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	05/19/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident had the right to request, refuse, and/or discontinue treatment, and to formulate an advance directive for 1 of 22 sampled residents (R53) and 1 of 1 supplement Residents (R9) reviewed for advance directives. The facility did not have guardianship paperwork on file for R9.The facility did not have a Do Not Resuscitate (DNR) form on file for R53 to match his wishes.This is evidenced by:The facility policy, titled Residents' Rights Regarding Treatment and Advance Directives, dated [DATE], states, in part: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive.Policy Explanation and Compliance Guidelines:. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on [sic] the chart as well as communicated to the staff.7. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. 9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.Example 1R9 admitted to the facility on [DATE] enrolled in hospice care with diagnoses that include, in part: cerebral palsy (brain condition that affects muscle control, movement, and coordination), quadriplegia (paralysis of all four limbs), and epilepsy (neurological condition with frequent, uncontrolled seizures). R9's face sheet indicated he had two activated guardians. Surveyor reviewed R9's advance directive information on file and noted he had an active DNR order signed by one of his guardians and his physician. No guardianship paperwork was located in his file. On [DATE] at 3:00 PM, Surveyor asked MR N (Medical Records) if she was able to locate any POA (Power of Attorney) or guardianship paperwork in R9's chart. MR N searched and was unable to locate any POA or guardianship documents on file for R9. MR N directed Surveyor to speak with Admissions O. MR N indicated Admissions O works with new admissions and handles POA documents. These documents are given to MR N and she scans them into the resident's medical record and keeps a paper copy as well.On [DATE] at 4:22 PM, Surveyor spoke with Admissions O. Admissions O indicated the facility's process is to request POA or guardianship documents immediately upon admission. Surveyor asked about R9. Admissions O indicated R9's guardianship documents should be in his file. Admissions O said she would check R9's file and would request these documents from his hospice agency if the facility did not have them. On [DATE], Surveyor reviewed R9's file and confirmed R9's hospice agency had faxed his guardianship paperwork to the facility, and the facility had uploaded it to his medical record. On [DATE] at 2:15 PM, Surveyor discussed the facility's issue with advance directives with DON B (Director of Nursing). DON B indicated he had been made aware of the issue. Example 2 R53 admitted to the facility on [DATE]. R53's most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], shows R53 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating R53 has moderate cognitive impairment. R53's face sheet indicated he did not have an activated HCPOA (Health Care Power of Attorney) or guardian. On [DATE], the banner on top of R53's (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronic Health Record (EHR) stated Do Not Resuscitate (DNR) with a DNR physician's order dated [DATE]. R53 did not have a copy of a signed Emergency Care Do Not Resuscitate Order (DNR) on file. R53 had a cardiopulmonary resuscitation (CPR) directive on file signed by R53 and a witness on [DATE] and a physician on [DATE]. There were no notes in R53's electronic file indicating that he had wished to change his advance directive order from full code to DNR. On [DATE] at 11:57 AM, Surveyor interviewed LPN M (Licensed Practical Nurse) and asked where she would look to find a resident's code status. LPN M indicated she would look in the miscellaneous tab in a resident's file to find his or her signed advance directive. LPN M indicated she would occasionally look at the banner on the front page of a resident's EHR to find the code status. LPN M looked at R53's banner and indicated his code status was DNR. LPN M pulled up R53's CPR form in the miscellaneous tab of his file and indicated that full code was checked. LPN M said she completed that form with R53 when he was admitted to the facility. LPN M indicated, That's a problem that they don't match. On [DATE] at 12:51 PM, Surveyor interviewed ADON E (Assistant Director of Nursing) regarding R53's code status. ADON E indicated staff can look at a resident's banner to determine a code status quickly. ADON E pulled up R53's EHR and indicated his code status was DNR. ADON E pulled up R53's CPR form dated [DATE] and indicated that form didn't match his DNR order on [DATE]. ADON E indicated he should have a signed DNR form. ADON E indicated R53's HCPOA must have changed his code status. Surveyor asked if R53 had POA paperwork on file. ADON E could not find this paperwork and directed surveyor to MR N (Medical Records) to find R53's DNR form and POA paperwork. On [DATE] at 2:05 PM, Surveyor spoke with R53. R53 indicated he elected to be a full code when he first admitted to the facility but changed his mind and would like his code status to be DNR now. On [DATE] at 2:13 PM, Surveyor spoke with MR N. MR N indicated the facility does not have DNR paperwork filled out for R53. MR N indicated the facility has POA paperwork for R53 and it is not activated. On [DATE] at 3:15 PM, Surveyor spoke with ADON E. ADON E indicated she now remembered speaking with R53 previously about changing his code status from full code to DNR. ADON E said she informed the NP (Nurse Practitioner) who put the DNR order in, but ADON E forgot to have R53 complete the DNR election form. ADON E indicated this form should have been completed. ADON E indicated the facility just changed R53's code status to full code while they are working on completing his DNR paperwork. On [DATE] at 4:08 PM, Surveyor verified that R53's completed DNR form had been uploaded into his EHR. R53's physician order on file still indicated he was a full code.On [DATE] at 4:20 PM, ADON E indicated R53's code status order had been changed to DNR.On [DATE] at 4:22 PM, Surveyor spoke with Admissions O and asked about the facility's process for advance directive paperwork. Admissions O indicated the CPR or DNR form is completed by a nurse who admits the resident, but she is unsure of the process after that. Admissions O indicated she requested that she will work with the resident or POA to get the paperwork completed as soon as the resident is admitted to ensure the process is completed correctly, as it is important to get these documents in order.On [DATE] at 4:30 PM, Surveyor checked R53's physician order and it still said full code. At 4:32 PM, Surveyor interviewed MDS RN P (Minimum Data Set Registered Nurse). MDS RN P indicated he forgot to change R53's order, but he would do it now. At 4:41 PM, Surveyor verified that R53's physician order for his code status was DNR. On [DATE] at 2:15 PM, Surveyor discussed the facility's issue with advance directives with DON B (Director of Nursing). DON B indicated he had been made aware of the issue.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident (R11) is free from sexual abuse, from another Resident (R3). R3 was found performing sexual acts on R11. At the time of the event, the facility was unaware whether these two individuals had the capacity to consent to a sexual relationship.Findings includeThe facility's Abuse/Neglect/Exploitation policy states, in part, The facility's Abuse/Neglect/Exploitation policy states, in part, Sexual abuse is non-consensual sexual contact of any type with a resident.The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation or resident property, and exploitation that achieves.Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship.Additionally, the facility's abuse policy states, Investigation of alleged abuse, neglect and exploitation: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.written procedures for investigations include: Identifying staff responsible for the investigation; Identifying and interviewing all involved person, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigationR3 was admitted to the facility on [DATE] and has diagnoses of schizophrenia, mild cognitive impairment and bipolar disorder. Her most recent MDS (Minimum Data Set), dated 2/18/26, includes a BIMS (Brief Interview for Mental Status) score of 10 indicating moderate cognitive impairment.R11 was admitted to the facility on [DATE] and has diagnoses of vascular dementia. His most recent MDS (Minimum Data Set), dated 4/3/26, includes a BIMS (Brief Interview for Mental Status) score of 8 indicating moderate cognitive impairment.A facility incident report dated 3/27/2026 at 12:55 AM states Resident (R3) was found engaging in oral sex with another resident (R11). Nurse was looking for resident (R3) during rounding and found resident in another room. When door was opened, residents separated and both were cooperative with no signs of distress or injury. Residents were interviewed separately and stated that the acts were consensual and risks were discussed with both residents.Of note: