STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 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 failed to have evidence that all alleged violations are thoroughly investigated for 2 of 6 resident-to-resident altercations involving 4 Residents (R9, R10, R2, and R8). Resident to Resident altercation between R9 and R10 was not thoroughly investigated. Resident to resident altercation between R2 and R8 was not thoroughly investigated. Findings include: Review of the undated policy titled, Abuse/Neglect/Exploitation, specified it is the policy of this facility to provide protection 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. Review of the facility's undated policy titled, Abuse/Neglect/Exploitation, revealed, The Administrator should will [sic] follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; . Investigating and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; . Providing complete and thorough documentation of the investigation. Review of the facility's undated investigation policy titled, Procedure, revealed it did not contain information on how to conduct and document a thorough investigation. Example 1 Review of the admission Record, located under the Profile tab in the electronic medical record (EMR) revealed R9 was admitted to the facility on [DATE] with diagnosis including unspecified dementia with agitation. Review of a 10/04/25 Incident Report, for R9, provided by the facility and documented by Licensed Practical Nurse (LPN) N, revealed that, Resident was leaving dining room in w/c [wheelchair] after breakfast. Resident rolled up to another resident [R10] who was sitting at a table close to the door and without saying anything started to open hand slap [R10] in [sic] head/face 3 times. Medication Technician (MT) U heard the commotion and removed resident from dining room and redirected resident. Both residents were separated and assessed for injury. The report indicated R9 was unable to give 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	description. The Incident Report included two typed statements, one by MT U, and one by Certified Nursing Assistant (CNA) M, who witnessed the incident. Review of the quarterly Minimum Data Set (MDS), located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 10/07/25 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. R9 had physical behavioral symptoms directed towards others. Review of a Trauma Informed Care Assessment, dated 10/10/25 and located in the Assessments tab of the EMR, revealed R9 denied experiencing any unusual or especially frightening, horrible, or traumatic events. Review of the admission Record, located under the Profile tab in the EMR revealed R10 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, moderate, with agitation and cognitive communication deficit. R10 died at the facility on 01/03/26. Review of R10's quarterly MDS, located under the MDS tab in the EMR with an ARD of 08/14/25 revealed R10 had a BIMS score of three out of 15, indicating severe cognitive impairment. R10 had physical behavioral symptoms directed towards others. Review of a 10/04/25 Incident Report, provided by the facility and documented by LPN N, revealed that MT U went into the dining room after hearing a commotion and saw resident being open handed slapped in [sic] head/face by [R9]. R10 was assessed for injury with no injuries noted. R10 was unable to give a description. Review of a Trauma Informed Care Assessment, dated 10/10/25 and located in the Assessments tab of the EMR, revealed R9 denied experiencing any unusual or especially frightening, horrible, or traumatic events. Review of the facility's investigation file, provided on 02/05/26, revealed it contained only the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, form used by the facility to initially report R9 hitting R10 to the SA on 10/04/25, the Misconduct Incident Report, and the two page Investigation Report. Review of the Misconduct Incident Report, indicated, Upon the completion of the entity's internal investigation of the incident, submit the completed form, any available documentation, and the results of your investigation within 5 WORKING days [Monday – Friday, excluding legal holidays] of the date the entity knew or should have known of the incident. The Report Submitted Date was 10/17/25, nine working days following the initial report on 10/04/25. Review of the Investigation Report, provided by the facility and dated 10/04/25, revealed that staff completed skin and pain assessments on the two residents, which were unremarkable. One-on-one supervision was maintained for both residents until they were calm. The facility completed a thorough investigation into the incident that occurred on 10/4/2025 between [R9] and [R10]. All staff working during the time of the incident were interviewed . All skin checks – including those for both involved residents and all other residents on the unit- were completed and revealed no injuries or additional concerns. During an interview on 02/05/26 at 4:30 PM, R9 was unable to recall hitting another resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/05/26 at 4:35 PM, Nursing Home Administrator (NHA) A and Corporate Nurse (CN) C confirmed that the resident-to-resident altercation was submitted to the SA on 10/04/25 and that the five-day investigation was submitted late on 10/17/25. CN C had submitted the initial report, and NHA A was locked out and unable to submit it timely. When asked if there was any documented communication with the SA regarding the inability to submit the report timely, they stated they would check. When asked for documentation of staff interviews and resident skin checks, documented as completed in the facility's Investigation Report, NHA A stated the skin checks for the two involved residents and others on the unit would be in the EMR and that he would have to check on the staff statements. During an interview on 02/06/25 at 9:20 AM, Social Services Director (SSD) R reported she was on vacation when R9 hit R10. Upon her return, she completed a BIMS on the two residents as well as a Trauma Informed Care Assessment. SSD R confirmed that the Trauma Informed Care Assessments were completed on 10/10/25, six days after the incident, since no one else was doing them at the time. NHA A instructed SSD R on her part in any abuse investigation. During an interview on 02/06/26 at 11:14 AM, LPN N was asked if she interviewed any staff or residents following R9 hitting R10. LPN N reported the risk management/ incident reporting form had an area for staff statements, and she recorded on it. LPN N reported she generally wrote a statement, or the facility asked her about incidents, but she could not recall either occurring for this incident. LPN N stated she had never been asked to do skin checks on additional residents on a unit following a resident-to-resident altercation. She had only done that with an injury of unknown origin. During an interview on 02/06/26 at 10:50 AM, MT U reported she witnessed R9 hit R10 on 10/04/25. She reported what occurred to the nurse but did not recall anyone following up with her to obtain additional information or write a witness statement. During a follow-up interview on 02/06/26 at 11:45 AM, NHA A and CN C were asked if there was any documentation with the SA about their difficulty submitting the five-day investigation timely. NHA A stated he had not communicated with the SA. CN C pulled up an email on her phone from the SA, saying she received it because she submitted the report. The email was dated 10/16/25, six days after the five-day investigation was due, and stated the SA was waiting for the report. CN C responded to the email saying that was what she had texted them about on Monday. During the interview, it was verified that the Monday in the text was 10/13/25, three days after the due date. NHA A stated he was responsible for ensuring investigations were reported timely. During an interview on 02/06/25 at 12:08 PM, Director of Nursing (DON) B stated that for resident-to-resident altercations, the facility interviewed all residents involved and all staff working that day. The interdisciplinary team determined who was responsible for each area of the investigation. All resident and staff interviews should be documented; they may be typed or handwritten. Skin assessments should have been completed on other residents on R9's and R10's hall. The nurses did them, and he assisted if needed. DON B reported he had not done any skin assessments following the incident between R9 and R10. The skin assessments were on paper and should be in the investigative file. During an interview on 02/06/26 at 1:17 PM, NHA A stated that R9's and R10's skin checks were documented in the Progress Notes area of the EMR. When asked about interviewing or completing skin checks on the other residents on the unit, NHA A stated the residents were not interview able because it was the dementia unit but provided the Angel Rounds documentation completed by Activity Director S who was the Manager on Duty on 10/04/25. NHA A provided handwritten statements by two staff members, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physical