistant (CNA)-I's statement dated 6/18/25 at 6:40 a.m. for R298 documents [Name of ] Registered Nurse-H said she wanted to see [first name of R298] butt so I asked if she just wanted to come in when I changed him. She said yes. [First name] call light went off so I answered it &amp; she wanted her remote. After I went to [R298's first name] room she was in the middle of changing him. She rolled rolled him aggressively onto his bad side &amp; wiping him aggressively also to the point where he was showing he was in pain.</p> <p>(continued on next page)</p> |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Tudor Oaks Health Center   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>S77 W12929 McShane Dr<br>Muskego, WI 53150 |  |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 8/6/25, at 12:50 p.m., Surveyor asked DSS-E if she is involved when there is an allegation of abuse. DSS-E replied yes. Surveyor inquired what DSS-E's role is. DSS-E informed Surveyor when an allegation is brought to her attention she will initiate an investigation, reports the allegation to the State, interviews residents and staff if needed and does the investigation summary. Surveyor inquired if this allegation of physical abuse in CNA-I's statement regarding RN-H with R298 was reported to the State. DSS-E replied no because he's his own person and said nothing happened. Surveyor informed DSS-E, CNA-I's statement dated 6/18/25 alleges physical abuse involving RN-H and should have been reported.</p> <p>On 8/6/25, at 1:46 p.m., Surveyor telephoned RN-C. Surveyor left a messaging asking RN-C to return Surveyor's call. Surveyor did not receive a return call from RN-C.</p> <p>On 8/6/25, at 1:54 a.m. Surveyor asked Nursing Home Administrator (NHA)-A if the physical abuse allegation involving R298 &amp; RN-H was reported to the State. NHA-A replied no. NHA-A informed Surveyor she thinks CNA-I's statement was emotionally charged. Surveyor informed NHA-A this allegation should have been reported to the State and should have been reported to her immediately. Surveyor asked NHA-A if the police were contacted. NHA-A replied no.</p> <p>The allegation of physical abuse involving R298 was not reported to the State agency and the police were not contacted.</p> <p>No additional information was provided.</p> |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Tudor Oaks Health Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>S77 W12929 McShane Dr<br>Muskego, WI 53150 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>                                   |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Based on interview and record review the facility did not ensure 1 (R298) of 3 allegations of abuse were investigated.* The facility did not conduct an investigation for R298's allegation of physical abuse. Findings include: The facility's policy titled, Abuse, Neglect and Exploitation and dated 4/24/25, documents under the policy section: 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. Under section V. Investigation of Alleged, Abuse, Neglect and Exploitation it documents: 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: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extend, and cause; and 6. Providing complete and thorough documentation of the investigation. On 8/6/25, at 8:39 a.m., Director of Social Services (DSS)-E provided Surveyor with Facility Reported Incidents (FRI) Surveyor had requested. On 8/6/25, at 9:20 a.m. Surveyor spoke with Anonymous Staff (AS)-F on the telephone. During this conversation AS-F informed Surveyor Registered Nurse (RN)-H verbally and physically abused two residents and provided Surveyor with the names of two residents including R298. AS-F informed this abuse occurred on the same night. Certified Nursing Assistant (CNA)-I reported this abuse to Registered Nurse (RN)-C and CNA-I wrote a statement which was placed under the Director of Nursing (DON) door. On 8/6/25, at 10:30 a.m., Surveyor reviewed the facility's self reported incident reports that DSS-E provided to Surveyor. Surveyor noted there was not an investigation for any allegation involving R298. R298's diagnoses includes hemiplegia (paralysis on one side of the body( and hemiparesis (weakness on one side) following cerebral infarction (type of stroke) affecting left non dominate side, heart failure (chronic condition in which the heart doesn't pump blood as well as it should), diabetes mellitus (high blood sugar), and dementia (loss of cognitive function that interferes with a person's daily life and activities). Certified Nursing Assistant (CNA)-I's statement dated 6/18/25 at 6:40 a.m. for R298 documents: [Name of ] Registered Nurse-H said she wanted to see [first name of R298] butt so I asked if she just wanted to come in when I changed him. She said yes. [First name] call light went off so I answered it &amp; she wanted her remote. After I went to [R298's first name] room she was in the middle of changing him. She rolled rolled him aggressively onto his bad side &amp; wiping him aggressively also to the point where he was showing he was in pain. On 8/6/25, at 12:50 p.m., Surveyor asked DSS-E if she is involved when there is an allegation of abuse. DSS-E replied yes. Surveyor inquired what DSS-E's role is. DSS-E informed Surveyor when an allegation is brought to her attention she will initiate an investigation, report the allegation to the state agency, interview residents and staff if needed, and complete the investigation summary. Surveyor inquired if there is an investigation regarding an allegation of physical abuse in CNA-I's statement regarding RN-H with R298. DSS-E replied no because he's his own person and said nothing happened. Surveyor informed DSS-E, CNA-I's statement dated 6/18/25 alleges physical abuse involving RN-H and that this allegation should have been investigated. On 8/6/25, at 1:46 p.m., Surveyor telephoned RN-C. Surveyor left a messaging asking RN-C to return Surveyor's call. Surveyor did not receive a return call from RN-C. On 8/6/25, at 1:54 a.m. Surveyor asked Nursing Home Administrator (NHA)-A if the physical abuse allegation involving R298 &amp; RN-H was investigated. NHA-A replied no. NHA-A informed Surveyor she thinks CNA-I's statement was emotionally charged. Surveyor informed NHA-A this allegation should have been investigated. No additional information was provided as to why the facility did not ensure that the statement involving R298 and alleged abuse was thoroughly investigated.</p> |   |  |