The facility was unable to provide any documentation that R3 and R11 were assessed for capacity to consent to sexual relations before 3/27/26. The incident was not reported to the State Agency. The facility did not interview any other residents or staff other than the 3 that were working the night shift at the time of the incident. On 5/14/26, Surveyor interviewed RA W (Resident Assistant) at 9:52 AM, LPN M (Licensed Practical Nurse) at 9:30 AM, CNA Z (Certified Nursing Assistant) at 9:32 AM, CNA AA at 9:27 AM, LPN J at 11:31 AM and LPN X at 11:37 AM. All stated they were unaware that R3 and R11 had been in a sexual relationship, were unaware if they could consent and did not believe either should be in each other's rooms. On 5/14/26 at 11:12 AM, CNA S stated that she was working the night of the sexual encounter between R3 and R11. CNA S stated that she had heard that R3 could not be found but was not sure if there was a sexual encounter and she was never instructed on anything regarding the relationship between R3 and R11, and was unaware if they could consent to a sexual relationship. Additionally, CNA S indicated that staff are to follow the guidelines on their CNA Kardex (care plan) for guidance of resident cares. On 5/14/26 at 11:40 AM, CNA F stated she was aware of R3 and R11 having had a sexual encounter but she didn't ask for any details and was unsure what to do if they wanted to engage in sexual activity again.On 5/14/26 at 11:42 AM. CNA K stated that R3 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and R11 are very close and she heard that R3 had been having oral sex with R11 in his (R11's) room. CNA K stated it was only talked about once and she was concerned if they could do this again, but DON B (Director of Nursing) stated that they (R3 and R11) are 2 consenting adults and staff need to give them privacy. CNA K stated there was no guidance on how to monitor or accommodate this.On 5/14/26 at 12:20 PM. CNA Y stated there was one incident when R3 went into R11's room and performed oral sex on him (R11). CNA Y stated that staff are just supposed to keep the door open and keep the room in view. R3 can go in R11's room but the door needs to stay open and they are not to engage in anything. CNA Y stated that she can not remember who gave her this guidance. It should be noted that neither R3's nor R11's Kardex (CNA care plan) indicated any approach, monitoring, or guidance for sexual relations. On 5/19/2026 at 9:13 AM, Surveyor interviewed DON B who stated that the facility did not have any other documentation on the incident of 3/27/26, nor did he interview other staff on other shifts regarding any other sexual incidents or activity between R3 and R11, or any other residents. DON B indicated they did not interview any other residents. DON B also stated they did not assess R3 or R11 for capacity to consent prior to 3/27/26. The facility was unaware if R3 or R11 could consent to a sexual relationship as they did not assess them for this capacity and therefore did not have a plan in place to accommodate their privacy for such a relationship or protect them from potential abuse. The facility did not put measures into place after the event to ensure continued monitoring or appropriate approaches for the relationship.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law through established procedures for 2 of 2 incidents involving 3 residents (R3, R11, and R42). R3 was found performing sexual acts on R11 and the facility did not report the event to the State Agency. During a PM shift on 5/1/26, CNA S (Certified Nursing Assistant) and CNA T (Certified Nursing Assistant) reported to LPN U (Licensed Practical Nurse) that R42 has a black eye, an IUO (Injury of Unknown Origin). LPN U states CNA S and CNA T did not report R42's black eye. However, LPN U administered medication twice to R42 during her shift and did not note his black eye. LPN U failed to report and observe R42's black eye during her shift. Findings include: The facility's Abuse/Neglect/Exploitation policy states, in part, Sexual abuse is non-consensual sexual contact of any type with a resident.The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation or resident property, and exploitation that achieves.Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. Additionally, the policy states, The facility will have written procedures that include: reporting of all alleged violations to the administrator, state agency, adult Protective Services and to all other required agencies within specified timeframes: immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve use or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. Example 1: R3 was admitted to the facility on [DATE] and has diagnoses of schizophrenia, mild cognitive impairment and bipolar disorder. Her most recent MDS (Minimum Data Set), dated 2/18/26, includes a BIMS (Brief Interview for Mental Status) score of 10 indicating moderate cognitive impairment. R11 was admitted to the facility on [DATE] and has diagnoses of vascular dementia. His most recent MDS (Minimum Data Set), dated 4/3/26, includes a BIMS (Brief Interview for Mental Status) score of 8 indicating moderate cognitive impairment. A facility note, dated 3/26/26 for both residents states, Writer received a call from staff stating that Resident was engaging in consensual sexual intimacy with another resident. Residents separated (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when staff opened the door. Per staff, both residents appeared calm and were cooperative with no signs of injury, distress, or coercion. Additionally, a progress note in both R3's and R11's chart states, Writer and SS [name] at bedside with resident in regard to resident having oral sex with another resident. Resident alert and oriented at this time. Resident stating that sexual acts were consensual. Writer discussed risks of sexual acts including potential STD or infections. Resident stating she is aware of the potential risks involved. Also discussed with resident the risk of emotional distress if the resident who she was having sexual relations with decided to start having a relationship with someone else or another resident. Resident denies any concerns at this point. It should be noted that the facility did not have any assessments or knowledge of either resident's capacity to consent prior to 3/26/26. On 5/19/2026 9:13 AM, Surveyor interviewed DON B (Director of Nursing) who stated that the facility did not have any capacity to consent assessments before the 3/26 incident for either R3 or R11 and were unaware about their ability to consent. DON B also stated that they did not report the incident due to privacy reasons. Example 2: The facility's policy, Abuse/Neglect/Exploitation, states, in part, as follows: Reporting/Response: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury. The State Operations Manual under F600 states in part; 483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. 483.12(a) The facility must- 483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. R42's Minimum Data Set (MDS) dated [DATE], indicates R42 scored 3/15 on his Brief Interview for Mental Status (BIMS) indicating he is severely cognitively impaired. R42 requires assistance of 1 for transferring, dressing, toileting, and hygiene. R42 was admitted to the facility 4/7/26 with diagnoses including, but not limited to, dementia with behaviors (a group of thinking and social symptoms that interferes with daily functioning; symptoms may include aggression, wandering, anxiety or delusions) and amnesia (the inability to recall past experiences). On 5/1/26 PM shift, the following three (3) staff were working together on the unit: CNA S (Certified Nursing Assistant), CNA T (Certified Nursing Assistant-Agency), and LPN U (Licensed Practical Nurse-Agency). CNA S and CNA T reported to LPN U that R42 has a black eye. LPN U did not report this potential allegation of abuse to the management team or any RN (Registered Nurse) for follow up. Furthermore, there is no documentation regarding R42's black eye on this date. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/26 AM shift, CNA K and CNA V observe the bruise to R42's eye. CNA K and CNA V report to ADON/IP C (Assistance Director of Nursing). ADON/IP C assessed R42 and passed the information along to the oncoming RN (Registered Nurse). On 5/2/26 at 10:46 AM, The RN (Registered Nurse) on duty documented, in part, the following Change in Condition assessment: Nursing observations, evaluation, and recommendations are: Resident (R42) has a bruise to left eye (black eye), skin intact (Note, based on staff statement R42's skin is not intact). ADON/IP C reported to DON B (Director of Nursing). DON B immediately initiated the reporting process to the State Agency and began investigating. DON B (Director of Nursing) documented the following typed statement for CNA S (Certified Nursing Assistant): I (CNA S) came on the unit around 4:00 PM and noticed that the resident (R42) had bruising on his face. I reported to the nurse (LPN U-Licensed practical Nurse) when I saw. DON B (Director of Nursing) documented the following typed statement for CNA T (Certified Nursing Assistant): I (CNA T) came onto the unit at 3:00 – 3:30 PM and noticed that the resident (R42) had bruising on his face. Resident (R42) stated that he was rubbing his eye. I reported to the nurse (LPN U-Licensed Practical Nurse) who stated that she was aware and resident (R42) stated he was rubbing and scratching his eye. DON B (Director of Nursing) documented the following typed statement for LPN U (Licensed Practical Nurse): I (LPN U) was the nurse on the unit on 5/1. I did not notice resident (R42) having a black eye. I was taking care of resident (R42) however resident (R42) was sleeping most of the day. Last saw the resident (R42) around 9:00 PM on 5/1. I did not get a good look at his face as when I was in his room helping him he was facing the other way. On 5/2/26 AM shift, the following three (3) people were working together on the floor: CNA K (Certified Nursing Assistant), CNA V (Certified Nursing Assistant) and ADON/IP C (Assistant Director of Nursing/Infection Preventionist). CNA K (Certified Nursing Assistant) documented the following handwritten statement: Today 5/2/26 me (CNA K) and CNA V (Certified Nursing Assistant) went into R42 and his roommate's room to get R42's roommate up for breakfast around 8:00 AM when we saw R42's huge black eye we asked R42 if he was okay and he seemed to be fine so we asked to changed [sic] his sheets because they [sic] were blood everywhere. He was hesitant but he agreed and stood on his walker. We told the nurse (ADON/IP C – Assistant Director of Nursing/Infection Preventionist) immediately because we thought it was a fall that has not yet been reported by [sic] R42 said otherwise. It was because of him rubbing it (his eye) too much it says. CNA V (Certified Nursing Assistant) documented the following handwritten statement: Today May 2, me (CNA V) and CNA K went into R42's room to get his roommate ready for breakfast around 8:00 AM when we noticed that R42 had a huge black eye and blood on his sheets. We asked him what happened he said nothing. He said he was okay. I (CNA V) asked to change his (R42's) sheets he hesitated because he said he wanted to keep sleeping but eventually he agreed. We immediately reported it to the nurse (ADON/IP C – Assistant Director of Nursing/Infection Preventionist) in case it hadn't been reported or seen. He stated that the bruise was from rubbing his eye. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/26 at 9:45 AM, Surveyor spoke with R42. Surveyor observed R42's left eye was still black and blue. R42 stated he thinks a fall may have caused his black eye (this is inconsistent with R42's earlier recollection of events). R42 stated, It's no big deal. R42 stated he feels safe at the facility. On 5/18/26 at 1:57 PM and 5/19/26 at 2:30 PM, Surveyor spoke with LPN U (Licensed Practical Nurse). Surveyor asked LPN U, during your shift on 5/1/26 did any staff report that R42 has a black eye. LPN U stated, No, I didn't' hear anything or see it when passing meds. LPN U stated, I didn't see anything on my shift, I gave him (R42) his medicine twice that shift and didn't see any black eye. Surveyor asked LPN U, did you receive a write up from the facility regarding this incident. LPN U stated, yes, she must tell management when she observes residents with bruises or anything happens. LPN U stated, I have to report it. Surveyor asked LPN U when you administered medication to R42 were the lights on. LPN U stated, yes. LPN U stated, R42 sat up partially in bed twice during her shift to take medication. On 5/19/26 at 9:20 AM, Surveyor spoke with CNA S (Certified Nursing Assistant). CNA S stated, when she arrived at the unit she saw R42's face. CNA S stated, that she and CNA T told LPN U (Licensed Practical Nurse) about the bruise to R42's face. CNA S stated, she might have even sworn she is not sure. CNA S added, we were so alarmed. CNA S stated, LPN U told her I don't know and left it at that when she asked what happened to R42's face. CNA S stated that R42's face was severely bruised. CNA S added, R42's face did not look swollen but it was badly bruised. Surveyor asked CNA S was R42 able to tell you what happened. CNA S stated, no, a lot of times R42 does not want to talk with us. CNA S stated, for example when we bring his meal tray he will tell us to get out. CNA S stated, R42 told her nothing happened. CNA S stated, that is when we went to LPN U (Licensed Practical Nurse). CNA S asked LPN U what happened to R42's face, he has a black eye. CNA S stated, LPN U told her, I don't know I haven't seen it. Surveyor asked CNA S if she wrote a statement following this incident. CNA S stated, yes, she provided the facility with a handwritten statement. CNA S stated, facility staff interviewed her. CNA S added, we (staff) don't type our statements. On 5/19/26 at 11:05 AM, Surveyor spoke with NHA A (Nursing Home Administrator). NHA A stated he is unable to locate the handwritten staff statements for this investigation. NHA A stated, the handwritten statements must have made it into the Shred-it box. On 5/19/26 at 3:43 PM, Surveyor spoke with CNA T (Certified Nursing Assistant). CNA T stated she and CNA S (Certified Nursing Assistant) entered R42's room on 5/1/26 PM shift to find R42 with a black eye. CNA T stated she and CNA S reported R42's black eye to LPN U (Licensed Practical Nurse). CNA T stated that LPN U did not respond to their concern. CNA T stated they (staff) do not care. On 5/19/26 at 11:55 AM, Surveyor spoke with ADON/IP C (Assistant Director of Nursing/Infection Preventionist). ADON/IP C stated, on 5/2/26 she worked from 6:00 AM-11:00 AM. ADON/IP C stated, on 5/2/26 around 9:00 AM CNA K (Certified Nursing Assistant) reported to her that R42 has a black eye and stated she was unsure how he (R42) got it. ADON/IP C stated it was close to the end of her shift. ADON/IP C stated, she reported to the oncoming staff. ADON/IP C stated it is not fun to transfer all that information to the next staff. ADON/IP C stated she went to check it out and talk with R42. ADON/IP C stated, R42 told her it was from rubbing his eye, his eyes are dry and he was rubbing it frequently. Surveyor asked ADON/IP C, to describe the bruising. ADON/IP C stated the bruise was from the inside of R42's left eye around the top and up to his forehead. Surveyor asked ADON/IP C if R42 falls is he able to get himself up off the floor. ADON/IP C stated, she has never seen him get up off the floor but she thinks he is capable of getting himself off the floor. ADON/IP C stated, we all (continued on next page)

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	525338	A. Building B. Wing	05/19/2026

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thought this was a new IUO (injury of unknown origin). ADON/IP C stated, she reported this new IUO to DON B (Director of Nursing) and he went through the steps of reporting and forwarding the information to the oncoming nurse. On 5/19/26 at 1:45 PM, Surveyor spoke with DON B (Director of Nursing). DON B stated, the bruising to R42's face was reported to him on 5/2/26 between 9:00-9:30 AM. DON B stated, CNA K (Certified Nursing Assistant) reported the bruising to ADON/IP C on the morning of 5/2/26. DON B stated, on 5/2/26 at 9:35 AM he called LPN U (Licensed Practical Nurse). LPN U stated to DON B that R42 was sleeping most of the PM shift on 5/1/26 and the last time LPN U saw R42 was around 9:00 PM. DON B stated, LPN U asked DON B if something happened. Surveyor asked DON B, did LPN U deny CNA S (Certified Nursing Assistant) and CNA T (Certified Nursing Assistant) reported R42's black eye to her. DON B stated, he is not going to lie he cannot recall. Surveyor provided DON B with a copy of the typed statement for LPN U. DON B reviewed the typed statement for LPN U. In the typed statement LPN U denied any knowledge. Surveyor asked DON B, when LPN U administered medication to R42 twice during the PM shift on 5/1/26 would you expect her to have observed R42's black eye. DON B stated, yes. DON B stated, when obtaining statements from staff we noted that staff were not looking at residents' faces. Surveyor asked DON B, was the facility looking at R42's IUO as potential abuse. DON B stated, absolutely, R42 stated it was from scratching his eye. DON B stated, he wants to make sure the facility is doing their due diligence. The facility contacted police regarding this IUO (injury of unknown origin). On 5/2/26 at 10:52 AM, a police officer documented in part, as follows: .Staff noticed the R42 had a black eye this morning. They did not know how this injury occurred. I (Officer) met with R42. He had a black left eye (discoloration of skin that was black and blue), and a quarter or so in size bruise to the left side of his head near his forehead that is also black and blue. R42 did not even realize this. R42 advised that he believed it was from itching his eye. It is not from that. LPN U (Licensed Practical Nurse) failed to report an IUO (Injury of Unknown Origin) to management. LPN U is required to report an IUO (Injury of Unknown Origin) immediately, but not later than 2 hours after the allegation is made, as the events that caused the allegation may have involved abuse or resulted in serious bodily injury.