Therapy Assistant (PTA) BB and MT U. No documentation was provided for skin checks for other residents on the unit. Review of the Angel Rounds, provided by NHA A on 02/06/26 at 1:17 PM and completed by Activity Director S on 10/04/25, revealed four columns for documentation on each resident: Appearance Clothes Changes, Concerns Voiced, and Room Clean along with Comments. There was no documentation of whether residents felt safe, had witnessed any abuse, or had concerns about abuse. During an interview on 02/06/26 at 1:44 PM, CNA M reported observing R9 hit R10 on 10/04/25. CNA M thought she had written a statement but was unsure. During an interview on 02/06/26 at 2:00 PM, NHA A stated the facility only interviewed staff who witnessed R9 hit R10. They had not interviewed other staff who worked the hall that day or previous shifts to see if there were any behaviors leading up to or following the incident or if anyone had additional information. NHA A verified he had not provided any skin assessments that his investigation summary stated were done on other residents. NHA A verified that the Trauma Informed Care assessments were completed six days after the incident and said the facility had a plan in place now for when SSD R was not in the facility. During an interview on 02/06/26 at 2:33 PM, Activity Director S reported DON B notified her there had been an incident with R9 and R10 when she was Manager on Duty on 10/04/25 and asked her to get statements from staff who had witnessed R9 hit R10 and to check on the residents and ask if they felt safe or had witnessed altercations. Activity Director S reported she asked staff on that side of the building (the dementia unit) for statements and received two. She believed that one other staff member had witnessed the incident. DON B stated she filled out the Angel Rounds documentation and acknowledged it did not refer to residents feeling safe but said she would have written in the comments section if they did not feel safe. She could not recall being asked to notify staff to do skin assessments. Example 2 Review of R 2's Record of admission located under the Profile tab of the EMR revealed an admission date of 06/25/25 with diagnoses including personal history of traumatic brain injury, vascular dementia, and depression Review of R2's Care Plan, dated 06/26/25 located under the Care Plan tab in the EMR revealed that R2 had impaired neurological status related to cerebrovascular accident (stroke), seizure disorder, and traumatic brain injury. Interventions or tasks for employees instructed staff to have pleasant interactions with the resident when he is confused to give reassurance. A care plan, dated 09/26/25, revealed R2 sometimes had behaviors which include yelling and cursing. He would also shout and throw snacks at other residents. R2 was a bouncer at a bar; his job was to intervene when customers were belligerent. R2 thinks it is his responsibility to intervene. R2 is sometimes triggered when someone is rude to the staff. R2 sometimes had behaviors which included calling other residents' names when R2 sees other residents being rude to staff, when other residents are telling R2 what to do, or when other residents called female staff names. Interventions or tasks for this care plan, dated 09/26/26, instructed staff to attempt interventions before R2's behavior begins. Attempt to separate R2 if they get into an altercation with another resident and have staff help R2 avoid situations or people that were upsetting him. If R2 is the aggressor, place him on a one to one until he is calm. Make sure R2 is not in pain or uncomfortable. Additional interventions or tasks, dated 12/11/25, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instructed staff to encourage R2 to move away from the person if he is feeling provoked to avoid a confrontation. Interventions or tasks, dated 01/01/26, instructed staff to call law enforcement if R2 is unable to be redirected when being aggressive and staff is to also move other residents away from the area. R2 is to have one on one supervision on AM and PM shifts. Interventions or tasks, dated 01/19/26, also notified staff that if R2 is in their private room, one on one supervision can be removed unless needed. A care plan, dated 01/21/26, revealed R2 sometimes had behaviors which included verbal aggression towards other residents including using racial slurs, sexual preference, and body shaming others. Interventions and tasks instructed staff to assess and address the situation for contributing sensory deficits. Staff were to discuss the resident's behavior, explain, reinforce, and/or educate why the behavior is not appropriate or acceptable. Staff were instructed to give R2 his personal space but also to intervene before escalation when R2 becomes agitated and engage calmly in conversation. Reapproach the resident later if the resident gets aggressive. Review of R2's significant change MDS with an ARD of 01/01/26 and located under the MDS tab of the EMR, revealed a BIMS score of four out of 15, which indicated the resident had severe cognitive impairment. The MDS also indicated R2 had physical behavioral symptoms directed towards others one to three days in the seven day look back period. Review of R8's admission Record, located in the Profile tab of the EMR revealed an admission date of 08/15/25 with diagnoses including major depressive disorder, anxiety disorder, and severe obesity. Review of R8's Care Plan, dated 09/15/25 located under the Care Plan tab in the EMR revealed R8 sometimes had behaviors which included cursing, yelling during cares, throwing urine at staff, and throwing food in dining room when extra items were not available. R8 would also sit in the hallway in his wheelchair and not allow others to pass and he would follow staff and not allow them to complete their duties. R8 would also tell staff that Director of Nursing (DON) B had approved of something that was not approved; intentionally being untruthful to get what he wants. Interventions or tasks, dated 09/15/25, instruct staff to attempt to intervene before behaviors begin such as offering a tabletop activity like a magazine about dogs or football or offering to turn on a television show of their choice. Staff were instructed to notify R8's physician and psychiatric physician of behaviors. A care plan, dated 09/26/25, revealed R8 sometimes had behaviors which included yelling, cursing, and shouting at other residents. Interventions or tasks instructed staff to attempt to separate the residents that are having altercations. Staff were instructed to encourage R8 to leave the area and notify the nurse if another resident is starting an altercation. If R8 is the aggressor, place R8 on one-to-one supervision until he calms down. Staff was to offer a diversion. Interventions or tasks, dated 10/20/25, instructed staff to encourage positive communication and encourage R8 to express his feelings every Friday during his sessions with his therapist. Staff were to validate R8's emotions, not his accusations, and attempt to intervene before behaviors begin. Staff were to help R8 avoid situations or people that are upsetting him. Review of R8's quarterly MDS with an ARD of 11/14/25 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, which indicated the resident had intact cognition. The MDS also indicated R8 had no behavioral symptoms directed towards others in the seven-day look back period. A review of Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, submitted on 10/04/25, revealed on 10/03/25 R8 reported R2 walked up to him and said, I'll slap you in your face right now, then walked away. The incident was not witnessed. It also revealed, explain what steps the entity took upon learning of the incident to protect the affected person(s) and other from further (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potential misconduct.Staff statements, staff interviews and resident interviews. A review of Misconduct Incident Report, submitted on 10/17/25, revealed on 10/03/25 R8 reported R2 walked up to him and said, I'll slap you in your face right now, then walked away. The final submission date was 10/17/25. A review of the Investigation Report, dated 10/10/25, provided by the facility, revealed R8 reported R2 walked up to him and said, I'll slap you in your face right now, then walked away. The incident was not witnessed by staff and was reported by R8 on 10/04/25 at 11:31 AM. The facility conducted a comprehensive investigation regarding this allegation. All staff working during the time of the incident were interviewed. Any available residents were interviewed as well. The investigation did not reveal any witnesses or evidence substantiating the allegation. A subsequent review of the facilities investigation revealed no staff interviews and additional resident interviews were obtained. A review of an untitled and undated document, provided by the facility, revealed on 12/11/25 at approximately 7:40 AM while in the dining room R2 approached R8 and struck him. Staff were present; however, they did not directly witness the incident. Additionally, it revealed a comprehensive investigation was conducted including