STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525354	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineral Point Health Services	109 N Iowa St Mineral Point, WI 53565

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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 protect a resident's (R) (R2) right to be free from sexual abuse by another resident (R1).On 3/20/26, R2 was found in bed with R1. Staff at the facility did not report this incident to management. On 4/13/26, R1 was found in R2's room and was inappropriately touching R2. On 4/18/26, R2 was found in R1's room being inappropriately touched by R1.The facility's failure to provide adequate supervision and protect R2 from sexual abuse by R1 created a reasonable likelihood for serious psychosocial harm, thus resulting in a finding of immediate jeopardy (IJ) that began on 4/13/26. Surveyor notified NHA A (Nursing Home Administrator) of the immediate jeopardy on 4/28/26 at 2:50 PM. The immediacy was removed and corrected on 4/18/26. The deficient practice is being cited as past noncompliance. Evidenced by:The facility policy, Abuse, Neglect and Exploitation, dated 3/2018, with last review date of 7/15/22, states in part: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident. and prevent abuse. Policy Explanation and Compliance Guidelines: 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. III. Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse. A. Establishing a safe environment. by establishing policies and protocols for preventing sexual abuse, such as the identify of when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded. B. Identifying, correcting and intervening in situations in which abuse. is more likely to occur. D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents. IV. Identification of Abuse, Neglect and Exploitation. A. The facility will have written procedures to assist staff in identifying the different types of abuse. V. Investigation of Alleged Abuse, Neglect and Exploitation. A. An immediate investigation is warranted when allegation or suspicion of abuse. occur. VI. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include, but are not limited to:. C. Increased supervision of the alleged victim and residents. VII. Reporting/Response. 1. Reporting of all alleged violations to the Administrator. Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following: a. Analyzing the occurrence(s) to determine why abuse. occurred, and what changes may be needed to prevent further occurrences; b. Defining whether care provision should be changed and/or improved to protect residents receiving services. d. Identification of staff responsible for implementation of corrective actions.f. Identification of staff responsible for monitoring the implementation of the plan.R1 was admitted to the facility on [DATE] with diagnoses that include in part: Major depressive disorder, Anxiety disorder, Alzheimer's disease, and Unspecified dementia.R1's most recent Minimum Data Set (MDS) indicates R1 has a Brief Interview for Mental Status (BIMS) score of 3 indicating R1 is severely cognitively impaired. R1 has an activated power of attorney.R1's Comprehensive Care Plan in March 2026 states in part: Focus: At times [Resident Name] exhibits socially inappropriate behaviors. Date Initiated: 1/16/26. Interventions: If [Resident Name] wants to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	watch TV with other residents, ensure it is in a public place where she can be monitored. Date Initiated: 3/2/26. Offer resident to hold baby doll or kitten. Offer something for resident to hold in hands to keep her pre-occupied. Date initiated: 3/7/24. Interventions: Exhibits inappropriate sexual advances. Calmly redirect and intervene when inappropriate behavior begins. Distract with alternate activities like puzzles or watercolor painting. Redirect [Resident Name] and offer newspapers/magazines/copies to organize. Date Initiated: 3/5/25. Interventions: If wandering toward resident rooms offer to close other resident's door as this makes the room less appealing for [Resident Name] to go into. Date Initiated: 3/1/24. Intervention: Provide safe and comfortable environment for [Resident Name]. Date Initiated: 3/1/24. Revision on: 10/27/25.A review of R1's Electronic Health Record (EHR) includes the following progress notes:On 5/5/25: .Increased disruptive behaviors r/t psychotropic medication changes r/t sexually inappropriate behaviors. On 9/10/25: .Changes to psychotropic medications per pharmacy recommendation r/t over-affection/sexual behaviors.R2 was admitted to the facility on [DATE] with diagnoses that include in part: Traumatic subdural hemorrhage with loss of consciousness, Adjustment disorder with depressed mood, Mild cognitive impairment, and Generalized anxiety disorder.R2's most recent MDS indicates R2 has a BIMS score of 4 indicating R2 is severely cognitively impaired. R2 has an activated power of attorney.R2's Comprehensive Care Plan in March 2026 states in part: Focus: At risk for behavior symptoms. Date Initiated: 2/26/26. Revision on: 4/21/26. Interventions: Exhibits inappropriate sexual advances. Calmly redirect [Resident Name] to a common area when inappropriate behavior begins. Distract with alternative activities such as watching TV programming. Redirect [Resident Name] and offer newspapers/magazines.1. A nursing progress note in R2's EHR written by LPN G (Licensed Practical Nurse) on 3/20/26 at 1:38 AM states the following: At 0010 (12:10 AM), room bed alarm