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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. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. and failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for 1 of 2 incidents involving 2 residents (R3 and R11). R3 and R11 were observed engaging in a sexual act and the facility did not conduct a thorough investigation.Findings includeThe facility's Abuse/Neglect/Exploitation policy states, in part, The facility's Abuse/Neglect/Exploitation policy states, in part, Sexual abuse is non-consensual sexual contact of any type with a resident.The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation or resident property, and exploitation that achieves.Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship.Additionally, the facility's abuse policy states, Investigation of alleged abuse, neglect and exploitation: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.written procedures for investigations include: Identifying staff responsible for the investigation; Identifying and interviewing all involved person, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigationR3 was admitted to the facility on [DATE] and has diagnoses of schizophrenia, mild cognitive impairment and bipolar disorder. Her most recent MDS (Minimum Data Set), dated 2/18/26, includes a BIMS (Brief Interview for Mental Status) score of 10 indicating moderate cognitive impairment.R11 was admitted to the facility on [DATE] and has a diagnosis of vascular dementia. His most recent MDS (Minimum Data Set), dated 4/3/26, includes a BIMS (Brief Interview for Mental Status) score of 8 indicating moderate cognitive impairment.A facility incident report dated 3/27/2026 at 12:55 AM states Resident (R3) was found engaging in oral sex with another resident (R11). Nurse was looking for resident (R3) during rounding and found resident in another room. When door was opened, residents separated, and both were cooperative with no signs of distress or injury. Residents were interviewed separately and stated that the acts were consensual. Risks were discussed with both residents.Of note: The facility was unable to provide any documentation that R3 and R11 were assessed for capacity to consent to sexual relations before 3/27/26. The facility did not interview any other residents or staff other than the 3 that were working the night shift at the time of the incident. On 5/14/26, Surveyor interviewed RA W (Resident Assistant) at 9:52 AM, LPN M (Licensed Practical Nurse) at 9:30 AM, CNA Z (Certified Nursing Assistant) at 9:32 AM, CNA AA at 9:27 AM, LPN J at 11:31 AM and LPN X at 11:37 AM. All stated they were unaware that R3 and R11 had been in a sexual relationship, were unaware if they could consent and did not believe either should be in each other's rooms. Additional interviews on 5/14/26:*At 11:12 AM CNA S stated that she was working the night of the sexual encounter between R3 and R11. CNA S stated that she had heard that R3 could not be found but was not sure if there was a sexual encounter and she was never instructed on anything regarding the relationship between R3 and R11 and was unaware if they could consent to a sexual relationship. Additionally, CNA S indicated that staff are to follow the guidelines on their CNA Kardex (care plan) for guidance of resident cares. *At 11:40 AM, CNA F stated she was aware of R3 and R11 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	having had a sexual encounter, but she didn't ask for any details and was unsure what to do if they wanted to engage in sexual activity again.*At 11:42 AM, CNA K stated that R3 and R11 are very close, and she heard that R3 had been having oral sex with R11 in his (R11's) room. CNA K stated it was only talked about once and she was concerned if they could do this again, but DON B (Director of Nursing) stated that they (R3 and R11) are 2 consenting adults and staff need to give them privacy. CNA K stated there was no guidance on how to monitor or accommodate this.*At 12:20 PM CNA Y stated there was one incident when R3 went into R11's room and performed oral sex on him (R11). CNA Y stated that staff are just supposed to keep the door open, and keep the room in view. R3 can go in R11's room but the door needs to stay open and they are not to engage in anything. CNA Y stated that she cannot remember who gave her this guidance. It should be noted that neither R3's nor R11's Kardex (CNA care plan) indicated any approach, monitoring or guidance for sexual relations. On 5/19/2026 at 9:13 AM, Surveyor interviewed DON B who stated that the facility did not have any other documentation on the incident of 3/27/26, nor did he interview other staff on other shifts regarding any other sexual incidents or activity between R3 and R11, or any other residents. DON B indicated they did not interview any other residents. DON B also stated they did not assess R3 or R11 for capacity to consent prior to 3/27/26. The facility was unaware if R3 or R11 could consent to a sexual relationship as they did not assess them for this capacity. When R3 and R11 were found engaging in sexual activity on 3/27/26, the facility did not conduct a thorough investigation that included interviews of staff and residents, and they did not put a plan in place to monitor the continued relationship that they had deemed consensual. Most staff were unaware that sexual activity had occurred and others were unaware of how to accommodate a potential sexual relationship between R3 and R11.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 of 5 residents (R5) reviewed for hospitalizations was provided a bed hold and transfer notice. R5 was hospitalized on [DATE], 5/7/26, and 5/14/26 without a bed hold or transfer notice provided.This is evidenced by: The facility's policy, titled Transfer and Discharge (Including AMA (Against Medical Advice)), dated 10/1/25, states, in part: Policy: It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances.Policy Explanation and Compliance Guidelines:.12. Emergency Transfers/Discharge - initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified).g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated.R5 admitted to the facility on [DATE] following a left leg below-knee amputation. R5's most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 4/2926, shows R5 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R5 was cognitively intact. R5's face sheet indicated he did not have an activate HCPOA (Health Care Power of Attorney) or guardian.Review of R5's Progress Notes from 4/22/26 to 5/19/26 indicate he was admitted to the hospital on the following dates:-5/6/26 at 12:45 PM: Resident has large amount of drainage found from incision from left lower knee amputation.NP (Nurse Practitioner) gave orders to send resident out to the ER (Emergency Room) nonemergent to be seen. 11:21 PM: Resident was sent out to the hospital at 1440 (2:40 PM). He cam [sic] back at 1916 (7:16 PM).-5/7/26 at 8:30 AM: Change of Condition: .Edema (new or worsening) shortness of breath. Recommendations: Send to ER for evaluation.- 5/09/26 at 3:24 PM: Resident arrived back to facility around 3:00 PM.-05/14/26 at 7:11 AM: During morning cares @ 0640 (at 6:40 AM) cna alerted nurse that resident was not responding to verbal stimuli. Floor nurse went to resident and checked blood sugar, blood sugar at that time was 39.911 arrived at facility @ 0710 (at 7:10 AM) to transfer resident to ER.