interviews with available staff and residents. A subsequent review of the facility investigation revealed one staff member interview. During an interview on 02/05/26 at 1:36 PM, NHA A stated he did not have any documentation for the investigation regarding the incident that occurred on 10/03/25. During an interview on 02/06/26 at 11:45 AM, NHA A and Corporate Nurse C stated they verified the resident-to-resident allegations with reports submitted to the state agency on 10/04/25 had a submission deadline on 10/10/25 for the follow-up five-day report. They confirmed the two submissions were submitted on 10/17/25. NHA A stated he was responsible for submitting the reports to the state. During a telephone interview on 02/06/26 at 12:07 PM, DON B stated investigations need to include interviews with all staff that were involved and the ones that were working on the day of the incident. Residents should also be interviewed. DON B added they may not recall anything, but the facility staff need to ask. DON B stated the interviews should be a statement or a questionnaire of some kind. He then added he does not know if the facility staff was getting any written statements during investigations. DON B also confirmed that NHA A sent all reports to the SA. During an interview on 02/06/26 at 2:00 PM, NHA A stated he did interview staff but did not have any documentation for the interviews with staff and residents. He confirmed he did not, however, interview all staff and all residents, only the ones he knew were involved. He then added he understood the importance of the additional interviews. NHA A stated the administration does Angel Rounds with residents every day. He added that the residents would have been asked if they felt safe but acknowledged there is no documentation of this. During an interview on 02/06/26 at 2:48 PM, CN C stated she understood the need for documentation of the interviews done with staff when doing investigations. She confirmed they did not have any of the interviews. She also confirmed there were no additional resident interviews done when the incidents were investigated. CN C stated the five-day report for the incident on 10/03/25 was submitted late to the SA, confirming it was submitted on 10/17/25 and not 10/10/25, when it was due.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 each resident receives adequate supervision to prevent accidents/hazards with smoking material. Staff observed R3 to be smoking while using oxygen in his room this had the potential to affect R3 and 12 of 12 residents (R12, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, and R24) who reside on the 100 hall. R4 was observed not to have smoking material secured, R4 handed a cigarette lighter to R5 in the hallway. R3, R12, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, and R24 are cited at a severity level 4 (immediate jeopardy/pattern); R4 and R5 are being cited at a severity level 2 (potential for more than minimal harm).The facility's failure to ensure all staff follow proper safety interventions to prevent accidents created a finding of Immediate Jeopardy that began on 1/6/26. Surveyor notified the NHA A (Nursing Home Administrator) of the Immediate Jeopardy on 2/4/26 at 12:22 PM. The Immediate Jeopardy was removed on 2/5/26, however, the deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as the facility continues to implement its action plan.Evidenced by:The facility policy titled Resident Smoking includes: It is the policy of the facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protection applies to smoking and non-smoking residents. Smoking is prohibited in all areas except the designated smoking area. Safety measures. will include, but not limited to: prohibition of oxygen use in smoking area. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. Smoking materials of all residents will be maintained by nursing staff. 1.R3 admitted to the facility on [DATE] with diagnoses including Bipolar, COPD (Chronic Obstructive Pulmonary Disease), Anxiety, Post Traumatic Stress Disorder, Insomnia, and Agitation.R3's Medical Record contained the following:Physician Note dated 12/6/25 at 10:44 AM includes: Reason for visit - self care deficits. more than 35 minute visit spent with R3's record and staff. Assessment and plan - . 3/20/25 chronic hypoxic respiratory failure (condition where the lungs cannot effectively exchange oxygen and carbon dioxide, leading to chronically low oxygen levels or high carbon dioxide levels in the blood.) in a patient with COPD, oxygen needed for survival benefit long term. Patient advised that we will be looking for oxygen lower than 88% in order to continue supplementing to saturation goal above 90%. Patient examined. Chart reviewed, patient compliant . R3 requires oxygen equipment related to the following physical exam findings: breathlessness, confusion, cough, disorientation, fatigue, headaches, tachycardia, and shortness of breath. 8/19/25 chronic hypoxic respiratory failure in a patient with COPD, oxygen needed for survival benefit long term. Patient advised that we will be looking for oxygen lower than 88% in order to continue supplementing to saturation goal above 90%. Patient examined. Chart reviewed, patient compliant. R3 requires oxygen equipment related to the following physical exam findings: breathlessness, confusion, cough, disorientation, fatigue, headaches, tachycardia, and shortness of breath.(It is important to note R3's MAR/TAR (Medication Administration Record/Treatment Administration Record) does not contain the above Physician orders related to R3's need for oxygen therapy.)Nurse Note dated 12/25/25 at 12:30 PM, includes: .Resident up before 6:30 AM this morning per his request. Resident has been noted to be smoking (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	outside. Resident outside with another resident during lunch which is out of character for resident to miss a meal.SBAR (Situation, Background, Assessment, Recommendation) Change In Condition form, dated 12/25/25 at 12:52 PM, includes: .Resident wanted to get out of bed at 6:30 AM which is out of resident's normal time. Recently started to smoke.Nurse Note dated 12/25/25 at 9:29 PM, includes: .He has smoked 2 full packs of cigarettes in the last two days. In the previous 3 years he has never smoked cigarettes.(of note: R3 does not have a smoking assessment or Care plan even though staff are aware R3 is currently smoking.)Physician Note dated 12/26/25 at 11:17 AM, includes Reason for visit - Patient request and tobacco use disorder. Social history - tobacco use/smoking status-every day. type-cigarettes. Years since quitting-7.8. 12/26/25 Cigarettes, still craving. Assessment and plan . 3/20/25 chronic hypoxic respiratory failure in a patient with COPD, oxygen needed for survival benefit long term. Patient advised that we will be looking for oxygen lower than 88% in order to continue supplementing to saturation goal above 90%. Patient examined. Chart reviewed, patient compliant . R3 requires oxygen equipment related to the following physical exam findings: breathlessness, confusion, cough, disorientation, fatigue, headaches, tachycardia, and shortness of breath. 8/19/25 chronic hypoxic respiratory failure in a patient with COPD, oxygen needed for survival benefit long term. Patient advised that we will be looking for oxygen lower than 88% in order to continue supplementing to saturation goal above 90%. Patient examined. Chart reviewed, patient compliant. R3 requires oxygen equipment related to the following physical exam findings: breathlessness, confusion, cough, disorientation, fatigue, headaches, tachycardia, and shortness of breath.(It is important to note the above Physician order is not on R3's MAR/TAR. R3's MAR/TAR does not contain orders for oxygen use.)Nurse Note dated 12/29/25 at 10:30 PM, includes: .Resident was transferred into his chair and he immediately went outside to have a cigarette.Nurse Note dated 12/30/25 at 5:53 AM, includes: Resident has not slept at all tonight. All he did was smoke several cigarettes each time he went out. Resident was caught smoking inside the two doors and there were also two cigarette butts on the floor below him. When he was asked to not go out any longer because he was smoking in the building, he stated that he was not and continued to go outside. He would also not go to the sidewalk because he could not get himself up and down the ramp.(It is important to note R3 is found smoking inside of the doors.)Nurse Note dated 12/30/25 at 9:18 PM, includes: .Resident outside smoking frequently on this shift.Nurse Note dated 12/31/25 at 7:19 AM, includes: .Resident was placed in bed around 3:00 AM and then at 3:35 AM he put half his body off the bed making sure that we had to help get him up, so he could get a cigarette.Nurse Note dated 12/31/25 at 1:52 PM, includes: Resident outside smoking cigarettes blocking the main entrance. Writer informed R3 that this is a non-smoking facility and he would need to go to the sidewalk to smoke if he chooses to smoke. Resident stated he will smoke his cigarette right here. Writer discussed that R3 and visitors need to come through this door and some of them have oxygen, however resident disregarded. Police Department was called and informed. Officer (named) spoke with resident and resident stated he will go to the sidewalk to smoke.