

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Suring Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Manor Dr Suring, WI 54174	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure the resident environment was free from abuse for 5 residents (R) (R3, R5, R6, R10, and R11) of 10 sampled residents. R3, R5, R6, R10, and R11 reported to staff on multiple occasions that Certified Nursing Assistant (CNA)-D was rough with cares and they did not want CNA-D to provide care or enter their rooms. The facility did not implement measures to ensure R3, R5, R6, R10, R11 and other residents were free from abuse. Findings include: The facility's Abuse, Neglect, and Exploitation policy, revised 7/1/25, indicates: It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies that prohibit and prevent abuse .V. Investigation of Alleged Abuse: A. An immediate investigation is warranted when suspicion of abuse .or reports of abuse occur .VI. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include: A. Responding immediately to protect the alleged victim(s) and integrity of the investigation, a. This should include staying with the alleged perpetrator to ensure no further contact (verbal or physical) until removal from the facility/environment . 1. From 1/6/26 to 1/7/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including fracture of the left humerus, type 2 diabetes with neuropathy, anxiety disorder, and cellulitis of the left lower extremity (LLE) and right lower extremity (RLE). R3's Minimum Data Set (MDS) assessment, dated 12/16/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 had intact cognition. R3 was responsible for R3's healthcare decisions. On 1/6/26 at 1:53 PM, Surveyor interviewed R3 who stated R3 was physically and mentally abused since R3 was admitted to the facility and was yelled at for being incontinent. R3 indicated CNA-D was rough with cares, had a bad attitude, would not get R3 out of bed to use the bathroom, and made R3 use a bedpan. R3 stated CNA-D often pinched or jabbed R3 in the hip during cares which was painful. R3 reported the concerns to Nursing Home Administrator (NHA)-A four days after R3 was admitted . R3 felt NHA-A did not take the allegations seriously and did not follow-up with R3. R3 stated NHA-A told R3 that R3 might be anxious or depressed and need medication. R3 stated R3 was not anxious or depressed and declined medication but worried staff would put something in R3's medication to sedate R3. R3 stated R3 had thrown out medications when the nurse did not tell R3 which medications were administered. R3 stated R3 specifically told NHA-A that R3 felt physically and mentally abused. R3 stated several staff were aware of the issues with CNA-D and other residents reported similar concerns. A provider visit note, dated 11/11/25 at 5:51 PM, indicated R3 expressed concerns to the provider regarding care at the facility and wanted to transfer to another facility. The provider asked NHA-A speak with R3 about the concerns. A progress note, completed by NHA-A and dated 11/13/25 at 8:40 AM, indicated a care conference was held with R3 on 11/11/25 to discuss R3's care</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525363
		If continuation sheet Page 1 of 9

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>concerns, including transfers and safety with bed mobility. NHA-A indicated therapy would work with R3 on transfer status and bed mobility. The note indicated R3 appeared anxious and tearful. Telehealth therapy and medications were offered but R3 declined. The note did not list specific care concerns. The note indicated referrals were sent to other nursing facilities, however, no other facilities were able to accept R3. On 1/6/26 at 3:35 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility did not have an investigation for R3's concerns. 2. From 1/6/26 to 1/7/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including rheumatoid arthritis, history of stroke, depression, and peripheral vascular disease. R5's MDS assessment, dated 12/23/25, had a BIMS score of 9 out of 15 which indicated R5 had moderately impaired cognition. R5 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions. On 1/7/26 at 9:23 AM, Surveyor interviewed R5 who stated CNA-D was rough with cares on the night shift and R5 did not want CNA-D to provide care for R5. R5 could not recall if CNA-D provided care for R5 after R5 reported the concerns. On 1/7/26 at 1:11 PM, Surveyor interviewed R5's Family Member ((FM)-I) who stated R5's family reported concerns to staff about CNA-D. FM-I stated CNA-D was mean and rough with cares for R5 and was mean when communicating with R5's family. FM-I stated R5 did not want CNA-D in R5's room. FM-I stated CNA-D worked for an agency and was no longer at the facility. 