

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Juliette Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 482 Oak Street Berlin, WI 54923	

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 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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, staff did not report an allegation of abuse in a timely manner for 1 resident (R) (R1) of 4 sampled residents. On 8/27/25, Certified Nursing Assistant (CNA)-C witnessed CNA-D yell and swear at R1. R1 reported that CNA-D told R1 to urinate in R1's brief. The allegation of abuse was not reported timely to Nursing Home Administrator (NHA)-A. Findings include The facility's Long Term Care (LTC) Resident Abuse Prevention and Reporting Policy, revised 4/11/25, indicates: .G. Reporting: 1. Anyone who witnesses an act that may potentially meet the definition of abuse or any other defined misconduct, or to whom someone has reported abuse or any other defined misconduct, will immediately ensure resident safety and then report the allegation to the Administrator. 2. The proper method of reporting is in-person or phone call to assure prompt notification is made .5. For alleged violations of abuse, or if there is serious bodily injury, the facility must report the allegation to the Division of Quality Assurance (DQA) immediately, but no later than two hours after the allegation is made in accordance with state law. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. 6. For alleged violations of neglect, exploitation .or mistreatment that do not result in great bodily injury, the facility must report the allegations to DQA no later than 24 hours in accordance with state law. On 9/10/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, major depressive disorder, nicotine dependence, and contracture to left hand. R1's Minimum Data Set (MDS) assessment, dated 8/28/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1 had intact cognition. R1's was responsible for R1's healthcare decisions. On 9/10/25, Surveyor reviewed a facility-reported incident (FRI) that was submitted to the State Agency (SA) on 8/27/25 at 8:38 PM. The FRI indicated CNA-C reported on 8/27/25 that CNA-D entered R1's room, yelled, pointed, and swore at R1, and told R1 to urinate in R1's brief. CNA-D was suspended upon report of the incident and the facility contacted local law enforcement. On 9/10/25, Surveyor reviewed the facility's investigation which was submitted to the SA on 9/2/25 at 11:17 AM. The investigation indicated there was a delay in providing care to R1 because CNA-D did not provide assistance or change R1's brief when R1 activated the call light. CNA-D admitted to yelling at R1. The investigation indicated there was willful intent and CNA-D acted deliberately by yelling at R1 and denying R1 care. On 9/10/25 at 11:11 AM, Surveyor interviewed CNA-C via phone who stated on 8/27/25 at approximately 5:00 AM, CNA-C noted staff kept turning R1's call light off. CNA-C went to see what R1 needed because R1 was yelling for assistance. R1 stated R1 needed to use the bathroom and wanted to go outside to smoke but the other CNAs kept turning R1's light off. CNA-C stated CNA-D entered R1's room, pointed at R1 and yelled, This is bullshit. You need to stay in bed and wait. This smoking shit is going to stop or you will have it taken away. R1 was upset and yelled back at CNA-D. R1 told CNA-C that CNA-D always tells R1 to piss in R1's brief. CNA-C stated Registered Nurse (RN)-E entered R1's room seconds after CNA-D left and was also aware that CNA-D yelled at R1 and did not provide assistance. CNA-C reported that R1 told RN-E that staff told R1 to piss in R1's brief. CNA-D finished the shift and left for the day. CNA-C went home and was still bothered by the incident. CNA-C returned to the facility the same day (8/27/25) at approximately 1:00 PM to complete training and reported the incident to RN-F at approximately 3:00 PM. CNA-C verified CNA-C should have reported the incident sooner. On 9/10/25 at 3:21 PM, Surveyor interviewed NHA-A, Director of Nursing (DON)-B, and RN-F via phone conference. DON-B indicated CNA-C reported the incident to RN-F. RN-F confirmed CNA-C reported the incident to RN-F on 8/27/25 at approximately 4:00 PM. RN-F immediately educated CNA-C regarding reporting requirements and told CNA-C that CNA-C should have reported the incident to administration immediately. On 9/10/25 at 4:08 PM, Surveyor interviewed Regional Nurse Consultant (RNC)-G who stated the facility's policy indicates if there is no serious bodily injury, the facility has up to 24-hours to report. Surveyor informed RNC-G of the regulation and reviewed the facility's policy with RNC-G. The facility's policy indicates for alleged violations of abuse, OR if there is serious bodily injury, the facility must report the allegation to the SA immediately but no later than two hours after the allegation is made. RNC-G acknowledged the verbiage in the policy and confirmed the facility's investigation substantiated that abuse occurred.