(It is important to note R3 is found smoking outside the main entrance and not 20 feet from the entrance in the designated smoking area. It is also important to note staff identified a risk with having oxygen equipment near smoking materials. R3 does not have a smoking assessment or smoking care plan in his medical record even after numerous observations of R3 smoking unsafely.)Facility Self Report, dated 1/7/26, includes: On January 6th at approximately 3:00 AM R3 was observed in his room smoking while oxygen was in use. Staff identified the situation as an immediate safety concern. In accordance with the resident's care plan, two staff members responded. A licensed nurse asked the resident to relinquish the smoking materials due to safety concerns. The resident refused. During the interaction, the resident became (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	physically aggressive toward the nurse. Classification of injury mechanism: During the interaction, while the nurse was attempting to remove smoking materials due to immediate safety concerns and protect herself, the resident moved forward and bit the nurse's hand. The bite occurred during close proximity while staff were attempting to disengage and ensure safety. No chokehold or restrictive hold was used. Immediate Action Taken: Staff intervened to ensure safety. Emergency services were contacted. Law enforcement responded. The nurse elected to press charges. The resident was transferred to the hospital for psychiatric evaluation. At the time of the incident, the resident was unable to be safely redirected within the facility setting. Post-Incident Assessment: Following the incident, the resident received a skin integrity assessment, and no injuries or concerns were identified. Post-Incident Allegation: Following return from the hospital, the resident reported to the Nursing Home Administrator that during the prior incident the nurse jumped on him, placed him in a chokehold, and punched him. Facility Review and Findings: The allegation was reviewed immediately. Staff members present during the incident stated the alleged actions did not occur. No injuries consistent with the allegation were observed or documented. The report was made following recent psychiatric hospitalization. The resident's report was reviewed in the context of the resident's psychiatric condition and mental status at the time of the incident. Care Plan Review and Preventive Interventions: The resident has an active behavioral care plan addressing periods of behavioral dysregulation, including agitation, verbal escalation, and refusal of care. Following this incident, the resident's care plan was reviewed and reinforced to emphasize resident and staff safety and reduce hands-on interaction during periods of escalation. Interventions include a two staff approach, maintaining appropriate staff positioning (including doorway support), minimizing close physical contact when possible, and providing redirection in a calm environment. As part of the resident's behavioral interventions, 1:1 supervision from a distance is utilized as clinically indicated. Staff are directed to maintain appropriate distance, move other residents away for safety, and avoid close physical contact when the resident is exhibiting aggressive behaviors. Additional structure and monitoring were implemented, and the resident was subsequently transferred for psychiatric evaluation and stabilization. Outcome and follow up: The resident remained under the hospital care for psychiatric stabilization following the incident. Required notifications, documentation, and reporting were completed in accordance with facility policy and regulatory requirements.CNA P's (Certified Nursing Assistant) Statement: I was CNA working during the shift and was positioned outside of the resident's room per the resident's current care plan. At approximately 3:00 AM. I smelled cigarette smoke and observed that the resident was smoking in his room while oxygen was in use. I immediately notified RN CC (Registered Nurse), and we responded to the room together. RN CC entered the room, and I remained positioned nearby for observation and support. The nurse asked the resident to relinquish the smoking materials due to safety concerns. The resident refused. During the interaction, the resident became physically aggressive toward RN CC, striking her and subsequently biting her hand. I contacted emergency services. The nurse was able to remove the lighter, and the situation was stabilized until EMS (Emergency Services) and law enforcement arrived. At no time did the nurse or I strike the resident. After emergency responders departed, the nurse and I did not re-enter the room, and another staff member was assigned to meet the resident's care needs. RN CC's statement: At approximately 3:00 AM, I was at the nurse station when CNA P reported that R3 was smoking in his room. I responded to the room and observed the resident smoking while oxygen was in use. In accordance with safety procedures, I asked R3 to relinquish the smoking materials due to the immediate risk. R3 refused and became increasingly agitated. During the interaction, R3 became physically aggressive, striking me and subsequently biting my left hand. I (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	attempted to protect myself and disengage while removing the lighter. Emergency Services were contacted. CNA P was present during the interaction and assisted with contacting 911. I exited the room once it was safe to do so. EMS and law enforcement responded. I later received medical attention for a human bite. NHA A (Nursing Home Administrator) was notified of the incident. ADON Q's (Assistant Director of Nursing) statement: I cared for R3 during the night shift following the incident involving staff. During routine care and interactions, R3 did not express any concerns regarding the care provided by staff the prior shift. R3 was assisted with repositioning and routine care as needed. No new concerns were identified during my shift.Nurse Note dated 1/9/26 at 4:38 PM, includes: Resident smoking cigarettes in room. Resident was asked to put the cigarette out which he refused initially. Oxygen was taken out of his room for safety. Police Department was called as resident was not putting cigarette out. Resident eventually started putting the cigarette out on the window drapes. Writer expressed to resident that this was unsafe and could cause a fire. Resident continued to put out cigarette on drapes. Writer pulled drapes back so they were out of reach. Police Department arrived and resident started being uncooperative and verbally aggressive toward Police Department. Police Department contacted crisis who came to building to speak with resident.During interview on 2/3/26 at 2:11 PM, CNA O indicated R3 used to be the Resident Council President and she did not know him to smoke until recently.During an interview on 2/3/26 at 2:24 PM, LPN N indicated R3 started smoking recently and he was observed smoking in his room while oxygen was in use. LPN N indicated if she observed a resident smoking while using oxygen, she would let them know they can't smoke inside. LPN N indicated if a CNA observes a resident to be smoking while using oxygen they are to make sure the cigarette is put out and report it to the nurse. LPN N stated, When a resident admits who is a smoker, we have to do an assessment for safety - where to light, where to extinguish.During an interview on 2/3/26 at 2:28 PM, CNA P indicated she was sitting outside of R3's room providing supervision when she smelled smoke. She looked in the room and saw R3 had a lit cigarette in his mouth while wearing oxygen. While standing outside of door, CNA P called to nurse station, RN CC, he has a lit cigarette in his mouth. CNA P stated, She came and we went in together. She asked him 2-3 times to put his cigarette out or give to her so she could put it out. That is when she reached out for cigarette to break it in half. He bit the outside of her hand and he was punching the upper half of her body. We got the cigarette out of his mouth after he bit her. She got it and we left the room. EMS and police arrived. Staff from other side came to assist EMS and police so we were not in there after altercation. He wasn't being very cooperative. Surveyor asked if CNA P received any education after the incident. CNA P indicated she received education related to how to handle residents with aggressive behaviors. CNA P indicated management told her next time to just unplug the oxygen source, call the cops, make sure everyone around is safe, and do not put herself in danger. Surveyor asked if CNA P received any further education related to the smoking policy. CNA P indicated she had not.On 2/4/26 at 8:21 AM, Surveyor observed R5 smoking outside in the designated smoking area. R5 indicated to Surveyor staff are to lock up smoking materials and give residents who wish to smoke one cigarette and their lighter to them