3. From 1/6/26 to 1/7/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including osteoarthritis, chronic kidney disease, osteoporosis, and edema. R6's MDS assessment, dated 12/24/25, had a BIMS score of 15 out of 15 which indicated R6 had intact cognition. R6 was responsible for R6's healthcare decisions. On 1/7/26 at 2:48 PM, Surveyor interviewed R6 who stated CNA-D worked too fast and was rough with transfers, including when CNA-D transferred R6 to the toilet. R6 indicated R6 self-transferred from the toilet despite the fact that it was unsafe so that CNA-D would not touch R6. When CNA-D reminded R6 of R6's transfer restrictions, R6 told CNA-D not to touch R6. R6 told an (unidentified) CNA about the concerns and reported the concerns three times before CNA-D stopped entering R6's room. R6 did not receive follow-up about the concerns and stated R6 had not seen CNA-D in a while. 4. On 1/7/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including osteomyelitis of vertebra and severe septic shock. R10's MDS assessment, dated 10/27/25, had a BIMS score of 15 out of 15 which indicated R10 had intact cognition. R10 was responsible for R10's healthcare decisions. On 1/7/26 at 2:10 PM, Surveyor interviewed R10 who stated CNA-D was aggressive during cares on the night shift. R10 stated when CNA-D assisted R10 with the urinal, CNA-D pushed the urinal too hard and hit R10's testicles. R10 reported the concern to an (unidentified) nurse(s) multiple times. R10 stated R10 did not want CNA-D in R10's room. R10 did not receive follow-up regarding the concern and stated CNA-D no longer worked at the facility. 5. On 1/7/26, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including cerebral infarction and spastic hemiplegia affecting the right dominant side. R11's MDS assessment, dated 11/4/25, had a BIMS score of 13 out of 15 which indicated R11 had intact cognition. R11 was responsible for R11's healthcare decisions. On 1/7/26 at 2:30 PM, Surveyor interviewed R11 who stated CNA-D was mean and rough with cares and R11 was fearful of CNA-D. R11 was unsure if R11 reported the concern to staff but made it known to CNA-D that CNA-D was not allowed in R11's room. R11 had not seen CNA-D in a while. On 1/7/26 at 4:45 AM, Surveyor interviewed CNA-E who worked with CNA-D on the night shift. CNA-E verified CNA-D often put residents on bedpans instead of taking them to the bathroom. CNA-E stated several residents reported concerns to staff regarding rough care from CNA-D. CNA-E stated CNA-E often had to assist residents on CNA-D's unit because CNA-D was not allowed in their rooms; however, CNA-D</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>sometimes entered their rooms. CNA-E stated allegations of abuse should be reported to the charge nurse, the DON, or the NHA. On 1/7/26 at 11:54 AM, Surveyor interview CNA-F who verified residents complained about CNA-D and stated CNA-D was rough and short-tempered. CNA-F stated the concerns were reported to nursing and management. CNA-F stated there was a list of residents who did not allow CNA-D in their rooms, including R6, R5, and R11. On 1/7/26 at 12:45 PM, Surveyor interviewed CNA-G who stated several residents had concerns with CNA-D and reported that CNA-D was rough with cares. CNA-G reported the concerns to (unidentified) charge nurses and (unidentified) members of administration. CNA-G was unsure if the concerns were investigated. On 1/7/26 at 3:03 PM, Surveyor interviewed unit manager Licensed Practical Nurse (LPN)-H who stated several residents did not want CNA-D to provide care and did not want CNA-D in their room because CNA-D was rough with cares. LPN-H reported the concerns to DON-B. LPN-H verified CNA-D no longer worked at the facility. On 1/7/26 at 2:25 PM, Surveyor interviewed NHA-A, DON-B and LPN-H. NHA-A indicated some residents were discriminatory toward staff and did not want to work with CNA-D because of CNA-D's ethnicity and accent. NHA-A, DON-B, and LPN-H indicated several residents did not want CNA-D to provide care or enter their rooms due to cultural and racial differences. NHA-A denied receiving any reports from staff or residents that CNA-D was rough. NHA-A indicated the facility would thoroughly investigate any concern that a staff member was rough through the grievance process or a self-report to the State Agency. DON-B stated the facility would also initiate pairs with cares to ensure the resident's needs were appropriately met. NHA-A verified there were no grievances, facility-reported incidents, or investigations completed for the concerns with CNA-D.