was going off. Staff went down to this room to check on the resident and (R2) was completely in bed, covered up, lying next to (R1) resident! Staff asks [sic] the resident what are you doing in this room? He stated, she wanted me to get in bed with her. Staff redirected this resident back to his room, and as he was crawling in bed he asks the staff, can you touch my penis a little? Staff said no, and he stated, can't I have a little fun?On 4/28/26 at 11:52 AM, Surveyor interviewed LPN G about the progress note she entered regarding the incident on 3/20/26. LPN G stated at that time there were no alarms on R2's door, so when he came out of his room, they were not aware of it. LPN G stated she was doing rounds on the night shift on 3/20/26, checking to see if all the residents were in bed, when she came to R1's room and saw R2 crawling in bed with R1. LPN G stated R1 was lying on her back in the bed, and R2 was lying on his side facing R1. LPN G stated both R1 and R2 were fully clothed, and she did not witness any inappropriate touching between R1 and R2. LPN G stated she returned R2 to his room and then charted the behavior in R2's progress note. LPN G indicated she also reported what happened to the oncoming shift during shift report. Surveyor asked LPN G if finding R1 and R2 in bed together could be abuse? LPN G stated she would consider it abuse if there was touching involved, but she had come upon them in time and she did not witness any inappropriate touching between R1 and R2. Surveyor asked if R1 and R2 were consenting adults for the sexual behavior? LPN G stated with R1's dementia and R2's cognitive issues she didn't know if they would be able to give consent. LPN G indicated R1 is very friendly with everyone and R2 is a very flirty man, but that she was shocked to find them in bed together. Surveyor asked LPN G if she had reported this incident to management. LPN G stated she had not reported it to management, only the oncoming shift. Surveyor asked LPN G if she had reported this incident to R1 and R2's POAs. LPN G stated she had not.On 4/28/26 at 11:23 AM, Surveyor interviewed R2's POA H (Power of Attorney) who stated she was unaware of the incident which occurred on 3/20/26 where R2 was found with R1 in her bed.There were no changes to the care plans for either R1 or R2.2. The facility completed a self-report/investigation which states: On 4/13/26 CNA D (Certified Nursing Assistant) witnessed R1 in R2's room. CNA D reported R2 was ?slumped over with his hands on R1's wheelchair arm rests with his pants partially down'. CNA D reports he intervened, sat R2 on the bed and he (CNA (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	D) hollered out for CNA C to come and assist. R1 was removed from the room immediately by CNA C and both CNAs reported the incident to Charge Nurse/ADON I (Assistant Director of Nursing) and DON B (Director of Nursing). NHA A (Nursing Home Administrator), doctors and families were contacted. Police department was also contacted as well as the Ombudsman.Facility interviewed residents and staff. A door alarm was placed on R2's door to alert staff if anyone is entering his room. Education was provided to all staff on not allowing R1 in R2's room and about the door alarm. Trauma Informed Care and Psychosocial assessments were completed on both R1 and R2, and a skin assessment was completed on R1 with no concerns.Facility conclusion summary states, in part: Following a thorough investigation into the incidents involving R1 and R2, the facility believes both were looking to engage with one another, however were stopped prior to anything happening. The findings indicate both may have had intent on initiating something but were separated immediately. As a result of this situation, [Facility name] placed an alarm on R2's door. Alarm box will always be monitored when he's in the building by Charge Nurse or Assigned Management. Additional interventions were placed on R1 and R2's care plans to encourage safety. This report, as well as other concerns and allegations, with be brought to QAPI monthly for review. The facility will continue to conduct routine audits. to monitor for any unwanted contact between residents.These measures will remain in place to strengthen oversight, promote resident safety. On 4/28/26 at 9:45 AM, Surveyor called and left a message for CNA D. CNA D did not return the call. On 4/28/26 at 9:47 AM, Surveyor interviewed CNA C, who stated on 4/13/26 she was passing water and clean linens to the rooms at the start of her shift, and CNA D was also passing water on the hall. CNA C stated she heard CNA D calling her to come to R2's room. CNA C stated she witnessed R1 in R2's room, fully dressed and in her wheelchair facing R2. CNA C stated she witnessed R2 sitting on the bed facing R1 with his pants all the way down and his brief halfway down. CNA C stated R1 told them to leave. CNA C stated she and CNA D took R1 out of R2's room and to the nurse's station, where they reported the incident to DON B. Following this incident, R1's care plan was updated as follows:Date Initiated: 4/13/26. Revision on: 4/21/26. Focus: Potential for elopement r/t cognitive impairment. Date Initiated: 4/13/26. Revision on: 4/21/26. Focus: At risk for unavoidable decreased social interaction and/or increased withdrawal, anger or depressive behavior.R2's care plan was updated to include the following:Alarm placed on door 4/13/26 to allow time for intervention in case of another resident entering room, including [R1 Resident Number]. Resident