on the way outside. R5 indicated residents are to turn their lighter in when they come inside after smoking, but the facility does not always enforce this.R3's Medical Record, reviewed 2/4/26, does not contain a Resident Safe Smoking Assessment.R3's Comprehensive Care Plan, reviewed 2/4/26, does not contain any goals or interventions related to safe smoking.On 2/4/26 at 9:25 AM, DON B (Director of Nursing) indicated staff should have completed a Resident Safe Smoking Assessment for R3, but he is not sure that was done.On 2/4/26 at 9:42 AM, Surveyors observed R3's room and 12 other resident rooms to be on a unit with 1 fire safe door upon entrance.On 2/4/26 at 9:50 AM, Corporate RN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	C indicated a Resident Safe Smoking Assessment was not completed for R3. Corporate RN C and Surveyor reviewed R3's comprehensive care plan. Corporate RN C indicated staff should have care planned goals and interventions related to safe smoking for R3 but did not. Corporate RN C indicated the facility did not do house wide education related to the facility smoking policy, including the storing of smoking materials, assessing safety of residents who choose to smoke, or care planning goals and interventions for residents with a desire to smoke.In interview on 2/4/26 at 10:15 AM, NHA A indicated a safe smoking assessment was not completed for R3, R3's care plan was not updated to include interventions or goals related to safe smoking, and R3's medical record did not have oxygen orders in his MAR/TAR and staff continued using it. NHA A indicated staff did not collect smoking materials to be stored per facility policy, staff did not document that R3 had smoking materials on him/had already been observed smoking in the building/and also uses oxygen, did not educate staff on what to do if a resident who uses oxygen refuses to turn over smoking materials, and did not educate all staff on what to do if a resident is observed smoking while oxygen is in use. NHA A indicated he did educate staff on how to care for a resident with aggressive behaviors and what it means to be 1:1. NHA A indicated if R3's oxygen tank blew up due to activated smoking materials or started a fire, there is potential for serious harm or death to all residents on that side of the fire doors, including R3, R12, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, and R24. On 2/4/26 at 12:22 PM, Surveyor notified NHA A, DON B, and Corporate RN C of the finding of immediate jeopardy at F689.The facility failed to assess R3 for safety related to smoking. The facility failed to create a care plan with goals and interventions related to R3's smoking. The facility failed to secure residents' smoking materials per facility policy. The facility failed to document R3 was in possession of his smoking materials when they identified a risk having oxygen equipment near activated smoking materials. The facility failed to reeducate staff on the smoking policy and procedure after R3 was found to be smoking unsafely. These failures created a reasonable likelihood for serious harm to occur, thus leading to a finding of immediate jeopardy. The immediate jeopardy was removed on 2/5/26, however, the deficient practice continues at a scope/severity level of E (potential for more than minimal harm/pattern) as the facility continues to implement the following action plan:The facility educated all staff on the following. Education began 2/4/26 on pm shift and All staff educated prior to working their shift moving forward:Facility smoking policy that includes Staff received immediate education on the facility smoking policy, including resident eligibility, and safe smoking practices. The spoken policy was revised to include provisions for residents who elect to self-store smoking materials. These residents must demonstrate safe management and utilize and proof locked storage box in accordance with the plan of care.Facility storage of smoking materials for residents Education included proper storage of smoking materials at the nurses station or in approved locked boxes per the resident's plan of care.Steps to take when residents display unsafe smoking staff were also trained on immediate actions for unsafe smoking, including redirection to securing materials, addressing oxygen risks, and notifying leadershipAll residents who smoke were reeducated on the smoking policy and the requirements of keeping materials on 2/4/26.On 1/26/26 the facility completed the followingGenerated a comprehensive list off all residents who expressed a desire to smokeCompleted a smoking evaluation for each identified resident along with care plan revisions and offering of smoking cessationOn 2/4/26 the facility reviewed and updated the smoking policyAdministrator or designee will conduct random audits 4 times weekly for 8 weeks of residents who smoke to ensure smoking is done safely and policy is followed, assessments are completed, and care plans in place along with updates as appropriate along with correct storage of smoking materials. Results of the audits will be reviewed at QAPI for further (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	recommendations. 2. (the following example is at the severity/scope level of isolated no actual harm, potential for minimal harm/isolated).R4 admitted to the facility on [DATE] with the following diagnoses: anxiety, bipolar disorder, major depressive disorder, and type 2 diabetes mellitus.R5 admitted to the facility on [DATE] with the following diagnoses: acquired absence of left leg below the knee, anxiety, major depressive disorder, post traumatic stress disorder, alcohol abuse, and tobacco use.On 2/4/26 at 3:24 PM, Surveyors observed R4 hand R5 a lighter in the facility's hallway. Surveyor immediately reported this observation to LPN N. LPN N indicated that residents had the right to keep their own smoking materials and she stayed seated in the nurse station.On 2/4/26 at 3:26 PM, Surveyor reported to DON B (Director or Nursing) the observation of R4 handing R5 a lighter in the hallway. DON B indicated residents are to return their smoking materials to staff when they are done smoking and should not be handing them off to other residents. DON B indicated LPN N should follow facility policy and procedures related to safe smoking. DON B indicated he would take care of this right away.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident is offered sufficient fluid intake to maintain proper hydration and health for 1 of 1 resident (R1) reviewed for hydration.R1 did not consistently meet his required fluid intake goals and was sent to the hospital, where he received IV (intravenous) fluids, on 3 occasions between 12/12/25 and 1/17/26. The facility failed to complete hydration assessments, monitor R1's fluid intake, failed to update the Dietitian and R1's provider when indicated and failed to implement additional interventions to prevent dehydration.Evidenced by:Surveyor requested the facility's hydration policy. No policy was provided.R1 admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (a loss of muscle tissue and mass leading to weakness); morbid obesity; polyneuropathy (a condition characterized by damage to multiple peripheral nerves causing numbness, tingling, pain, and weakness); and chronic pain syndrome (chronic pain lasting for months or years, leading to emotional and physical symptoms, such as depression, anxiety, fatigue, and sleep disturbances, interfering with daily life.)R1's H&P (History and Physical), dated 11/24/25 and completed by NP H (Nurse Practitioner,) states in part: .Given the recent weight gain and mild bilateral lower extremity edema (swelling caused by excess fluid trapped in body tissues), fluid status should be closely monitored.On 2/4/26 at 10:49 AM, Surveyor interviewed ADON Q (Assistant Director of Nursing) who stated that 'fluid status should be closely monitored' referenced in the H&P would need to be clarified; do weights need to be monitored, are we just watching fluid intake. Surveyor asked if there had been clarification. ADON Q indicated she was unsure.On 2/4/26 at 1:32 PM, Surveyor interviewed DON B (Director of Nursing) who stated that 'fluid status should be closely monitored' means that staff should visualize how much the resident is drinking and put the information into the electronic health record. If there is a decline, notify the nurse to review. The nurse should update the provider if there are concerns. Surveyor asked if R1 was at risk for dehydration. DON B stated yes, due to his wounds. DON B stated the dietician was monitoring; saw R1 in November and was due to see R1 again in January, but R1 passed away.On 2/4/26 at 3:06 PM, Surveyor interviewed NP H and asked what is expected of the facility when H&P states to closely monitor fluid intake. NP H stated, make sure the resident is drinking the water provided and document how much fluid is going in each day. Surveyor asked if staff reported on R1's fluid intake. NP H stated, not that I recall.R1's Fluid Intake records indicate the following milliliter intakes:11/25/25 75011/26/25 185011/27/25 227511/28/25 2050R1's Dietary Note dated 11/28/25 at 5:43 