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff, resident, and resident representative interview and record review, the facility did not ensure allegations of abuse were reported to the State Agency (SA) for 5 residents (R) (R3, R5, R6, R10, and R11) of 10 sampled residents. R3, R5, R6, R10, and R11 reported to staff that Certified Nursing Assistant (CNA)-D was rough with cares. The facility did not report the allegation of abuse to the SA. Findings include: The facility's Abuse, Neglect, and Exploitation policy, revised 7/1/25, indicates: Reporting/Response: Report 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: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1. From 1/6/26 to 1/7/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including fracture of the left humerus, type 2 diabetes with neuropathy, anxiety disorder, and cellulitis of the left lower extremity (LLE) and right lower extremity (RLE). R3's Minimum Data Set (MDS) assessment, dated 12/16/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 had intact cognition. R3 was responsible for R3's healthcare decisions. On 1/6/26 at 1:53 PM, Surveyor interview R3 who stated R3 was physically and mentally abused and yelled at for being incontinent since R3 was admitted to the facility. R3 stated CNA-D was rough with cares, had a bad attitude, would not get R3 out of bed to use the bathroom, and made R3 use the bedpan. R3 stated CNA-D often pinched or jabbed R3 in the hip during cares which was painful. R3 reported the concerns to Nursing Home Administrator (NHA)-A four days after R3 was admitted. R3 did not feel NHA-A took the allegations seriously and did not receive any follow-up. R3 stated NHA-A told R3 that R3 may be anxious or depressed and need medication. R3 stated R3 was not anxious or depressed and declined medication but worried that staff would put something in R3's medication to sedate R3. R3 stated R3 had thrown medications away when the nurse did not tell R3 which medications were administered. R3 stated R3 told NHA-A that R3 felt mentally and physically abused. R3 stated several staff were aware of the issues with CNA-D and several residents reported similar concerns. A progress note, completed by NHA-A and dated 11/13/25 at 8:40 AM, indicated a care conference was held with R3 on 11/11/25 to discuss R3's concerns, including concerns with transfers and safety with bed mobility. The note indicated R3 appeared anxious and tearful and declined Telehealth therapy and medications. The note did not indicate the specific concerns R3 had with CNA-D. 2. From 1/6/26 to 1/7/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including rheumatoid arthritis, history of stroke, depression, and peripheral vascular disease. R5's MDS assessment, dated 12/23/25, had a BIMS score of 9 out of 15 which indicated R5 had moderately impaired cognition. R5 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions. On 1/7/26 at 9:23 AM, Surveyor interviewed R5 who stated CNA-D was rough with cares on the night shift and R5 did not want CNA-D to provide care for R5. On 1/7/26 at 1:11 PM, Surveyor interview R5's Family Member ((FM)-I) who stated R5's family reported concerns about CNA-D to staff. FM-I stated CNA-D was mean and rough with cares for R5 and was mean when communicating with R5's family. FM-I stated R5 did not want CNA-D in R5's room. 3. From 1/6/26 to 1/7/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including osteoarthritis, chronic kidney disease, osteoporosis, and edema. R6's MDS assessment, dated 12/24/25, had a BIMS score of 15 out of 15 which indicated R6 had intact cognition. R6 was</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>responsible for R6's healthcare decisions. On 1/7/26 at 2:48 PM, Surveyor interviewed R6 who stated CNA-D worked too fast and was rough with transfers, including when CNA-D transferred R6 to the toilet. R6 stated R6 self-transferred from the toilet despite the fact it was unsafe so CNA-D would not touch R6. When CNA-D reminded R6 of R6's transfer restrictions, R6 told CNA-D not to touch R6. R6 stated R6 told an (unidentified) CNA about the concerns and reported the concerns three times before CNA-D stopped entering R6's room. R6 did not receive follow-up about the concerns. 4. On 1/7/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including osteomyelitis of vertebra and severe septic shock. R10's MDS assessment, dated 10/27/25, had a BIMS score of 15 out of 15 which indicated R10 had intact cognition. R10 was responsible for R10's healthcare decisions. On 1/7/26 at 2:10 PM, Surveyor interviewed R10 who stated CNA-D was aggressive with cares on the night shift and R10 did not want CNA-D in R10's room. R10 stated when CNA-D assisted R10 with a urinal, CNA-D pushed the urinal too hard and hit R10's testicles. R10 reported the concern to an (unidentified) nurse(s) on multiple occasions. R10 did not receive any follow-up about the concern. 