</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>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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated and corrective actions were taken to prevent further abuse for 1 resident (R) (R1) of 4 sampled residents. On 8/27/25, Certified Nursing Assistant (CNA)-C witnessed CNA-D enter R1's room, yell and swear at R1, and tell R1 to urinate in R1's brief. The facility's investigation did not include thorough staff education on abuse prevention and reporting or ensure education retention. In addition, staff did not immediately intervene and remove CNA-D from resident care per the facility's policy. Findings include: The facility's Long Term Care (LTC) Resident Abuse Prevention and Reporting Policy, revised 4/11/25, states the purpose of the policy is to outline standards and processes to ensure: (1) Residents live in a safe environment where they are free from abuse and neglect and are treated with respect and dignity, and, (2) to be in compliance with state and federal laws and regulations. E. Protection. (2) Safety, security, and support of the residents will be provided. The facility will take immediate action to correct the issue to reduce risk of further harm occurring. The alleged perpetrator will immediately be removed and the resident protected. Team members accused of alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation. F. Investigation. (3) The investigation will include. F. Interviewing team members who worked previous shifts to determine if they aware of any injuries or incident. G. Reporting: 1. Anyone who witnesses an act that may potentially meet the definition of abuse or any other defined misconduct, or to whom someone has reported abuse or any other defined misconduct, will immediately ensure resident safety and then report the allegations to the Administrator. 2. The proper method of reporting is in-person or phone call to assure prompt notification is made. 5. For alleged violations of abuse, or if there is serious bodily injury, the facility must report the allegation to the Division of Quality Assurance (DQA) immediately, but no later than two hours after the allegation is made, in accordance with state law. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. 6. For alleged violations of neglect, exploitation, or mistreatment that do not result in great bodily injury, the facility must report the allegations to DQA no later than 24 hours, in accordance with state law. On 9/10/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, major depressive disorder, nicotine dependence, and contracture to left hand. R1's Minimum Data Set (MDS) assessment, dated 8/28/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1 had intact cognition. R1 was responsible for R1's healthcare decisions. On 9/10/25, Surveyor reviewed a facility-reported incident (FRI) that was submitted to the State Agency (SA) on 8/27/25 at 8:38 PM. The full investigation was submitted on 9/2/25 at 11:17 AM. The FRI indicated CNA-C reported on 8/27/25 that CNA-D swore at R1 and told R1 to urinate in R1's brief. CNA-D was suspended upon report of the incident and the facility contacted local law enforcement. CNA-D admitted to yelling at R1. The facility determined there was willful intent and that CNA-D acted deliberately by yelling at R1 and denying R1 care. On 9/10/25 at 11:11 AM, Surveyor interviewed CNA-C via phone who indicated on 8/27/25 at approximately 5:00 AM, CNA-C noted staff kept turning off R1's call light. CNA-C went to see what R1 needed because R1 was yelling for assistance. R1 stated R1 needed to use the bathroom and wanted to go outside to smoke but the other CNAs keep shutting R1's light off. CNA-C stated CNA-D then entered R1's room, pointed at R1, and yelled, This is bullshit. You need to stay in bed and wait. This smoking shit is going to stop or you will have it taken away. R1 was upset and yelled back at CNA-D. R1 reported to CNA-C that CNA-D always tells R1 to piss in R1's brief. CNA-C stated Registered Nurse (RN)-E entered R1's room seconds after CNA-D left and was also aware that CNA-D yelled and did not provide assistance for R1. CNA-C indicated R1 also told RN-E that staff told R1 to piss in R1's brief. CNA-C finished the shift, went home, and continued to be bothered by the incident. CNA-C returned to the facility the same day (8/27/25) at 1:00 PM to complete training and reported the incident to RN-F at approximately 3:00 PM. CNA-C confirmed CNA-C should have reported the incident sooner. CNA-C denied the facility provided CNA-C with written or verbal education regarding abuse reporting requirements. CNA-C stated that since 8/27/25, CNA-C was aware of other instances when residents' call lights were intentionally not answered and residents were told to urinate in their briefs. CNA-C did not reported the additional instances to administration but planned to do so during CNA-C's next shift. Surveyor encouraged CNA-C to immediately notify administration. The FRI included a</p>		