STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525375	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hebron Oaks	510 Genomic Drive Madison, WI 53719

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 - 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, record review and policy review, the facility failed to protect the resident's right to be free from verbal and physical abuse by a Registered Nurse (RN A). This failure affected 1 of 3 residents (R1) reviewed for abuse.Resident #1 was subjected to verbal and physical abuse on 10/09/2025, when Registered Nurse (RN) A verbally berated the resident and turned the resident onto their side against their will. This failure resulted in unnecessary pain and anxiety for the resident. Findings included: A facility policy titled, Abuse, Neglect, Misappropriation, Mistreatment, and Exploitation, Preventing, Investigating, and Mandatory Reporting Policy, updated on 08/25/2023, revealed, Residents will not be abused by anyone, including but not limited to [facility name] staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The policy revealed, Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy continued, Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled using technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. An admission Record revealed the facility admitted Resident #1 on 10/02/2025. According to the admission Record, the resident had a medical history that included diagnoses of osteomyelitis of the vertebra of the lumbar region, discitis of the lumbar region, anxiety disorders, muscle weakness, and pain in the right thigh. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/08/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident rejected care one to three days during the assessment period. The MDS indicated the resident was dependent on staff assistance for toileting hygiene and for rolling to their left or right side. The MDS indicated that Resident #1 experienced frequent pain over the previous five days of the assessment period, which frequently affected sleep, frequently limited participation in therapy activities, and frequently limited day-to-day activities. Resident #1's Care Plan Report included a focus area initiated 10/10/2025 that indicated the resident had chronic pain to the bilateral hips related to arthritis and acute pain to the back related to lumbar osteomyelitis. Interventions directed staff to anticipate the resident's need for pain relief and respond immediately to any complaint of pain (initiated 10/15/2025). The Care Plan Report also included a focus area initiated 10/02/2025 that indicated the resident had activities of daily living (ADL) self-care deficit related to activity intolerance, limited mobility, and hospice services. Interventions directed staff to check and change the resident frequently (initiated 10/02/2025). An Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, submitted on (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 - Minimal harm or potential for actual harm Residents Affected - Few	10/10/2025 at 11:00 AM by the Administrator (ADM), revealed that an allegation of abuse occurred on 10/09/2025 at approximately 5:00 PM. Per the Report, RN A was observed by the Interim Director of Nursing (IDON), telling Resident #1 you just need to knock it off or therapy will cut you and we will throw you out. The Report indicated that RN A had completed her shift, left the facility, and was suspended. An email correspondence, titled Incident Report PM Shift 10/09/2025, dated 10/09/2025, sent to the former Director of Nursing (FDON) and IDON (interim Director of Nursing) from Certified Nursing Assistant (CNA) B revealed CNA B and CNA C entered the resident's room around 4:00 PM to assist Resident #1 with incontinence care and to change the resident's bedding. The document indicated Resident #1 was joking and laughing with the staff as they were washing the resident. CNA B informed Resident #1 that they needed to roll the resident over to change the resident's bedding and to clean the resident's back and buttocks. Per the document, CNA B and CNA C began to roll Resident #1, but Resident #1's back began to spasm, and the resident yelled out. The document revealed Resident #1 did not want to continue care at that time and needed a minute to recover. CNA B and CNA C reattempted to roll Resident #1, but the resident screamed again when the staff members touched the resident. The document revealed CNA B left to get the IDON for assistance in calming the resident down. CNA B spoke to the IDON and requested assistance. The document revealed RN A overheard the conversation between CNA B and the IDON and that RN A said Resident #1 could not refuse anymore and needed changed. Per the document, CNA B told RN A that she understood but could not force the resident to be changed. The document revealed RN A walked to Resident #1's room with CNA B following, and when they arrived in the resident's room, RN A started to lecture Resident #1. Per the document, RN A said, I am not doing this with you anymore, You need to be changed, repositioned, and up in your chair at least twice a day, and This isn't an option. Then RN A pulled Resident #1 over on their side and told CNA C to clean the resident. Resident #1 was pushing and screaming, and CNA B was holding the resident so the resident would not fall out of the bed, while CNA C assisted with cleaning Resident #1. Per the statement, Resident #1 continued to scream and push, while RN A continued to lecture the resident. The document revealed at that time, the IDON entered Resident #1's room and the staff members repositioned Resident #1 on their back but still needed to roll the resident to the other side to change the resident's bedding, absorbent pad, and incontinence brief. The document revealed that RN A pushed the resident to their other side and at that point stood over the resident and started pointing at the resident, stating, You need to knock this off or you are going to get cut from therapy and kicked out next week. An email correspondence, titled Incident 10/09/2025 PM