(Of note: there were no progress notes indicating R5 had received a bed hold or transfer notice during any of his transfers to the hospital.)R5 did not return to the facility following his hospitalization on 5/14/26. On 5/19/26 at 2:00 PM, Surveyor noted R5's electronic health record was moved from Current residents to discharged .On 5/19/26 at 3:00 PM, Surveyor asked ADON D (Assistant Director of Nursing) who handles bed holds notices for residents being sent out to the hospital. ADON D indicated the nurse on the unit who is handling the discharge works on the bed hold and it is either verbal or signed. Signed bed holds should be uploaded to the resident's file. Verbal bed hold notices should be in the progress notes. ADON C was also in the room and indicated it would be difficult to find the bed hold documentation.On 5/19/26 at 3:05 PM, Surveyor requested a bed hold and transfer notice for R5 from DON B (Director of Nursing).On 5/19/26 at 3:38 PM, Surveyor followed up with DON B and NHA A (Nursing Home Administrator) and asked if they were able to find any of the bed hold or transfer notifications for R5. DON B indicated they were not able to locate them. NHA A indicated R5 had discharged from the facility as of today and his family had picked up his belongings, so he did not need a bed hold form. Surveyor noted R5 should have received a bed hold and transfer notice each time he was sent to the hospital, as it was presumed that he would return to the facility. Surveyor asked if the resident and/or his family should have been given bed hold and transfer paperwork when he left the facility. DON B said yes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that services provided by the facility meet professional standards of quality for 4 of 5 residents (R6, R7, R4 and R8) reviewed for unnecessary medications. R6 is receiving Trazodone for insomnia, depression, and anxiety related to depression and did not have a sleep assessment/tracking completed for the insomnia diagnosis. R7 is receiving Melatonin for insomnia and did not have a sleep assessment/tracking completed. R4 is receiving antipsychotic medication and did not have a tardive dyskinesia (a neurological disorder characterized by uncontrollable, repetitive body movements) assessment completed. R8 is receiving antipsychotic medication and did not have a tardive dyskinesia assessment completed. Findings Include: The undated facility policy, Sleep Medication/Hypnotic Medication Monitoring Policy, indicates, in part: .Procedure.2. A sleep log will be initiated and completed for a minimum of three (3) consecutive days to monitor sleep patterns, frequency of awakenings, behaviors impacting sleep, daytime fatigue or lethargy, and effectiveness of interventions. The facility's policy Tardive Dyskinesia Monitoring Policy, dated 1/26, includes; The facility will monitor residents receiving antipsychotic medications and other medications associated with movement disorders for signs and symptoms of tardive dyskinesia to ensure early identification, timely intervention, and resident safety in accordance with CMS (Centers for Medicare and Medicaid Services) regulations and accepted standards of practice. 1. Residents receiving antipsychotic medications or other medications associated with tardive dyskinesia will be monitored for abnormal involuntary movements. 2. Monitoring will include completion of an AIMS (Abnormal Involuntary Movement Scale) assessment or other approved assessment tool at least every six (6) months and as needed. Example 1 R6 was admitted to the facility on [DATE] with diagnoses that include, in part: Insomnia, Major Depressive Disorder, and Generalized Anxiety Disorder. R6's physician orders include, in part: Trazadone 50mg oral tablet. Give 1.5 tablets by mouth at bedtime for Insomnia, depression, anxiety related to depression. Start date: 1/30/26. R6 did not have sleep assessment completed related to trazadone use. Example 2 R7 was admitted to the facility on [DATE] with diagnoses that include, in part: Insomnia. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's physician orders include, in part: Melatonin 3mg tablet. Give 2 tablets by mouth one time a day for Insomnia. Start date: 3/3/26. On 5/19/26 at 2:48PM, Surveyors interviewed DON B (Director of Nursing). During the interview DON B indicated usually they would complete a sleep pattern form that is either for one night or three, he will have to review this to be sure of the length. DON B indicated that if they are admitted to the facility on a sleep medication the sleep assessment should be completed right when they come in. If a new order is placed for a current resident, it should be completed when it is started. DON B indicated that anyone that has a medication that says it is for sleep should have an assessment. DON B indicated he would expect that sleep assessments were completed for R6 and R7 and they are still working on finding them. On 5/19/2026 at 4:58PM, DON B informed surveyors they do not have the sleep assessments for the residents requested. Example 3 R4 was admitted to the facility on [DATE] with diagnoses including mood affective disorder, and severe agitation. R4 has a physician order, dated 4/19/26, quetiapine fumarate (an antipsychotic medication) oral tablet 100 mg, give 2 tablet by mouth three times a day. R4 does not have a tardive dyskinesia assessment completed. On 5/19/26 at 2:48 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated tardive dyskinesia assessments should be completed on admission and every 6 months after and at the start of an antipsychotic or any dose changes. DON B indicated R4 should have had a tardive dyskinesia assessment completed and did not. Example 4 R8 was admitted to the facility on [DATE] with diagnoses including panic disorder, persistent mood affective disorder, psychotic disorder with delusions, and psychotic disorder with hallucinations. R8 has the following physician orders:Quetiapine fumarate 100 mg, give 1 tablet at bedtime, start 12/12/25.Quetiapine fumarate 25 mg, give 1 tablet by mouth one time a day QAM (Every AM), start 1/13/26.Quetiapine fumarate 25 mg, give 2 tablet by mouth in the afternoon, start 5/15/26. R8 does not have a tardive dyskinesia assessment completed. On 5/19/26 at 2:48 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated tardive dyskinesia assessments should be completed on admission and every 6 months after and at the start of an antipsychotic or any dose changes. DON B indicated R8 should have had a tardive dyskinesia assessment completed and did not.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident receives adequate supervision and safety to prevent accidents and hazards for 1 of 5 residents (R79) reviewed for accidents and hazards.On 4/26/26, R79 left the faciity on leave, and upon returning to the facility the following day, admitted to staff that he had used cocaine while he was out of the building. The facility failed to implement any ongoing monitoring for R79's substance use.Evidenced by:The facility policy, Substance Use Disorder, dated 2001, with a last revision date of November, 2022, states, in part: . Policy Explanation and Compliance Guidelines:. 4. The resident's history of substance use disorder and risk for using substances which could lead to an overdose while in the facility are identified to the extent possible and documented in the medical record. 6. Care plan interventions are directed at maintaining the safety of the resident, staff and other residents. Examples of appropriate care interventions for a resident with SUD (Substance Use Disorder) include: a. monitoring the resident for signs and symptoms of substance use. and overdose, especially after returning from a leave of absence or during/after visitation; b. increasing supervision of the resident.R79 was admitted to the facility on [DATE] with diagnoses that include, in part: Alcohol abuse, uncomplicated.R79's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/14/26 indicates R79 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R79 is cognitively intact.R79's most recent Comprehensive Care Plan states, in part:Focus: Risk for depression r/t (related to) statements made post his return from being away from the facility for a day related to his wife's death, financial concerns and medical issues at this time. Date Initiated: 4/28/26. Intervention: Hx (history) of cocaine use and had urine test after return to facility. Urine test did test positive for cocaine. Date Initiated: 4/30/26.A review of R79's progress notes included in the EHR (Electronic Health Record) include the following:On 4/27/26 at 1:31 PM: Resident is out of unit. RN (Registered Nurse) attempted to contacted (sic) resident and emergency contact without success. Both phone numbers went to an unidentified voicemail.On 4/28/26 at 7:14 PM: RN spoke with resident at 0500 (5:00 AM) and he stated that he wanted to know if we still had his room. RN informed him that we did, and he stated that he would be coming back. He stated that he had some health issues with his PTSD (post-traumatic stress disorder) at church.On 4/28/26 at 8:04 AM: Went to talk to [Resident Name] regarding his absence from the facility for a couple days. [Resident Name] in his room sitting on his bed and eating breakfast. I asked him how he was doing and where did he go. He responded that he was depressed. Has PTSD and needed money. Feeling very depressed. Asked him if he had any medical appointments coming up. He stated I'm canceling them. I haven't eaten in 3 days and need to eat. I told him to finish eating and I would come back to talk to him a little later.On 4/28/26 at 9:42 PM: urine sample collected and sent to the lab. awaiting the resultsOn 4/28/26 a rapid urine test was completed on R79. The results of the test came back on 4/29/26, which indicated positive for cocaine use.On 4/28/26 a NP (Nurse Practitioner) note states, in part: Patient presented for evaluation due to change in condition following recent two-day out of facility pass, including increased depression and abnormal mouth movements. Reports increased depressive symptoms and history of PTSD. Subjective: Patient reported increased depressive symptoms and difficulty holding conversation. Nursing staff noted patient more depressed than normal and exhibiting tardive dyskinesia movements of his mouth. History includes alcohol abuse, substance abuse. PTSD. Patient appears altered during the visit. Assessment: Increased depressive symptoms. Tardive dyskinesia movements of mouth. Possible cognitive impairment or altered mental status.Plan: Urine drug screen ordered to evaluate possible substance involvement. Monitor symptoms closely, especially cognition and fall risk.On 5/1/26 at 10:12 PM: Resident LOA (Leave of Absence) without medications. Resident did not notify staff how long he would be leaving for. No acute concerns.On 5/4/26 at 4:09 PM: Resident on LOA (continued on next page)