5. On 1/7/26, Surveyor reviewed R11's medical record. R11 was admitted to the facility 6/27/20 and had diagnoses including cerebral infarction and spastic hemiplegia affecting the right dominant side. R11's MDS assessment, dated 11/4/25, had a BIMS score of 13 out of 15 which indicated R11 had intact cognition. R11 was responsible for R11's healthcare decisions. On 1/7/26 at 2:30 PM, Surveyor interviewed R11 who stated CNA-D was mean and rough with cares and R11 was fearful of CNA-D. R11 could not recall if R11 reported the concerns to staff but made it known to CNA-D that CNA-D was not allowed in R11's room. On 1/7/26 at 4:45 AM, Surveyor interviewed CNA-E who verified several residents reported concerns to staff regarding rough care from CNA-D. CNA-E stated CNA-E often had to assist residents on CNA-D's unit because CNA-D was not allowed in their rooms. CNA-E stated the concerns were reported to administration multiple times by staff and residents. CNA-E stated allegations of abuse should be reported to the NHA, the Director of Nursing (DON), or the charge nurse. On 1/7/26 at 11:54 AM, Surveyor interviewed CNA-F who verified residents reported that CNA-D was rough and short-tempered and there was a list of residents who did not allow CNA-D in their rooms, including R5, R6, and R11. CNA-F stated the concerns were reported to nursing and management. On 1/7/26 at 12:45 PM, Surveyor interviewed CNA-G who verified several residents reported concerns with CNA-D, including that CNA-D was rough with cares. CNA-G reported the concerns to (unidentified) charge nurses and (an unidentified member of) administration. On 1/7/26 at 3:03 PM, Surveyor interviewed unit manager Licensed Practical Nurse (LPN)-H who verified several residents reported that CNA-D was rough and did not want CNA-D to provide care for them or be in their rooms. LPN-H reported the concerns to DON-B. On 1/7/26 at 2:25 PM, Surveyor interviewed NHA-A, DON-B and LPN-H. NHA-A indicated some residents were discriminatory toward staff and did not want to work with CNA-D because of CNA-D's ethnicity and accent. NHA-A, DON-B, and LPN-H verified several residents did not want CNA-D to provide care or enter their rooms but thought it was due to cultural and racial differences. NHA-A denied receiving any reports from staff or residents that CNA-D was rough with cares. NHA-A confirmed a facility-reported incident (FRI) should be submitted to the SA for all allegations of abuse.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff, resident, and resident representative interview and record review, the facility did not ensure allegations of abuse were thoroughly investigated for 6 residents (R3, R1, R5, R6, R10, and R11) of 10 sampled residents. R3 reported an allegation of abuse to Nursing Home Administrator (NHA)-A regarding Certified Nursing Assistant (CNA)-D. The facility did not thoroughly investigate the allegation of abuse. R1's Power of Attorney for Healthcare (POAHC) reported allegations of abuse to the local police department. The facility did not thoroughly investigate the allegations of abuse. R5 and R5's family reported that CNA-D was rough with cares and R5 did not want CNA-D to provide care or enter R5's room. The facility did not thoroughly investigate the allegation of abuse. R6 reported that CNA-D was rough with cares and did not want CNA-D to touch R6. The facility did not thoroughly investigate the allegation of abuse. R10 reported that CNA-D was aggressive with cares and pushed a urinal into R10's testicles. R10 did not want CNA-D in R10's room. The facility did not thoroughly investigate the allegation of abuse. R11 reported that CNA-D was mean and rough with cares. R11 was fearful of CNA-D and did not want CNA-D in R11's room. The facility did not thoroughly investigate the allegation of abuse. Findings include:</p> <p>The facility's Abuse, Neglect, and Exploitation policy, revised 7/1/25, indicates: An immediate investigation is warranted when suspicion of abuse, neglect, or reports of abuse, neglect, or exploitation occur. B. Written procedures for investigations include: .3. Investigating different types of alleged violations. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause. 6. Providing complete and thorough documentation of the investigation. VI. Protection of the Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.</p> <p>1. From 1/6/26 to 1/7/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including fracture of the left humerus, type 2 diabetes with neuropathy, anxiety disorder, and cellulitis of the left lower extremity (LLE) and right lower extremity (RLE). R3's Minimum Data Set (MDS) assessment, dated 12/16/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 had intact cognition. R3 was responsible for R3's healthcare decisions.