Shift, dated 10/09/2025, sent to the former FDON and IDON from CNA C, revealed that around 4:00 PM, CNA B asked CNA C to assist her in changing Resident #1's incontinence brief and bedding. The document revealed that when CNA C entered Resident #1's room, CNA B had everything set up to perform incontinence care on the resident. They rolled Resident #1 toward CNA C, and the resident started to yell, Please put me back down. The document revealed CNA B and CNA C returned Resident #1 to a back lying position, and the resident did not want to roll again. After talking with the resident, CNA B and CNA C attempted to roll Resident #1 again, but when they touched the resident, she started to have another back spasm and yelled for the staff members not to touch the resident. The document revealed CNA B left Resident #1's room to get the IDON. Per the document, about a minute later, RN A entered the room yelling that the staff needed to change Resident #1, or the resident would never get better if the resident continued lying in bed. Per the document, RN A rolled Resident #1 to one side, at which point the IDON entered the room. The document indicated RN A rolled Resident #1 to their other side while CNA C placed a new fitted sheet and new brief under the resident and then they rolled the resident back onto their (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not tell the resident they would be thrown out of the facility and reiterated to the resident what the physical therapist told her. RN A stated that she returned to the nurse's station, finished charting, and left the facility without any further conversation with the resident. RN A stated she could not remember assisting Resident #1 with care on 10/09/2025 at any time during the shift. RN A stated she left the faciity on [DATE] and did not think she did anything wrong. During a telephone interview on 01/08/2026 at 9:00 AM, the ADM stated that on 10/09/2025, RN A was attempting to assist with Resident #1 because the resident was resisting therapy, and RN A spoke very harshly to the resident, The ADM stated RN A then left Resident #1's room and the facility because her shift was over. The ADM stated they tried to notify RN A that she was suspended pending investigation, but the staff member did not have a cell phone or voicemail. The ADM stated that RN A was removed from the schedule, and a police report was filed. The ADM stated they discovered during the investigation that staff were trying to provide incontinence care for Resident #1 and the resident was crying out during the care, which alerted RN A to enter the room. The ADM stated that according to statements gathered from facility staff, RN A forced Resident #1 to receive incontinence care. During an interview on 01/08/2026 at 9:47 AM, the facility's Executive Director (ED) stated RN A should not have lectured Resident #1 or forced the resident to receive incontinence care against their will. During a telephone interview on 01/08/2026 at 9:50 AM, the ADM stated that RN A was terminated following the investigation. During an interview on 01/08/2026 at 9:58 AM, the ED stated that the facility substantiated the allegation of abuse.

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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. Based on interview, record review, and facility document and policy review, the facility failed to report an allegation of abuse within the required timeframe for 1 (Resident #1) of 3 residents reviewed for abuse prohibition. Findings included: A facility policy titled, Abuse, Neglect, Misappropriation, Mistreatment, and Exploitation Preventing, Investigating, and Mandatory Reporting Policy, updated on 08/25/2023, revealed, All personnel, residents, family members, visitors, etc., are expected to report incidents of, or suspected incidents of, abuse, neglect, mistreatment, misappropriation of resident property, and exploitation. Such reports must be made immediately to the Administrator and may be made without fear of retaliation from the facility or its staff. If such incidents occur or are discovered after hours, the Administrator must still be notified. The facility will ensure that all allegations of abuse, including injuries of unknown source, neglect, mistreatment, misappropriation of resident property, and exploitation, are reported to DQA [The Department of Quality Assurance]. For allegations of abuse or serious bodily injury, immediately, but not later than 2 hours after the allegation is made. An admission Record revealed the facility admitted Resident #1 on 10/02/2025. According to the admission Record, the resident had a medical history that included diagnoses of osteomyelitis of the vertebra of the lumbar region, discitis of the lumbar region, anxiety disorders, muscle weakness, and pain in the right thigh. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/08/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident rejected care one to three days during the assessment period. The MDS indicated the resident was dependent on staff assistance for toileting hygiene and for rolling to their left or right side. The MDS indicated that Resident #1 experienced frequent pain over the previous five days of the assessment period, which frequently affected sleep, frequently limited participation in therapy activities, and frequently limited day-to-day activities. Resident #1's Care Plan Report included a focus area initiated 10/10/2025 that indicated the resident had chronic pain to the bilateral hips related to arthritis and acute pain to the back related to lumbar osteomyelitis. Interventions directed staff to anticipate the resident's need for pain relief and respond immediately to any complaint of pain (initiated 10/15/2025). The Care Plan Report also included a focus area initiated 10/02/2025 that indicated the resident had activities of daily living (ADL) self-care deficit related to activity intolerance, limited mobility, and hospice services. Interventions directed staff to check and change the resident frequently (initiated 10/02/2025). An Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, revealed