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Beaver Dam Health Care Center	410 Roedl Ct. Beaver Dam, WI 53916

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and has not returned. Several calls to phone number on file with no answer, message left. Call placed to local hospital and law enforcement, no hospitalizations or arrest. APS (Adult Protective Services) call as a precaution. Provider notified. Resident alert and oriented and physically capable of self-care. Resident recently voiced having a significant other and daughter he was trying to visit. Resident did not sign out, reported to staff on unit he was leaving for a while. Resident chooses not to sign out when leaving the facility despite education given in the past.On 5/7/26 an NP note states, in part: Reason for visit [Resident Name] is seen for a follow-up visit at the skilled nursing facility related to acute care management. He reports having knee replacement surgery scheduled for tomorrow and general concerns regarding his overall health and recent illicit drug use findings. Subjective: Recently tested positive for cocaine use, stated as a one-time event. Denies ongoing illicit drug use . Plan: . Tramadol discontinued due to recent illicit drug use. Continue to observe for changes in physical and mental status. On 5/13/26 at 1:02 PM, Surveyor interviewed R79, who stated he had really bad pain from his knee replacement surgery, and PTSD from being a police officer. R79 stated that his wife passed away recently and that he was working on coping with that. R79 indicated that he was seeing a psychiatrist, who was helping him deal with his issues in a healthy manner. R79 indicated that he had a history of using alcohol, but that he had only used drugs one time, which he told staff about. R79 stated that he doesn't really have any family in the area now, and that some of the facility staff feel like they have become his family.On 5/18/26 at 2:24 PM, Surveyor interviewed CNA F (Certified Nursing Assistant) about illegal drug use. Surveyor asked CNA F what type of monitoring she would be doing for someone who had used illegal drugs. CNA F stated she would report to management anything that she observed if a resident were acting differently from their norm. Surveyor asked CNA F what monitoring was being done for R79. CNA F stated none that she knew of.On 5/18/26 at 2:37 PM, Surveyor interviewed LPN G (Licensed Practical Nurse) about illegal drug use. Surveyor asked LPN G what type of monitoring he would be doing for someone who had used illegal drugs. LPN G stated he would report it to management, initiate the protocol, check their vital signs and do assessments. Surveyor asked LPN G what monitoring was being done for R79. LPN G stated that based on his drug use, he would look to see if he was shaky, rapid heart rate, or in any way not acting his normal self.On 5/18/26 at 3:06 PM, Surveyor interviewed CNA H about illegal drug use. Surveyor asked CNA H what type of monitoring she would be doing for someone who had used illegal drugs. CNA H stated she would report it to the nurse so that they could take action such as holding their medications. CNA H stated that if anyone was acting funny or she smelled something like if they had been drinking, she would report that to the nurse right away. Surveyor asked CNA H what monitoring was being done for R79. CNA H stated she normally doesn't work that end of the hall, so she wasn't sure, but that she knew he had PTSD. CNA H also stated that R79 had left the building for several days at a time, and that had happened at least a few different times. On 5/18/26 R79's care plan was updated to include the following: Focus: I have a history/active substance use disorder. I had a one time cocaine substance use episode while oop (out on pass). Date Initiated: 5/18/26. Goal: I will not engage in illicit drugs or alcohol use through the next review. Date Initiated: 5/18/26. Interventions: Administer medication as tolerated. Date Initiated: 5/18/26. Monitor for signs/symptoms of withdrawal and notify MD (Medical Director) appropriately. Date Initiated: 5/18/26. Offer emotional support as needed. Date Initiated: 5/18/26. Offer substance abuse treatment if desired. Date Initiated: 5/18/26. Psychiatry/Psychology consult and treat as ordered. Date Initiated: 5/18/26.On 5/19/26 at 11:26 AM, Surveyor interviewed CNA I about illegal drug use. Surveyor asked CNA I what type of monitoring she would be doing for someone who had used illegal drugs. CNA I stated anytime someone appears like they might be high, like agitated or anxious, and that is not normal for them, she would report it to the nurse. Surveyor asked CNA I what monitoring was being done for R79. CNA I stated that she wasn't sure, but that it should be on his care plan.On 5/19/26 at 12:40 PM, Surveyor interviewed ADON E (Assistant Director of Nursing) about R79's illegal drug use. ADON E stated that R79 had left the facility for a day or two, and when he came back, he slept a lot and was not as perky (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as he normally was. ADON E stated that R79 told her that he had done some not so good things while he was out, so she reported that to the NP, and it was the NP who decided to run the drug test. ADON E stated that R79 told her that the drug screen would come back dirty. ADON E stated that she didn't think that R79 acted impaired in any way. ADON E stated that she did not see the results of the drug test, but that due to his history of drug use, she decided to put the depression and drug use on his care plan so that the people taking care of him would know about it. Surveyor asked ADON E if she would expect the care plan to have specific interventions that include what staff should be monitoring for someone with a history of drug use. ADON E states yes, she would expect that to be on R79's care plan. Surveyor asked ADON E if R79 had left the facility since this incident. ADON E stated not that she knew of.On 5/19/26 at 1:06 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing) and asked about R79's illegal drug use. DON B stated that there was only the one incident when R79 went out on pass and used cocaine. DON B stated he added it to R79's care plan just yesterday. Surveyor asked if this should have been added to R79's care plan two weeks ago when it happened. DON B stated yes, it should have been added to the care plan earlier. Surveyor asked DON B if the care plan interventions should include what staff should be monitoring for such as signs of a drug overdose. DON B stated yes, that should have been added to the care plan. Surveyor asked if R79 had been out of the facility on pass since this incident. NHA A stated yes, that R79 had also left the faciity on 5/1/26.The facility failed to implement adequate interventions and monitoring after R79 returned from being out on leave and used illegal drugs.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for experiences and preferences in order to eliminate or mitigate triggers that may care re-traumatization for 1 of 2 residents (R79) reviewed for PTSD (Post-Traumatic Stress Disorder).R79 admitted to the facility with a diagnosis of PTSD. The facility failed to include PTSD on R79's comprehensive plan of care, nor were staff aware of any of R79's PTSD triggers. Evidenced by:The facility policy, Trauma Informed Care, dated [DATE], states, in part: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Policy Explanation and Compliance Guidelines:. 2. The facility will use a multi-pronged approach to identifying a resident's history of trauma. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event. 4. The facility will collaborate with resident trauma survivors. to develop and implement individualized care plan interventions. 