is to be further than arm's length from resident [R1 Resident Number] during activities and in public areas. Date Initiated: 4/16/26. Focus: Wandering/pacing r/t cognitive impairment. Date Initiated: 3/10/26. Interventions: Motion sensor to handrail outside of room pointed towards resident's doorway. Date Initiated: 4/13/26. Focus: Inappropriate undressing and verbal conversations with women (such as removing clothing) r/t cognitive impairment, hx (history of) TBI (traumatic brain injury). Date Initiated: 4/13/26. Revision on: 4/21/26. Interventions: Notify family and make arrangements to obtain adaptive clothing if needed. Date Initiated: 4/13/26. Resident [R1s Resident Number] was moved to the 200 wing on 4/18/26 to provide space and distance. Date Initiated: 4/13/26. Focus: At risk for unavoidable decreased social interaction and/or increased withdrawal, anger or depressive behavior.3. The facility completed a second self-report/investigation which states: On 4/18/26 at 7:20 AM, CNA F noticed R1's room was closed. Upon opening the door, she witnessed R2 sitting in R1's recliner with his pants down. CNA F states R1 was touching his (R2's) penis. CNA F said R1 backed away from R2 and put her hands in her lap. CNA F had R2 stand up, put his pants on and escorted him out of the room. R1 began to follow. CNA F asked R1 to go to the nurse's station, which she willingly did. CNA F ensured the safety of both residents and reported the incident to DON B, who began 1:1 (one on one) (monitoring) with R1. Police department, POAs (Powers of Attorney), and physicians were contacted. Families do not wish to press charges.On 4/28/26 at 10:33 AM, Surveyor interviewed CNA F who stated on 4/18/26, she was walking down the hall when she noticed that R1 had her door shut. CNA F stated she knocked on the door and entered the room to see R2 in R1's recliner facing R1, who was seated in her wheelchair. CNA F stated she (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	witnessed R1 pull her hand back from R2's private area when she entered the room. CNA F stated R2's pants were on, but the zipper was down and his penis was exposed. CNA F indicated she had R1 go to the nurses' station while she helped R2 get put back together. CNA F stated she was unaware of any prior incidents of R2 being in R1's room. CNA F stated that after this incident on 4/18/26, R1 and R2 both have 1:1 staff monitoring and they are to make sure they stay separated when they are out of their rooms, and that they eat in different dining rooms. CNA F indicated there is a binder at the nurses' station where the staff write down the location of R1 and R2 each hour.On 4/28/26 at 10:00 AM, Surveyor interviewed LPN E who stated on 4/18/26 she was doing medication pass when CNA F came to her and told her that R2 had been in R1's room and when CNA F entered the room she witnessed R1 pull her hand away from R2's lap.LPN E stated that it was her understanding from CNA F that both R1 and R2 were fully clothed. LPN E stated that she made sure that R1 and R2 were separated and notified DON B. LPN E stated she had the alarm with her in the medication room, but it never alarmed while she was in the med room. LPN E stated that after separating R1 and R2, her and DON B checked that the batteries were working and tested the alarm in all parts of the building to ensure that it worked. LPN E stated she was unaware of the previous incident of R1 and R2 being found in bed together.Facility interviewed residents and staff. The door alarm for R2's door was tested and safety checks were initiated for failure to alarm due to being out of range frequency. R1 was moved down another hallway, and a door alarm was also placed on her door. Both R1 and R2 were placed on 1:1 (monitoring) when out of their rooms. Education was provided to all staff on interventions and safety plan. Trauma Informed Care, Psychosocial assessments, and skin assessments were completed on both R1 and R2 with no concerns.Facility conclusion summary states in part: Following a thorough investigation into the incident involving residents R1 and R2, the facility believes both residents continue to seek each other out. They did make contact, which the facility did attempt to prevent by having a door alarm in R2's room. Unfortunately, the nurse trying to monitor the alarm had taken it into the med room and it did not sound due to being out of frequency. The findings show that R1 and R2 were alone for about 10 minutes or less when CNA F entered the room and separated them. As a result of this situation, [Facility name] relocated R1 down another hall, placed an alarm on her door and started 1:1 (monitoring) with her when out and about. R2 has also been placed on 1:1 (monitoring) when out of his room. A past noncompliance was started to educate regarding the alarm being out of range. Alarm box will be monitored when (R2) is in the building at the Nurse's station. Additional interventions were placed on R1 and R2's care plans to encourage safety. This report, as well as other concerns and allegations, with be brought to QAPI monthly for review. The facility will continue to conduct routine audits. to monitor for any unwanted contact between residents. Staff will be trained on red flags or potential of impending sexual abuse at an all staff meeting to further prevent and protect our residents. A review of the manufacturer's recommendations for the door alarm, provided by the facility, states, in part: Important Information: Cordless and wireless systems rely on