PM, states in part: .Estimated needs.Fluids: 1ml (milliliter)/1 kcal (kilocalorie; a unit of energy representing 1,000 calories)=2376-2640 mls/day (milliliters per day). Resident is at risk for malnutrition related to multiple medical diagnoses including obesity, atrial fibrillation, HTN (hypertension; high blood pressure), seizures, chronic pain syndrome; CKD (Chronic Kidney Disease)-stage 3, mood disorder, and need for therapeutic diet and skilled nursing care. Goals: .Resident will consume and tolerate > (greater than) 50% of meals consistency to help maintain good skin integrity with no signs of dehydration or malnutrition.Appetite and meal/fluid intake appear adequate at this time.RD (Registered Dietician) to continue to monitor and f/u (follow up) prn (as needed).R1's Fluid Intake records indicate the following milliliter intakes:11/29/25 2400 (R1 met his estimated fluid needs (EFN))11/30/25 120012/1/25 195012/2/25 3100 (R1 met his EFN)12/3/25 195012/4/25 100012/5/25 168012/6/25 195012/7/25 192012/8/25 97012/9/25 145012/10/25 217412/11/25 195012/12/25 600Is it important to note that from 11/29/25 to 12/12/25, R1 did not meet the recommended fluid goal on 12 out of 14 days.R1's SBAR (Situation, Background, Assessment, Recommendation) Communication Form, dated 12/12/25, states in part: Summarize your observations and evaluation: Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0692 Level of Harm - Actual harm Residents Affected - Few	notified nurse that he was having pain and burning in his kidneys. Resident rated pain as 8/10. Resident seemed more out of it than usual.R1 was sent to the ED/UC (Emergency Department/Urgent Care) on 12/12/25. R1's ED/UC Note-Provider, service date 12/12/25, states in part: .History of Present Illness.On arrival patient is awake and alert but has very dry mucous membranes and it is difficult for him to talk. Medical Decision Making .Patient's acuity is acute with moderate symptoms. Multiple diagnoses have been considered for this patient that include but are not limited to, UTI (urinary tract infection), dehydration, pneumonia, .I made a plan with the patient to place an IV (intravenous-a medical process for delivering fluids into a person's vein for rapid distribution throughout the body) . Patient received 1 L (liter) of normal saline to help with rehydration as patient's tongue is dry and shriveled.Patient will have a second liter of normal saline to help with continued rehydration as his mouth is beginning to have saliva and tongue not be so dry. Patient looks improved and is able to speak and respond much more easily.Patient Instructions . Please continue to orally rehydrate patient with plenty of water and electrolyte (electrically charged minerals including sodium, potassium, calcium, magnesium, chloride, phosphate) drinks.(of note: R1 had a dry and shriveled tongue and lack of saliva prior to receiving 2 L of fluid. R1's Medical Record has no evidence that he was provided with electrolyte drinks, hydration assessment was completed, continued monitoring or new interventions were implemented to prevent further dehydration.)On 2/5/26 at 7:44 AM, Surveyor interviewed RD I (Registered Dietician) and asked if R1 was meeting the recommended fluid goals. RD I reviewed the intake records and stated no, not every day. Surveyor asked what is recommended when a resident is not meeting goals for fluids. RD I stated, usually we have a weekly resident at risk meeting and the facility asks me to take a peek. I was not notified of him, to the best of my knowledge. Sometimes we would recommend additional fluids at meals or to be given with medication administration. Some of these (fluid levels) should have been notified. 12/3/25 through 12/7/25, I should've been notified. I would've ordered additional fluids and maybe asked for labs to be sure of kidney function. After 3 days, we would have intervened so that intake could come up and we'd continue to review. Surveyor asked about recommendation of electrolyte drinks following ED/UC visit on 12/13/25. RD I stated that RD I was not aware of the ED/UC visit or the recommendations and RD I indicated that Gatorade would have been provided had RD I known.On 2/5/26 at 10:05 AM, Surveyor interviewed DON B and asked about adequate fluid intake for residents. DON B stated would need to refer to dietician. Surveyor asked if the RD fluid recommendations for R1 were being met. DON B stated, not every day. Surveyor asked what is to occur if a resident is not meeting their goal. DON B stated if the goal is not met, maybe it wasn't charted completely, but if the resident is not taking in water, the nurse is to be updated, the resident is to be assessed and the provider and dietician are to be updated. Surveyor asked what is included in the assessment. DON B stated skin, mucous membranes, vital signs. Surveyor asked if the dietician or provider was updated regarding R1 not meeting goals. DON B stated there was no documentation of notification. Surveyor asked if the dietician was updated about the hospital recommendation of electrolyte drinks. DON B stated I don't recall that recommendation in the discharge paperwork.R1's Fluid Intake records indicate the following milliliter intakes:12/14/25 11512/15/25 220012/16/25 180012/17/25 205012/18/25 95012/19/25 185012/20/25 235012/21/25 120012/22/25 120012/23/25 80012/24/25 25012/25/25 4600 (R1 met his EFN)12/26/25 80012/27/25 4400 (R1 met his EFN)12/28/25 4400 (R1 met his EFN)12/29/25 3600 (R1 met his EFN)12/30/25 108012/31/25 600It is important to note that from 12/14/25 to 12/31/25, R1 did not meet the recommended fluid goal on 14 out of 18 days.On 2/5/26 at 7:44 AM, Surveyor interviewed RD I (Registered Dietician) who reviewed fluid intakes and stated there were consecutive days of poor intake from 12/21/25 through 12/24/25. RD I indicated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0692 Level of Harm - Actual harm Residents Affected - Few	expectation of being notified, but was not notified.R1's SBAR Communication Form, dated 12/31/25, states in part: The change in condition, symptoms, or signs observed and evaluated is/are: Altered Mental Status.Summarize your observations and evaluation: Resident is very difficult to arouse, not alert per his usual. His words/sentences aren't making sense.R1 was sent out to the hospital on [DATE] and remained hospitalized until 1/2/26. R1's Hospital Discharge summary, dated [DATE], states in part: .Hospital Course / Treatment Rendered .was diagnosed with dehydration.was given IV hydration.(Of note: this is the 2nd hospital visit for R1 that required fluids to be given for rehydration. There is no evidence in R1's chart to indicate a hydration assessment , increased monitoring or new interventions were implemented to prevent further dehydration.)R1's Fluid Intake records indicate the following milliliter intakes:1/2/26 12001/3/26 14001/4/26 11231/5/26 250It is important to note that from 1/2/26 to 1/5/26, R1 did not meet the recommended fluid goal on 4 out of 4 days.R1's Nutrition-Fluids records indicate the following for task record question: how much did the resident drink (in ml)?1/6/261:45 AM not applicable1:59 PM not applicable7:47 PM 20001/7/261:18 AM 10001:44 PM not applicable9:59 PM 2501/8/263:45 AM not applicable8:06 AM 7509:59 PM 25011:58 PM not applicable1/9/269:37 AM 7509:59 PM 6001/10/261:42 AM not applicable1:59 PM 2509:48 PM not applicable1/11/261:56 AM 30009:58 PM 2501/12/261:12 AM 200010:21 AM 7504:01 PM 20001/13/261:01 AM not applicable1:17 PM 8505:24 PM 2501/14/264:03 AM 2409:51 AM 7509:16 PM 25010:59 PM 2401/15/269:30 AM 5007:48 PM 10001/16/268:08 PM resident refusedIt is important to note that from 1/6/26 to 1/16/26, R1 did not meet the recommended fluid goal for 9 out of 11 days.On 2/4/26 at 1:49 PM, Surveyor interviewed CNA E (Certified Nursing Assistant) and asked about R1's fluid intake. CNA E stated it was hit or miss; if R1 was awake and with it, R1 would do really good, but other days R1 might refuse or need extra cueing and sometimes assistance. Surveyor asked about intake listings of Not Applicable. CNA E stated there was nothing gone, it would mean zero.R1's SBAR Communication Form, dated 1/16/26, states in part: The change in condition, symptoms, or signs observed and evaluated is/are: Altered mental status, seems different than usual .Summarize your observations and evaluation: Resident is not alert per usual, difficult to arouse, having trouble staying awake enough to swallow food/medications, respirations are low at 12 and labored. DON and MD aware.called for transport to ER for eval.R1's ED/UC discharge instructions, dated [DATE], state in part: Patient Instructions: Please make sure R1 is getting enough fluids. Diagnoses from Today's Visit Dehydration .