6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents care plan.R79 was admitted to the facility on [DATE] with diagnoses that include, in part: Post-Traumatic Stress Disorder.R79's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] indicates R79 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R79 is cognitively intact. Section I6100 of R79's MDS states yes for PTSD.R79's most recent Comprehensive Care Plan states, in part:Focus: Resident is at risk for malnutrition related to multiple medical diagnoses including DM (Diabetes Mellitus). PTSD. need for therapeutic diet, and need for skilled nursing care. Date Initiated: [DATE].Of note, there is no other mention of PTSD in R79's care plan, including no PTSD focus, goal, or interventions.A review of R79's progress notes included in the EHR (Electronic Health Record) include the following:A psychiatry evaluation note on [DATE] states the following, in part: Chief Complaint: PTSD. Mood: Some depression and anxiety. Patient reports having some ongoing depression and anxiety due to his history of PTSD and personal issues. Discussed medication options to improve his mood, but patient declined medications. He stated, I don't believe in taking psychiatric medications for your mood. Sleep: OK. Patient reports having some ongoing trouble sleeping at night. He reports his sleep is off and on. Discussed sleep aid options, but patient declined medications. He stated, I don't want to take a sleep medication. Social history: Reports trauma from past police officer job. He reports that my police partner was shot while with me and he died in 1983. He reports that he had also been shot while on duty. Discussed psychotherapy would be beneficial for past trauma, but patient declined therapy at this time.On [DATE] at 7:14 PM: RN (Registered Nurse) spoke with resident at 0500 (5:00 AM) and he stated that he wanted to know if we still had his room. RN informed him that we did, and he stated that he would be coming back. He stated that he had some health issues with his PTSD (post-traumatic stress disorder) at church.On [DATE] at 8:04 AM: Went to talk to [Resident Name] regarding his absence from the facility for a couple days. [Resident Name] in his room sitting on his bed and eating breakfast. I asked him how he was doing and where did he go. He responded that he was depressed. Has PTSD and needed money. Feeling very depressed. Asked him if he had any medical appointments coming up. He stated I'm canceling them. I haven't eaten in 3 days and need to eat. I told him to finish eating and I would come back to talk to him a little later.On [DATE] a NP (Nurse Practitioner) note states, in part: Patient presented for evaluation due to change in condition following recent two-day out of facility pass, including increased depression and (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abnormal mouth movements. Reports increased depressive symptoms and history of PTSD.On [DATE] at 6:38 AM: Resident was very restless throughout the night. He was turning in the bed, making the mattress come partially off the frame. CNA (Certified Nursing Assistant) fixed this. Resident was heard crying, talking, hollering, all of this was in his sleep. RN continued to check on resident for safety.On [DATE] at 1:02 PM, Surveyor interviewed R79, who stated he had PTSD from being shot on duty when he was a police officer. R79 stated that his partner was also shot and died in his arms. R79 stated that when he hears other residents yelling for help in the hallway it triggers his PTSD. R79 stated that he knows it is not the other resident's fault, and that the staff are doing the best that they can, but that he was getting more depressed with his wife passing away recently and his issues with his PTSD. Surveyor asked R79 if he was receiving any behavioral health services at the facility. R79 stated that they offered for him to see a counselor but that he chose not to at this time.On [DATE] at 2:24 PM, Surveyor interviewed CNA F (Certified Nursing Assistant) and asked if any of the residents on that hall had a PTSD diagnosis. CNA F stated none that she knew of. Surveyor asked CNA F where she would find that information. CNA F indicated that it should be in their chart, on their care plan and Kardex. Surveyor asked CNA F how she would provide care differently for a resident who had PTSD. CNA F stated that it would depend on what their triggers were, but that she would try to stay calm and understanding when providing care. Surveyor asked CNA F what monitoring was being done for R79. CNA F stated none that she knew of.On [DATE] at 2:37 PM, Surveyor interviewed LPN G (Licensed Practical Nurse) and asked if any of the residents on that hall had a PTSD diagnosis. LPN G stated that R79 and two other residents on that hall had PTSD. Surveyor asked LPN G how he would provide care differently for a resident who had PTSD. LPN G indicated he would approach them calmly, give them time to collect their thoughts, and provide positive affirmation, but that mostly care would be specific to their triggers. Surveyor asked LPN G if he knew what R79's triggers were. LPN G stated that they would be in his care plan.On [DATE] at 3:06 PM, Surveyor interviewed CNA H and asked if any of the residents on that hall had a PTSD diagnosis. CNA H stated that R79 and one other resident on that hall had PTSD. Surveyor asked CNA H how she would provide care differently for a resident who had PTSD. CNA H stated that she would try to give them space, be calm, and validate their feelings. CNA H indicated that it is important to know the resident and their specific triggers. Surveyor asked CNA H if she knew what R79's triggers were. CNA H stated that she doesn't normally work that half of the hall, but that it should be on his care plan.On [DATE] at 9:12 AM, Surveyor interviewed LPN J and asked her if any of the residents on the hall had PTSD. LPN J stated that R79 and two other residents had PTSD. Surveyor asked LPN J if she knew what R79's triggers were. LPN J stated that they would be on his care plan.On [DATE] at 11:26 AM, Surveyor interviewed CNA I and asked if any of the residents on that hall had PTSD. CNA I stated not that she knew of. Surveyor asked CNA I how she would provide care differently for a resident who had PTSD. CNA I stated that that information would be on their care plan.On [DATE] at 1:28 PM, Surveyor interviewed CNA R via telephone and asked her if any of the residents on that hall had a PTSD diagnosis. CNA R stated that she wasn't sure, but that she would find that information in the resident's chart.On [DATE] at 1:06 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing) and asked about R79's PTSD. DON B stated that R79 had shared with him some of his stories about being a police officer and his PTSD, and that R79 had also talked to the psych NP (Nurse Practitioner) about it. Surveyor asked if R79's PTSD with specific interventions and triggers should have been added to R79's care plan. DON B stated yes, it should have been added to the care plan so that staff know what to monitor R79 for. The facility failed to include PTSD or R79's PTSD triggers in his comprehensive care plan, despite R79 having a diagnosis of PTSD prior to admission, PTSD being included on his facility diagnosis list, and PTSD indicated on his MDS. While some staff were aware of R79's PTSD diagnosis, none of staff were aware of R79's specific triggers or how to effectively monitor and prevent re-traumatization.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 75 residents who reside in the facility.Items in the refrigerator were improperly dated.Findings includeOn 5/13/2026 at 9:49 AM, Surveyor observed the following in the facility's main kitchen refrigerator:*9 nutritional shakes with dating that states thawed 4/28/26, use by 5/12/26. Of note, these nutritional supplements are stored in the freezer manufacturer recommendations printed on the shakes states the supplement is to be used within 14 days of thawing.