wireless technology which is subject to physical and environmental considerations. Please be aware that the transmitter will not be 100% accurate if it is out of range at any time. It is the end-user's responsibility to make sure that the product is used correctly and within range of each other. The Snart Caregiver Corporation devices are designed to be installed by the end user. As such, it is the entire responsibility of the buyer to ensure that the system is properly installed and tested. This Bed Exit Alarm Paging System alerts the caregiver wearing the pager of a resident's activities when the resident interrupts the Exit Alarm's infrared field, as long as they are within 150 feet of each other depending on the environment.On 4/28/26 at 9:24 AM, Surveyor interviewed DON B about the alarm device, who stated they were following the manufacturer's recommendations. DON B indicated they had tested the alarm at the 150 feet range but had not tested the alarm's range in all areas of the building and were unaware that it would not work in the med room.Following this incident, the facility updated R1's care plan as follows:Date Initiated: 4/21/26. [Resident Name] is currently on 1:1 supervision while out of her room due to interaction with a male (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident on 4/18/26. Date Initiated: 4/18/26. [Resident Name] was moved down 200 hall to distance her from [R2s Resident Number] on 4/18/26. Date Initiated: 4/21/26. Motion sensor alarm pointed towards resident's doorway for safety. Alarm to indicate if anyone leaves or enters room. Date Initiated: 4/18/26. Offer 1:1 visit/support during periods of socially inappropriate behaviors. Date Initiated: 4/8/26. Revision on: 4/21/26. Ensure [Resident Name] is not seated near resident [R2s Resident Number] when at activities, at meals, or in common areas. [Resident Name] must be further than arm's length away from resident [R2 Resident Number] at all times. [Resident Name] is NOT allowed in resident [R2 Resident Number] room. [Resident Name] currently dines in a different dining room from [R2 Resident Number].Facility staff updated R2's care plan as follows:Date Initiated: 4/21/26. [Resident Name] often removes clothing and prefers to be naked. Offer to close door and give privacy as needed. Date Initiated: 4/18/26. Intervention: Provide [Resident Name] with a safe environment. Date Initiated: 4/18/26. Revision on: 4/20/26.A review of R1 and R2's undated Sexual Consent Assessments provided by the facility indicates questions and answers about sexual contact and having a potential sexual relationship with the other resident, however there are no questions or indication that either resident would be able to consent to sexual activity in these Sexual Consent Assessments.On 4/28/26 at 9:30 AM, Surveyor interviewed NHA A about the Sexual Consent Assessments. NHA A stated she had reached out to the Ombudsman, and this was the tool the Ombudsman sent to see if they could consent. NHA A stated she determined that R1 and R2 didn't have the ability to consent since they couldn't recall the incident. NHA A stated R1 and R2 do fluctuate in cognition but knowing them, they would not be able to consent. NHA A indicated she didn't think R1 or R2 were traumatized, as they seem mutually attracted to one another. NHA A stated POA H (Power of Attorney) was aware of this. NHA A indicated the plan going forward was to keep R1 and R2 apart with the door alarms and 1:1 monitoring by staff.On 4/28/26 at 11:43 AM, Surveyor interviewed NHA A about the incidents involving R1 and R2. NHA A stated she was unaware of the incident on 3/20/26 where R2 was found with R1 in her bed. NHA A stated it was never reported to her. Surveyor asked NHA if it was her expectation to be notified of all abuse allegations. NHA A stated she should have been notified so she could put interventions in place right away and investigate and report the incident. Surveyor asked NHA A if she would have expected the door alarms to be tested for effectiveness. NHA A stated yes, unfortunately R2's door alarm did not sound in the med room, and the door alarm should have been tested in all areas of the building.The facility's failure to provide adequate supervision and protect R2 from sexual abuse by R1 created a reasonable likelihood for serious psychosocial harm, thus leading to a finding of immediate jeopardy which began on 4/13/26. The facility removed and corrected the immediate jeopardy on 4/18/26 when it completed the following:Alarm was placed on R1 and R2's door. Alarm must stay at nurse's station and be monitored at all times by Charge Nurse or Designee.R1's room was moved to a room further down the hallway to ensure further distance between her and R2.R1 must have 1:1 Supervision at all times, unless in her room and alarmed.R2 must be supervised (within eyesight) when in main areas. Family may provide the 1:1 supervision but must report to staff when leaving the building.If at Activities, residents are not allowed to sit next to each other and must be further than arm's length away from each other.R1 and R2 are not allowed to eat in the same dining room. The facility provided training to all staff on Intervention Safety Plan, Signs of a Potential Perpetrator, facility policies NSG Accidents and Supervision, Abuse, Neglect, and Exploitation (Including Reporting Timelines), and Resident Alarms.Audits Initiated for validating Safety Plan and Alarm Function.Documentation 1:1 supervision is being documented every hour on R1 and R2.