(of note: this is R1's third ED visit related to dehydration, there is no evidence in R1' chart that a hydration assessment or continued monitoring were put in place despite being dehydrated)R1's Progress Note, dated 1/17/26 at 4:49 AM, states in part: Resident returned back from ED. Report given from ED nurse: resident dehydrated. Given 3L of IV fluids.On 2/5/26 at 7:44 AM, Surveyor interviewed RD I and asked about resident being sent out to the ED and receiving IV fluids. RD I stated that RD I was not aware of the ED trips and added, Ideally, they should tell me about the trip out and fluids given; there would be additional orders.On 2/5/26 at 7:58 AM, Surveyor interviewed NP H and asked about expectations when a resident is not meeting recommended fluid goals. NP H stated that an update would be expected if the intake is significantly less; less than half. Surveyor reviewed R1's intakes with NP H. NP H stated that NP H did not recall being updated by the facility about fluid intakes for R1.On 2/5/26 at 10:05 AM, Surveyor interviewed DON B who stated that nursing should be completing full assessments after R1's return from the hospital, and the resident should continue to be assessed for 72 hours. Nursing would look to see if there were any concerns/indications to need a full assessment and make sure that the resident is receiving adequate fluid. DON B stated that vital signs should be checked daily. Surveyor asked if assessments had been completed for 72 hours following R1's ED and hospital visits. DON B stated no, I am not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0692 Level of Harm - Actual harm Residents Affected - Few	seeing the assessments in the chart.R1 did not meet his estimated fluid needs daily. The facility failed to monitor and assess R1's hydration status, failed to implement interventions to prevent further dehydration from occurring and failed to update the RD and Physician when indicated. This resulted in R1 being sent out to the hospital three times for dehydration and receiving IV fluids.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 needs respiratory care is provided such care consistent with professional standards of practice for 2 of 2 residents (R3 and R1) reviewed for oxygen. R3 had Physician Notes with orders for oxygen therapy. These orders were not in R3's MAR/TAR (Medication Administration Record/Treatment Administration Record). Staff were unsure how many liters of oxygen R3 was supposed to be on. R1 did not have orders for bipap (bilevel positive airway pressure, non-invasive ventilation therapy used to assist with breathing.) and oxygen. Evidenced by: The facility's Oxygen Administration policy, undated, states, in part: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.4. The residents' care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. the type of oxygen delivery system. B. When to administer, such as continuous or intermittent and/or when to discontinue. C. Equipment setting for the prescribed flow rates. D. Monitoring of SpOx (oxygen saturation) levels and/or vital signs as ordered. E. Monitoring for complications associated with the use of oxygen.Types of delivery systems include: .d. CPAP Mask – This mask is part of a system that allows a resident to receiver continuous positive airway pressure (CPAP), with or without an artificial airway. The system is comprised of a mask, tubing, and a machine that generates a constant flow of air pressure. Machines have different settings. Important to note: there is no mention of BiPaP (a non-invasive ventilation therapy, for sleep apnea, that delivers pressurized air through a mask at two alternating pressures; higher for inhalation, lower for exhalation; while simultaneously supplying supplemental oxygen to improve blood oxygen levels) in the oxygen policy. Example 1 R3 admitted to the facility on [DATE] with diagnoses, including Bipolar, COPD (Chronic Obstructive Pulmonary Disease), Anxiety, Post Traumatic Stress Disorder, Insomnia, and Agitation. R3's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 11/11/25, indicates R3's cognition is fully intact with a BIMS (Brief Interview for Mental Status) of 15 out of 15. R3's MD (Medical Doctor) Note, dated 12/6/25, includes: Reason for visit- self care deficits. more than 35 minute visit spent with R3's record and staff. Assessment and plan- . 3/20/25 chronic hypoxic respiratory failure in a patient with COPD, oxygen needed for survival benefit long term. Patient advised that we will be looking for oxygen lower than 88% in order to continue supplementing to saturation goal above 90%. Patient examined. Chart reviewed, patient compliant . R3 requires oxygen (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment related to the following physical exam findings: breathlessness, confusion, cough, disorientation, fatigue, headaches, tachycardia, and shortness of breath. 8/19/25 chronic hypoxic respiratory failure in a patient with COPD, oxygen needed for survival benefit long term. Patient advised that we will be looking for oxygen lower than 88% in order to continue supplementing to saturation goal above 90%. Patient examined. Chart reviewed, patient compliant. R3 requires oxygen equipment related to the following physical exam findings: breathlessness, confusion, cough, disorientation, fatigue, headaches, tachycardia, and shortness of breath. R3's Physician Orders, dated December 2025, are signed by R3's Physician and do not contain orders for oxygen therapy. R3's MAR/TAR (Medication Administration Record/Treatment Administration Record), dated December 2025, does not contain Physician Orders for oxygen therapy. Facility Self Report, dated 1/7/26, includes: On January 6th at approximately 3:00 AM R3 was observed in his room smoking while oxygen was in use. Staff identified the situation as an immediate safety concern. (It is important to note R3 is observed by staff using oxygen without an order.) Nurse Note, dated 1/9/26 at 4:38 PM, includes: Resident smoking cigarettes in room. Resident was asked to put the cigarette out which he refused initially. Oxygen was taken out of his room for safety. R3's Physician Orders, dated January 2026, are signed by R3's Physician and do not contain orders for oxygen therapy. R3's MAR/TAR, dated January 2026, does not contain Physician Orders related to oxygen therapy. (It is important to note oxygen equipment was in R3's room and in use without an order.) On 2/3/26 at 2:28 PM CNA P indicated she was sitting outside of R3's room providing supervision when she smelled smoke. She looked in the room and saw R3 had a lit cigarette in his mouth while wearing oxygen. On 2/4/26 at 9:25 AM DON B (Director of Nursing) indicated staff know how many liters to set R3's oxygen tank by looking at his orders. Surveyor and DON B reviewed R3's MD note, physician orders, and MAR/TAR. DON B indicated there are no orders transcribed for R3's oxygen and there should be. On 2/4/26 at 9:42 AM Surveyors observed R3's room to have an oxygen tank in it. Surveyor observed staff power on the oxygen tank and the tank gauge was at 2 liters. On 2/4/26 at 9:50 AM Corporate RN C indicated she was unable to find Physician Orders for R3's oxygen therapy. On 2/4/26 at 10:15 AM NHA A (Nursing Home Administrator) indicated residents using oxygen should have orders for the usage and staff should be documenting/monitoring the use of oxygen on resident's MAR/TAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2: R1 admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (a loss of muscle tissue and mass leading to weakness); morbid obesity; Obstructive Sleep Apnea (a common serious disorder where throat muscles relax excessively during sleep, causing the airway to collapse and breathing to repeatedly stop and start); restlessness and agitation R1's Physician Orders, dated 11/20/25, are signed by R1's Physician and do not contain orders for oxygen therapy or BiPAP or CPAP. R1's MAR/TARs (Medication Administration Record/Treatment Administration Record), dated November 2025, December 2025, and January 2026, do not contain physician orders for oxygen therapy, BiPAP or CPAP. On 2/4/26 at 10:49 AM, Surveyor interviewed ADON Q (Assistant Director of Nursing) who stated that R1 used oxygen with BiPAP at night. Surveyor asked if orders are needed for oxygen and BiPAP. ADON Q indicated yes. On 2/4/26 at 1:57 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) who stated that R1 used CPAP with oxygen. Surveyor asked how staff is aware when a resident uses CPAP with oxygen. LPN F stated it would be in the orders and in report. Surveyor asked if the order would be on the MAR/TAR. LPN F indicated she was uncertain if this would be on the MAR/TAR; sometimes things are put in differently. LPN F stated it should be in the orders and we should be checking their level of oxygen delivery. Surveyor requested R1's orders for oxygen and BiPAP/CPAP. No orders were provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 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 ensure that MAs (Medication Assistants) had 4 hours of medication based in-service training per year for 1 of 1 MA reviewed for in-service training.CNA/MA DD (Certified Nursing Assistant/Medication Assistant) did not have documentation of 4 hours of medication based in-service. Evidenced by:CNA/MA DD has a hire date of 3/20/06. CNA/MA DD's education record dated Year 2025 indicates 1 hour of completed inservice (0.5 hours in Quality Assurance and Performance Improvement and 0.5 hours in Compliance and Ethics. The record shows no medication based in-service. A Medication