STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525326	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health and Memory Care	2100 E Sixth St Merrill, WI 54452

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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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 observation, interview, and record review, the facility failed to protect the resident's right to be free from abuse by another resident for 1 of 3 residents reviewed (R1). R2 was found in R1's room sitting next to R1's bed in wheelchair with his hand under the blanket on R1's bed. Facility did not protect R1 from further potential abuse when Surveyor's observations confirmed 15-minute checks on R2 were not performed, and R2 entered R1's room four more times after the incident. Findings include: The facility policy entitled Nursing Home Abuse, Neglect, Misappropriation, Exploitation, Resident to Resident Altercations, Injury of Unknown Origin, and Caregiver Misconduct (MVCC) last revised on 12/14/23, reads in part: Will take all necessary steps to ensure its residents are protected from incidents of abuse, neglect, and exploitation by anyone .The resident has the right to be free from abuse Individual treatment plans will also identify known history of distressed behavior including physical, sexual, or verbal aggression to ensure appropriate interventions. The facility's standard wandering protocol, last updated 03/28/24 reads in part: Monitor risk for wandering routinely and prn (as needed) .provide 1:1 as needed. R1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease with late onset, dementia, severe with psychotic disturbance, and anxiety disorder, unspecified. R1's most recent Minimum Data Set (MDS) assessment on 4/7/25 shows a Brief Interview for Mental Status (BIMS) score of 3/15, which indicates severe cognitive impairment and a Patient Health Questionnaire-9 (PHQ-9) score of 0, which indicates minimal symptoms of depression. R1's care plan prior to incident reads in part: Focus (continued on next page)

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	Risk for alteration in psychosocial, physical, emotional wellbeing or re-traumatization R/T diagnosis/history of natural disasters (tornado), resident's potential/or perception that she was jumped on a walk, potential sexual assault, severe human suffering due r/t her foster son evident by symptoms of anxiety, expressing feeling down. Implemented on 01/21/25 (Trauma Informed Care Assessment completed on 01/20/25) Goal I will be free from physical, social, and emotional harm and free from trauma and re-traumatization during my stay in facility. Intervention When I am having a hard time emotionally, the following strategy helps me feel better: Looking at my wedding photo or taking a drive. R2 was admitted to the facility on [DATE] with diagnosis including attention and concentration deficit following a stroke. R2's most recent MDS assessment on 05/22/23 shows a BIMS score of 3/15, which indicates severe cognitive impairment and a PHQ-9 score of 2, which indicates minimal symptoms of depression. R2's care plan prior to incident reads in part: Focus Resident at risk for elopement related to attempting to leave facility by himself. Resident resides in secure unit of facility Last revised 02/6/24 Goal Safety will be maintained, and resident will be accepting of redirection Interventions Adhere to standard of care wandering protocol Redirect with occurring wandering On 06/16/25, Surveyor reviewed R1 and R2's records and noted the following: On 11/18/24, Sexual Activity Consent completed for R2 confirmed R2 cannot consent. On 06/05/25, Sexual Activity Consent completed for R1 confirmed R1 cannot consent. On 06/05/25, the facility submitted a Facility Reported Incident (FRI) reported to the State Agency (SA), to report the incident of R2 touching R1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility interviews with staff during the facility investigation read in part: [R1] wanders into [R2's] room at night. She calls him another name (her husband's name). - Certified Nursing Assistant (CNA) H Once when I was walking with [R1] to her room we walked by [R2], and he made a comment to [R1] about her going into his bed. - CNA E Always trying to go into [R1's] room, nothing verbal. - Registered Nurse (RN) J Asks staff to get into bed with him. - Licensed Practical Nurse (LPN) G Facility interview with Hospitality Aide (HA) D states: On Thursday June 5th, I was in the common area/dining area in 300 wing and noticed that [R2] wasn't there . I noticed he wasn't in his room at all I heard someone yell out what are you doing, get out of here I realized it was [R1] so I went into her room [R1] was laying in bed and [R2] was in his wheelchair next to her bed. [R1] had her clothes on and blanket over top I said [R2] you're in the wrong room. [R2] started pulling his hand out from under her blanket. I did not see his hand but where his hand came out you could tell it was around the peri area .