</p> <p>On 1/6/26 at 1:53 PM, Surveyor interviewed R3 who stated R3 was physically and mentally abused and yelled at for being incontinent since R3 was admitted to the facility. R3 stated CNA-D was rough with cares, had a bad attitude, would not get R3 out of bed to use the bathroom, and made R3 use the bedpan. R3 stated CNA-D often pinched or jabbed R3 in the hip during cares which was painful. R3 reported the concerns to NHA-A four days after R3 was admitted. R3 felt NHA-A did not take the allegations seriously and denied any follow-up from NHA-A. R3 stated NHA-A indicated R3 may be anxious or depressed and need medication. R3 stated R3 was not anxious or depressed and declined medication but was worried that staff would put something in R3's medication to sedate R3. R3 stated R3 threw away medications if the nurse did not tell R3 which medications were administered. R3 stated R3 specifically told NHA-A that R3 felt physically and mentally abused. R3 stated several staff were aware of the issues with CNA-D because other residents reported similar concerns.</p> <p>A progress note, completed by NHA-A and dated 11/13/25 at 8:40 AM, indicated a care conference was held with R3 on 11/11/25 to discuss R3's care concerns, including transfers and safety with bed</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>mobility. NHA-A stated therapy would work with R1 on transfer status and bed mobility. The note indicated R3 appeared anxious and tearful. Telehealth therapy and medication were offered to R3 who declined. The note did not contain specific concerns regarding cares and indicated referrals were sent to other nursing facilities which could not accept R3.</p> <p>Surveyor reviewed the facility's facility-reported incidents (FRIs) and grievances which did not contain an investigation for R3's allegation of abuse.</p> <p>2. From 1/6/26 to 1/7/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including adult failure to thrive, unspecified mood (affective) disorder, and generalized anxiety disorder. R1's MDS assessment, dated 10/9/25, had a BIMS score of 3 out of 15 which indicated R1 had severely impaired cognition. R1 had an activated POAHC ((POACH)-C) to assist with decision making.</p> <p>On 11/5/25, POAHC-C contacted the local police department when POAHC-C could not get a hold of anyone at the facility and was concerned for R1's welfare. The police did a welfare check and informed the facility of POAHC-C's allegations. The facility initiated an investigation and submitted a FRI to the State Agency (SA). The FRI indicated POAHC-C called the police and reported an allegation of abuse involving R1. The police chief went to the facility and informed staff that POAHC-C alleged the facility had engaged in abusive practices, including discontinuing R1's therapy and administering medication to sedate R1. Surveyor noted the investigation did not contain interviews with R1, POAHC-C, or other residents and staff.</p> <p>On 1/7/26 at 11:41 AM and 2:00 PM, Surveyor interviewed NHA-A who stated resident interviews were completed and NHA-A would find them. NHA-A confirmed staff interviews were not completed as part of the investigation. NHA-A stated POAHC-C did not return a phone call though an attempt to contact POAHC-C was not included in the investigation.</p> <p>On 1/7/26 at 1:30 PM, Surveyor reviewed resident interviews that NHA-A stated were found in R1's closed medical record. Surveyor noted the interviews were not dated and the interview questions were general and did not pertain to the specific allegations of overmedicating residents and discontinuing therapy.</p> <p>3. From 1/6/26 to 1/7/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including rheumatoid arthritis, history of stroke, depression, and peripheral vascular disease. R5's MDS assessment, dated 12/23/25, had a BIMS score of 9 out of 15 which indicated R5 had moderately impaired cognition. R5 had an activated POAHC who assisted with healthcare decisions.</p> <p>On 1/7/26 at 9:23 AM, Surveyor interviewed R5 who stated CNA-D was rough with cares on the night shift and R5 did not want CNA-D to provide care to R5. R5 could not recall if CNA-D provided care for R5 since R5 reported the concerns.</p> <p>On 1/7/26 at 1:11 PM, Surveyor interview R5's Family Member ((FM)-I) who stated R5's family reported concerns to staff about CNA-D. FM-I stated CNA-D was mean and rough with cares for R5 and was mean when communicating with R5's family. FM-I stated R5 did not want CNA-D in R5's room. FM-I stated CNA-D worked for an agency and was no longer at the facility.</p> <p>Surveyor reviewed the facility's FRIs and grievances which did not contain an investigation for R5</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Suring Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Manor Dr Suring, WI 54174	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>or R5's family's allegations of abuse.