Administration Education for Nursing Staff form, dated 11/6/25, signed by CNA/MA DD, does not include documentation of credited in-service hours.On 2/18/26 at 2:32 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked about in-service training for MAs. NHA A stated that MAs needed an additional 4 hours of education that is medication related. Surveyor asked if CNA/MA DD was provided with the additional 4 hours of education. NHA A stated there is no documentation of the extra 4 hours which should be completed annually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an effective pest control program so that the facility is free of pests, such as bed bugs for 4 of 4 residents reviewed (R14, R6, R15, R25). R6 indicated she has observed bed bugs in her room this week. Staff indicated they have seen bed bugs in R14's and R25's rooms within the last two weeks and captured one in a closed container to show NHA A (Nursing Home Administrator). Staff indicated they saw a bed bug in R15's room last night/this morning. Director of Maintenance K indicated he was not following manufacturer's guidelines for use of the facility's chemical treatment and does not know when the product was purchased or when it expires. NHA A indicated he was unaware the products were donated to the facility and not purchased. NHA A indicated he is unsure when the product expires or when it was opened. Evidenced by: Pest Control Invoice, dated 11/10/25, includes: Bed bug K9 inspection . Pest Control Invoice, dated 11/11/25, includes: Bed bug conventional treatment. Example 1 R6 admitted to the facility on [DATE]. Her most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 1/15/26, indicates R3's cognition is intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. On 2/5/26 at 8:21 AM R6 indicated she has bed bugs in her room and the facility does not do anything about it. R6 indicated she told NHA A (Nursing Home Administrator) and he replied, Are you sure, because we have to take everything out of your room. R6 indicated NHA A is trying to get her to say she did not see them. R6 indicated she has seen them in the last week. Example 2 R14 was admitted to the facility on [DATE]. Her most recent MDS with ARD of 1/5/26, indicates R14's cognition is moderately impaired with a BIMS score of 12 out of 15. R25 was admitted to the facility on [DATE]. Her most recent MDS with ARD of 1/23/26, indicates R25's cognition is intact with a BIMS of 15 out of 15. On 2/5/26 at 9:50 AM CNA/MT L (Certified Nursing Assistant/Medication Technician) indicated staff have seen bed bugs in R14's and R25's room within the last week. On 2/5/26 at 10:28 AM CNA M indicated last week, she was in R14's and R25's room when she caught a bed bug in a sealed container and confirmed it was a bed bug using the internet. She then stripped (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the beds and bagged up all of the clothes. Then she assisted R14 and R25 in the shower and gave them clean clothes while the housekeeping did a deep clean of the room. Example 3 R15 was admitted to the facility on [DATE]. Her most recent MDS with ARD of 1/1/26, indicated R15's cognition is severely impaired with a BIMS score of 3 out of 15. R15's Medical Record contained the following: 1/18/26: Resident has red, itchy bumps on right and left arms, middle of back, and back of neck under her hairline. 1/20/26: Numerous bug bite like bumps scabbed over, no issues. On 2/5/26 at 9:54 AM Housekeeper J indicated staff saw bed bugs in R15's room last night or this morning and sent photos to Director of Maintenance K. On 2/5/26 at 10:03 AM Director of Maintenance K indicated he has never found an infestation of bed bugs in the facility, but one or two pop up here and there every so often. Director of Maintenance K indicated a staff member sent him a photo on the social media outlet, Snapchat, last night, of a bug they thought was a bed bug in R15's room. Director of Maintenance K indicated he unzipped the mattress, looked around, but did not find anything. He also stated he planned to treat the room. On 2/5/26 at 12:51 PM Director of Maintenance K stated staff sporadically catch a bed bug here or there, but I was not aware of any bites. On 2/5/26 at 12:51 PM NHA A (Nursing Home Administrator) indicated he was made aware this morning about a bed bug issue. NHA A indicated he had staff bag up all of R15's clothing and linen to have it washed in high heat. He had staff assist R15 in the shower and gave her a gown to wear. Then NHA A indicated Director of Maintenance K chemically treated the room. NHA A indicated it is expensive to keep treating rooms when only one bug is observed every so often. NHA A indicated he had an exterminator come in, in November, and treated some of the building. NHA A indicated the exterminator brought a dog in to identify if there were any remaining bed bugs but the dog did not alert to any. NHA A indicated he instructed Director of Maintenance K to use facility owned chemicals to treat rather than calling an exterminator. On 2/5/26 at 3:40 PM, Surveyor interviewed DM K (Director of Maintenance) and asked about treatment for bed bugs. DM K stated that one container of Gentrol (one ounce vial of insect growth regulator designed to break the life cycle of pests including bed bugs) was mixed with one gallon of water in a pressure sprayer. The mix was then sprayed around the affected room. DM K stated that treatment has been performed three times with that one vial of Gentrol and there is still enough mixture left for an additional treatment. Surveyor asked when the treatments were done. DM K stated did not recall the date of first treatment, but second treatment was two weeks ago, and third treatment was today. DM K stated this was all done with the same mix. Surveyor observed the instructions on the box of Gentrol which state, in part; Dilution preparation:.use 1 fluid ounce of Gentrol to 1 gallon of diluent. Partially fill the mixing container with diluent, add the Gentrol, shake or stir, and fill to final volume. Use diluted solution within 48 hours of mixing. Surveyor asked if the solution was used within 48 hours, per manufacturer instruction. DM K stated no. Surveyor asked if it was possible that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the second and third treatments were not effective. DM K stated, it is possible. On 2/5/26 at 5:19 PM NHA A and Corporate RN C indicated Director of Maintenance K should be following manufacturer's recommendations when mixing and storing the chemical treatment. NHA A indicated he was unaware Director of Maintenance K received these chemicals from a job he worked at over 5 years ago. NHA A and Corporate Consultant C indicated chemicals should have an expiration date and an open date to determine shelf life, and staff should use and store chemicals according to manufacturer's recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility did not ensure CNAs (Certified Nursing Assistants) received the required 12 hours of annual in-service training for 5 of 5 CNAs reviewed for in-service training.This had the potential to affect all residents who reside in the facility.CNA P, CNA/MA DD (Certified Nursing Assistant / Medication Assistant), CNA EE, CNA FF, and CNA GG did not have documentation of 12 hours of annual in-service training.Findings include:The facilty's Required Training, Certification and Continuing Education of Nurse Aides policy, dated 10/1/22, states, in part: . 5. The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. a. Documentation of in-services will be forwarded to the HR (Human Resources) Director and maintained in the employee's personnel file.Surveyors randomly selected 5 CNAs to review their 12 hours of in-service training and requested the documentation from the facility CNA P has a hire date of 2/8/2023. CNA P's education record, dated Year 2025, indicates 10 hours of completed in-service. A Nurse Aide Competency Form, dated 3/15/25, signed by CNA P does not indicate the number of credited in-service hours.CNA/MA DD has a hire date of 3/20/06. CNA DD's education record dated Year 2025 indicates 1 hour of completed inservice. A Nurse Aide Competency Form, dated 3/9/25, signed by CNA/MA DD, does not indicate the number of credited in-service hours.CNA EE has a hire date of 5/12/13. CNA EE's education record dated Year 2025 indicates 1 hour of completed in-service.CNA FF has a hire date of 4/24/24. CNA FF's education record dated Year 2025 indicates 1 hour of completed in-service.CNA GG has a hire date of 5/23/18. CNA GG's education record dated Year 2025 indicates 1 hour of completed in-service. A Nurse Aide Competency Form dated 4/22/25, signed by CNA GG, does not indicate the number of credited in-service hours.On 2/18/26 at 2:32 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked about CNA in-service training. NHA A stated that the facility no longer has access to their computerized education system, as of about 3 months ago, and the facility has moved to in person in-services. NHA A stated that CNAs should receive at least 12 hours of continuing education. NHA A stated there is not documentation of 12 hours of in-service for these CNAs.