[R1] looked upset, and I pulled [R2] away and asked [R1] if she was ok. [R1] said she was but not to let it happen again [R1] came out of her room saying, where is he, where is he and at that time [CNA F] and [RN K] took [R1] to her room. [R2] laid down in bed for a nap There were a few more times early this week where [R2] was trying to go into [R1's] room. Facility interview with CNA F states: I proceeded to check on [R1], she was sleeping. About five minutes later she came out of her room upset and wanted to know where 'he' was. Then she started crying, talking about, 'he was touching' and she was confused. I tried calming her down, she was scared he was going to come back. She didn't like being alone, she was scared to be alone. Facility interview with RN K states in part: [R1] said she was scared and asked why he was touching her. I tried to explain but she kept crying and weeping [R1] asked if she could go back to sleep and make sure that guy didn't come in her room again We told [R1] we would watch [R2] closely and make sure he didn't come in again. The facility called law enforcement. Officer interviewed 3 staff members (Unit Manager (UM) C, HA D, and RN K) but no residents. No formal investigation was completed by law enforcement. The facility did not complete all staff education. R1's provider note from 06/16/25 reads in part, Wandering the halls at 3:30am trying to leave the facility . numerous questions for staff and anxiety behaviors discussed with husband and daughter increasing the Seroquel to 25mg at bedtime to see if this would improve her behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon record review, R1's Seroquel 12.5mg started on 06/02/25 and was increased to 25mg on 6/17/25 which was already discussed as an intervention on 6/2/25 prior to incident. On 06/17/25 at 10:38 AM until 10:59 AM, Surveyors observed R2 for 21 minutes and no staff checked on R2. R2 is to be on 15-minute checks. On 06/17/25 at 10:38 AM, Surveyors entered the unit. Surveyors observed R1 in the dining room walking and talking with staff. R2 was observed lying in bed. On 06/17/25 at 10:50 AM, Surveyor attempted to interview R1. R1 was unable to stay focused to hold a conversation and was determined to be non-interviewable. On 06/17/25 at 10:59 AM, Surveyor interviewed CNA F. CNA F stated she was working the day of the incident but was performing cares on another resident. CNA F stated HA D informed her of what happened. CNA F stated after the incident, R2 kept going to R1's room. R1 reported to CNA F that R2 had touched her all over, but did not specify any particular body parts. R1 waved her hands all over to indicate it was everywhere. R1 was crying and stated she was worried about R2 coming back in her room. CNA F stated she laid R1 down and observed R1 for the rest of the day. CNA F also stated interventions were put in for keeping R2 at arm's distance from other residents, having him eat at the men's table, and to keep him in line of sight when out of his room. CNA F stated she never heard R2 say anything sexual to other residents. CNA F also reported she has not seen much change in R1's mood/behavior since the incident. R1 is usually happy during the day until after her husband leaves at dinner time. CNA F stated R1 had been weeping/crying for a few days after incident, but she has not observed anything since. CNA F also stated R1 had not slept in 3 days and said that was a change for her. On 06/17/25 at 11:07 AM, Surveyor interviewed CNA E. CNA E stated staff will redirect R1 if she is wandering and has not observed any changes in R1's behavior, appetite, or sleep. CNA E reported R2 had sexual behaviors towards staff but not residents. R2 tried one day before the incident to go into R1's room but was easily redirected. CNA E said they try to redirect R1 when she is in her moods. CNA E also stated R2 is on visual supervision while out of his room. CNA E confirmed she heard R2 state to R1, a comment to R1 about going into his bed. CNA E stated R2 made this comment, a while ago, reporting it was more than one month ago, but less than six months ago. On 06/17/25 at 11:17 AM, Surveyor interviewed RN K. RN K stated she had no knowledge of R2 making sexual comments/advances to residents, and that occasionally he would make comments to staff. When asked about 15-minute checks, RN K stated, The CNAs usually do that. RN K said the CNAs do the charting in the electronic medical record (EMR) system and they have no paper logs. RN K stated R2 is also on direct supervision when out of his room and he must be arm's length from other residents. RN K stated she has not observed a change in R1's behaviors since the incident, and the only intervention was to monitor R1 for behaviors like weeping/crying. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/17/25 at 12:27 PM, Surveyor interviewed Hospitality Aide (HA) D. HA D was present during the incident and was the staff who removed R2 from R1's room. HA D stated at the time of the incident she witnessed R1's eyes were big, and she looked scared. When HA D asked R1 if she was ok, she said she was fine, but don't let it happen again. HA D reported R1 brought the incident up that day but not since. HA D stated the interventions for R2 were 15 minutes checks, direct supervision when out of room, and arm's length from other residents. HA D reported after the incident R2 wandered into R1's room, but R1 was not present in the room when this happened. HA D stated staff were busy during the times R2 was able to enter R1's room. HA D reported no adverse events related to R2 entering R1's room. HA D stated the unit is always staffed with one licensed nurse, two CNAs, and one hospitality aide for approximately 16 residents on the unit. HA D stated staffing on the unit was sufficient to provide the increased supervision R2 required. HA D stated staff completed abuse education in May, as part of annual training. HA D confirmed after the incident occurred, she did not receive further abuse training. On 06/17/25 at 1:30 PM, Surveyor interviewed Unit Manager (UM) C. UM C stated she wouldn't say R1's behaviors have been different, just her anxiety has been more difficult to redirect. UM C stated R1 waxes and wanes with her behaviors. Some days she has them and some days she doesn't. UM C