*48 chocolate milks (8oz) with sell by date of 5/12/26.DM Q (Dietary Manager) stated at this time that she uses the sell by date as the use by date and stated they would be removed along with the nutritional supplements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that they established and maintained an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections and conduct an annual review of its IPCP and update their program, as necessary, this has the potential to affect the census of 75. The facility does not have the IP (Infection Preventionist) on their Water Management Team. The facility has not reviewed all their infection control Policies and Procedures annually. Nurse did not clean the rubber cap of the insulin pen with alcohol before attaching the needle when administering insulin to R36. The facility failed to follow standards of practice during wound care for R1. This is evidenced by: Example 1 In reviewing the facility's Water Management Program, the Team documented as of August of 2025 is the NHA (Nursing Home Administrator) and the Director of Maintenance. On 5/14/26 at 4:01 PM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C if she is part of the Water Management Program team, ADON/IP C stated, I am not at this point. On 5/14/26 at 4:58 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if he would expect the IP to be part of the Water Management Program team, DON B said yes. Example 2 In reviewing the facility's Infection Control Policies, their Legionella Surveillance Policy and Procedure is dated 10/1/19 and their Hand Hygiene/Handwashing Policy is dated 2023. On 5/14/26 at 4:01 PM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C how often their infection control policies are reviewed, ADON/IP C said annually. Surveyor asked ADON/IP C if these should have been reviewed, ADON/IP C said yes. On 5/14/26 at 4:58 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if all infection control policies should be reviewed annually, DON B replied yes. Surveyor asked DON B if there is documentation of the Hand Hygiene/Handwashing and/or Legionella Surveillance policies reviewed in the facilities QA (Quality Assurance) Program, DON B said no, I don't think so. Example 3 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	LPN M (Licensed Practical Nurse) failed to clean the rubber cap of an insulin pen before attaching the needle when administering insulin to R36 during observation of the medication administration task. Surveyor requested a facility policy for insulin administration. The facility provided a policy titled Injectable Medication Administration, effective 10/25/14. The policy does not provide detailed instructions for insulin pens. Instructions for administering insulin using a NovoLog FlexPen, according to the company's website, are as follows: Step 1. Getting NovoLog FlexPen Ready: Start by washing your hands with soap and water. Then, pull off the pen cap and wipe the rubber stopper with an alcohol swab. Step 2. Attaching the NovoFine 32G Tip Needle: Take a new disposable needle and remove the protective tab. Screw the needle tightly onto your NovoLog FlexPen. (https://www.novolog.com/taking-novolog.html). R36 admitted to the facility on [DATE]. R36's physician orders included the following, in part: NovoLog FlexPen Subcutaneous Solution Pen Injector 100 unit/mL (Insulin Aspart) Inject 22 unit[s] subcutaneously in the afternoon related to type 2 diabetes mellitus with diabetic neuropathy.with lunch (Order Date: 1/5/26). On 5/18/26 at 11:23 AM, Surveyor observed LPN M preparing R36's insulin for administration. LPN M completed hand hygiene, checked the expiration date on the insulin pen, removed the cap from the insulin pen, and attached the needle to the rubber stopper of the pen. After LPN M had completed R36's insulin administration, Surveyor asked LPN M if she typically cleans the end of the insulin pen before attaching the needle. LPN M indicated she was never taught to do that, but she is willing to learn if she did something wrong. On 5/19/26 at 2:15 PM, Surveyor discussed the missed insulin pen cleaning during medication administration with DON B (Director of Nursing). DON B agreed that the insulin pen should have been cleaned with an alcohol swab before the needle was attached. Example 4 The facility policy titled Wound Care, with last revision date of April 2026, indicates in part: Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote wound healing. Steps in the Procedure:. 4. Establish clean field on resident's overbed table. 5. Place all items to be used during procedure on the clean field. On 5/19/26 at 8:27 AM, Surveyor observed wound care for R1 with ADON D (Assistant Director of Nursing) and WP L (Wound Physician). Surveyor observed ADON D prepare to clean the wound by propping R1's foot up on a pillow. Surveyor observed ADON D remove a piece of wet gauze from a cup and drop it onto the pillowcase. Surveyor observed ADON D pick the wet gauze up from the pillowcase and use it to clean R1's wound. After the wound care was completed, ADON D removed the pillowcase and returned the pillow to R1's bed. ADON D provided education to R1 on reducing smoking to promote wound healing and the importance of keeping his feet elevated. On 5/19/25 at 12:51 PM, Surveyor interviewed ADON D. Surveyor asked ADON D about R1's wound care observation earlier today. ADON D stated that she put the pillow under R1's foot because the foot rests on his wheelchair are metal and she didn't want to cause discomfort so she put the pillow under his foot. ADON D stated that she had taken the pillow off (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop, current up-to-date policies and procedures to ensure that each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized, this affects 1 of 5 residents (R8) reviewed for immunizations. The facilities Pneumococcal Vaccine (Series) dated 3/1/19 does not have the current up-to-date standard of practice involving an adults age. R8 has consent given for pneumococcal vaccine, the facility does not have documentation that the vaccine was offered or administered. This is evidenced by: Example 1The facilities Pneumococcal Vaccine (Series) dated 3/1/19, documents in part: .7. A series of vaccines will be offered to immunocompetent *adults > (greater than or equal to) 65, depending on current vaccination status and practitioner recommendation. The current Standard of Practice from the CDC (Center for Disease Control and Prevention) dated 10/24 is: Pneumococcal Vaccine Timing for Adults, Adults > (greater than or equal to) [AGE] years old. On 5/14/26 at 4:01 PM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C if this Pneumococcal Vaccine (Series) dated 3/1/19 is the most up-to-date, ADON/IP C stated, yes this is the up to date one. On 5/14/26 at 4:58 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if he would expect the Pneumococcal Policy and Procedure to be up-to-date, DON B said yes. Example 2The facilities Infection Prevention and Control Program Policy and Procedure dated 10/1/25, documents in part: .9. Influenza and Pneumococcal Immunization.b. Residents will be offered the pneumococcal vaccines recommended by the CDC (Centers for Disease Control and Prevention) upon admission, unless contraindicated or received the vaccines elsewhere.d. Residents will have the opportunity to refuse the immunizations. e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunization. The facilities Pneumococcal Vaccine (Series) dated 3/1/19, documents in part: .2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. R8's Immunization Consent or Declination marks yes for Pneumococcal vaccine, with verbal consent documented as obtained by POA (Power of Attorney) 11/4/25. R8's medical record does not reflect that she received a pneumococcal vaccine nor that she refused it at the time of injection. On 5/14/26 at 4:50 PM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C if she has documentation of R8 receiving a pneumococcal vaccine, ADON/IP C replied no. On 5/14/26 at 4:58 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if he would expect R8 to have been offered or administered a pneumococcal vaccine after consent was obtained, DON B stated yes.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility did not ensure that each resident is offered a COVID-19 immunization, unless the immunization is medically contraindicated or the resident has already been immunized, this affects 1 of 5 residents (R8) reviewed for immunizations. R8 has consent given for COVID-19 vaccine, the facility does not have documentation that the vaccine was offered or administered. This is evidenced by: The facilities Infection Prevention and Control Program Policy and Procedure dated 10/1/25, documents in part: .10. COVID-19 Immunization: a. Residents and staff will be offered the COVID-19 vaccine when vaccine supplies are available to the facility. R8's Immunization Consent or Declination marks yes for COVID-19 vaccine, with verbal consent documented as obtained by POA (Power of Attorney) 11/4/25. R8's medical record does not reflect that she received a COVID-19 vaccine nor that she refused it at the time of injection. On 5/14/26 at 4:50 PM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C if she has documentation of R8 receiving a COVID-19 vaccine, ADON/IP C said no. On 5/14/26 at 4:58 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if he would expect R8 to have been offered or administered a COVID-19 vaccine after consent was obtained, DON B stated yes.