</p> <p>4. From 1/6/26 to 1/7/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including osteoarthritis, chronic kidney disease, osteoporosis, and edema. R6's MDS assessment, dated 12/24/25, had a BIMS score of 15 out of 15 which indicated R6's had intact cognition. R6 was responsible for R6's healthcare decisions.</p> <p>On 1/7/26 at 2:48 PM, Surveyor interviewed R6 who stated CNA-D worked too fast and was rough with transfers, including when CNA-D transferred R6 to the toilet. R6 stated R6 self-transferred from the toilet despite the fact it was unsafe so that CNA-D would not touch R6. When CNA-D reminded R6 of R6's transfer restrictions, R6 told CNA-D not to touch R6. R6 told an (unidentified) CNA about the concerns and reported the concerns three times before CNA-D stopped entering R6's room. R6 did not receive follow-up about the concerns but had not seen CNA-D in a while.</p> <p>Surveyor reviewed the facility's FRIs and grievances which did not contain an investigation for R6's allegation of abuse.</p> <p>5. On 1/7/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including osteomyelitis of vertebra and severe septic shock. R10's MDS assessment, dated 10/27/25, had a BIMS score of 15 out of 15 which indicated R10 had intact cognition. R10 was responsible for R10's healthcare decisions.</p> <p>On 1/7/26 at 2:10 PM, Surveyor interviewed R10 who stated agency CNA-D was aggressive with cares on the night shift. R10 stated when CNA-D assisted R10 with a urinal, CNA-D pushed the urinal too hard and hit R10's testicles. R10 reported the concern to an (unidentified) nurse(s) on multiple occasions and did not want CNA-D in R10's room. R10 did not receive follow up regarding the concern.</p> <p>Surveyor reviewed the facility's FRIs and grievances which did not contain an investigation for R10's allegation of abuse.</p> <p>6. On 1/7/26, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including cerebral infarction and spastic hemiplegia affecting the right dominant side. R11's MDS assessment, dated 11/4/25, had a BIMS score of 13 out of 15 which indicated R11 had intact cognition. R11 was responsible for R11's healthcare decisions.</p> <p>On 1/7/26 at 2:30 PM, Surveyor interviewed R11 who stated CNA-D was mean and rough with cares and R11 was fearful of CNA-D. R11 did not recall if R11 reported the concern to staff but made it known to CNA-D that CNA-D was not allowed in R11's room.</p> <p>On 1/7/26 at 4:45 PM, Surveyor interviewed CNA-E who confirmed several residents reported to staff that CNA-D was rough cares. CNA-E stated CNA-E often had to assist residents on CNA-D's unit because CNA-D was not allowed in their rooms; however, sometimes CNA-D still went in their rooms. CNA-E stated the concerns were reported to administration multiple times by staff and residents.</p> <p>On 1/7/26 at 11:54 AM, Surveyor interview CNA-F who verified that residents reported CNA-D was rough and short-tempered and stated there was a list of residents who did not allow CNA-D in their rooms. CNA-F verified the concerns were reported to nursing and management by staff and residents. CNA-F stated R6, R5 and R11 were among the residents who voiced concerns about CNA-D.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Suring Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Manor Dr Suring, WI 54174	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/7/26 at 12:45 PM, Surveyor interviewed CNA-G who confirmed several residents reported concerns with CNA-D and stated CNA-D was rough with cares. CNA-G reported the concerns to (unidentified) charge nurses and (unidentified members of) administration.</p> <p>On 1/7/26 at 3:03 PM, Surveyor interviewed unit manager Licensed Practical Nurse (LPN)-H who verified several residents reported that CNA-D was rough with cares and did not want CNA-D to provide cares or enter their rooms. LPN-H reported the concerns to Director of Nursing (DON)-B and stated CNA-D did not work in the facility any longer.</p> <p>On 1/7/26 at 2:25 PM, Surveyor interviewed NHA-A, DON-B and LPN-H. NHA-A indicated some residents were discriminatory toward staff and did not want to work with CNA-D because of CNA-D's ethnicity and accent. NHA-A, DON-B, and LPN-H confirmed several residents did not want CNA-D to provide care or enter their rooms but thought it was due to cultural and racial differences. NHA-A denied receiving any reports from staff or residents that CNA-D was rough with cares. NHA-A verified a concern that a staff member was rough with cares should be thoroughly investigated and verified the the facility did not thoroughly investigate R3, R1, R5, R6, R10, and R11's allegations of abuse.</p>		