reported R1's antipsychotic medication was increased on 06/15/25; however, this was a change that was discussed when R1 was initially prescribed the medication on 06/02/25. The provider had indicated at that time, to start R1 on a half dose, and increase to full dose. The increase in R1's antipsychotic medication was not related to the incident or resulting impacts from the incident. On 06/17/25 at 2:49 PM, Surveyor interviewed R1's family member (FM) I. FM I stated, I don't think anything has necessarily changed, sometimes she talks about it. Last night [6/16/25], she was having kind of a manic night, she brought up a woman, who is from another incident, and a man who is [R2] from the incident which occurred on 06/05/25. She wasn't scared, I can't say that. She is going through med changes. Last night she wanted to go home and said something about being grabbed, by resident from other said incident, stating I don't want that to happen again, and that man [R2], that came in here, I don't want that to happen again. She was also talking about her childhood things during this conversation. I don't think there are any changes related to the incident or because of him. They are trying to dial in med changes, but I know it is still in her mind because she mentioned it. If it was ongoing I would want to do something about it, I feel the staff are doing what they can to prevent it from happening. I am excited about them (staff), they are super kind. On 06/17/25 at 3:14 PM, Surveyor interviewed Director of Nursing (DON) B regarding the incident between R1 and R2. DON B stated, We didn't really know for sure if this was sexual abuse, there was no evidence, but there was potential. He was not like that before with anyone else. When the CNA found him in [R1's] room, she moved him, his hand was not secured, he was not grabbing at anything, his hand moved with him when he was moved away from the bed. If he was doing something inappropriate, I think he would say or react when he was moved away, but he didn't react. We separated the residents immediately and began 15-minute checks on [R2]. SBAR was completed for [R2], as this behavior was a change in condition. Labs were done, and TSH was elevated, so [R2's] medications were adjusted. All other labs were normal. We implemented visual 1:1 when up and arm's length from others. This behavior was new for him. We wanted more eyes on him until we knew what was going on and for the protection of everyone. We completed abuse training in May. When we interviewed staff 1:1 we did informal education with them. DON B reported there was no documentation to confirm education had been completed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 8:44 AM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A reported he feels the current interventions are working well. NHA A stated he would have to pull up the charting to know for sure. NHA A also feels staff are able to redirect R2 and intervene. NHA A also stated he believes R1 is protected when R2 has been able to get in her room since interventions were put in place. NHA A said staff were able to know R2 wasn't where he should be. NHA A also talked about the layout of the unit for better visibility. Care plan for R1 after incident reads in part: Focus Risk for alteration in mood or behavior R/T male resident being in room with hand under blanket. (intentions unknown) resident clothed (Implemented on 06/5/25) Goal Will have minimal to no episodes of fearfulness or emotional distress Interventions Staff will report any signs or symptoms or situations that may bring of emotional distress to resident monitor resident for any s/s emotional distress or fearfulness Monitor targeted behaviors and offer interventions and provider follow up as needed Staff will console and report any situations that may cause fearfulness or emotional distress and remove resident from the area/situation immediately will keep resident free from interactions with [R2] R2's care plan after the incident reads in part: Focus Risk for alteration in mood, behavior and mobility R/T being found in another resident's room with hand under blankets of clothed female resident (intentions unknown) (Implemented 06/05/24) Goals Will report any inappropriate sexual desires to staff/nurse will be free from any sexual inappropriate comments, gestures or advances towards other Will have decreased episodes of wandering Will have no episodes of evidence of inappropriate sexual/touching interactions with others (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's pertinent physician orders/behavior monitoring: No related medications Behavior-Is resident free from inappropriately entering other resident's personal space (such as entering other resident's rooms or placing himself within arm's reach of other residents) 6/11/25 Behavior-Is resident free from sexual behavior this shift? Implemented on 6/9/25 Facility implemented the following interventions on 06/05/25: 15-minute checks Visual line of sight when out of bed Avoid interactions with [R1] Assist to avoid entering other resident's room to respect personal space and boundaries (Implemented 06/11/25) Assist to remain arm's length away from others to respect personal space and boundaries (Implemented 06/11/25) Redirect when wandering (Implemented 06/12/25) Upon record review of progress notes, despite these interventions, R2 entered or attempted to enter R1's room on the following dates: On 06/06/25, R2 attempted to enter R1's room. On 06/07/25, R2 wandered into R1's room x2. On 06/08/25, R2 wandered into R1's room x1. Staff reported they didn't think R1 was in her room during these events but could not verify it.