that an allegation of abuse occurred on 10/09/2025 at 5:00 PM. The Report was signed as submitted by the Administrator (ADM) on 10/10/2025 at 11:00 AM (18 hours after the allegation of abuse). Per the Report, Registered Nurse (RN) A was observed by the Interim Director of Nursing (IDON), telling Resident #1 you just need to knock it off or therapy will cut you and we will throw you out. The Report indicated that RN A had completed her shift, left the facility, and was suspended. During a telephone interview on 01/08/2026 at 9:00 AM, the ADM stated that when made aware of an allegation of abuse, he reported the allegation immediately. The ADM stated that on 10/09/2025, RN A was attempting to assist with Resident #1 because the resident was resisting therapy, and RN A stated very harshly to the resident, You just need to knock it off or therapy will cut you and throw you out, which was upsetting to the resident. The ADM stated that RN A was removed from the schedule, and a police report was filed. The ADM stated they discovered during the investigation that staff were trying to provide incontinence care for Resident #1 and the resident was crying out during the care, which alerted RN A to enter the room. The ADM stated that according (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to statements gathered from facility staff, RN A forced Resident #1 to receive incontinence care. During a telephone interview on 01/08/2026 at 10:17 AM, the ADM stated he was informed of the allegation of abuse on 10/09/2025 and submitted the initial report on 10/10/2025. The ADM stated that since the allegation did not involve physical bodily injury, they reported the allegation within the 24-hour timeframe. The ADM stated the initial report for the allegation of abuse was not filed within two hours, and he was not aware that it was part of the facility's policy. During a telephone interview on 01/08/2026 at 2:07 PM, the facility's Former Director of Nursing (FDON) stated she was familiar with the incident that occurred involving Resident #1 on 10/09/2025. The FDON stated she could not remember all the details of the allegation, but she and the ADM were made aware of it during the morning meeting on 10/10/2025. The FDON stated she conducted verbal education with the IDON on the importance of reporting allegations of abuse immediately. During a telephone interview on 01/08/2026 at 2:39 PM, the ADM stated he expected facility staff to report any allegations of abuse to him right away.

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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, record review, and facility document and policy review, the facility failed to protect residents from potential further abuse by allowing an alleged abuser to return to the facility during an ongoing investigation of staff-to-resident abuse involving 1 (Resident #1) of 3 residents reviewed for abuse prohibition. On 10/09/2025 around 5:00 PM, Resident #1 was subjected to verbal and physical abuse from Registered Nurse (RN) A. RN A re-entered the facility on 10/11/2025, 10/12/2025, and 10/13/2025 during an ongoing investigation. This failure resulted in RN A having access to all residents of the facility during an ongoing investigation of an allegation of abuse. Findings included: A facility policy titled, Abuse, Neglect, Misappropriation, Mistreatment, and Exploitation Preventing, Investigating, and Mandatory Reporting Policy, updated on 08/25/2023, revealed, Residents will not be abused by anyone, including but not limited to [facility name] staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The policy continued, The first responsibility of the facility is to assure resident safety. In the event of an allegation of abuse, neglect, mistreatment, misappropriation of resident property, and exploitation made against a staff member, visitor, contractor, and/or family member, the facility shall take immediate steps to ensure the safety of the resident(s) and prevent the risk of future or further harm. Such steps shall minimally include: Suspension of the staff member until an investigation of the allegation is complete. An admission Record revealed the facility admitted Resident #1 on 10/02/2025. According to the admission Record, the resident had a medical history that included diagnoses of osteomyelitis of the vertebra of the lumbar region, discitis of the lumbar region, anxiety disorders, muscle weakness, and pain in the right thigh. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/08/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident rejected care one to three days during the assessment period. The MDS indicated the resident was dependent on staff assistance for toileting hygiene and for rolling to their left or right side. The MDS indicated that Resident #1 experienced frequent pain over the previous five days of the assessment period, which frequently affected sleep, frequently limited participation in therapy activities, and frequently limited day-to-day activities. Resident #1's Care Plan Report included a focus area initiated 10/10/2025 that indicated the resident had chronic pain to the bilateral hips related to arthritis and acute pain to the back related to lumbar osteomyelitis. Interventions directed staff to anticipate the resident's need for pain relief and respond immediately to any complaint of pain (initiated 10/15/2025). The Care Plan Report also included a focus area initiated 10/02/2025 that indicated the resident had activities of daily living (ADL) self-care deficit related to activity intolerance, limited mobility, and hospice services. Interventions directed staff to check and change the resident frequently (initiated 10/02/2025). An Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, submitted on 10/10/2025 at 11:00 AM by the Administrator (ADM), revealed that an allegation of abuse occurred on 10/09/2025 at 5:00 PM. Per the Report, Registered Nurse (RN) A was observed by the Interim Director of Nursing (IDON), telling Resident #1 you just need to knock it off or therapy will cut you and we will throw you out. The Report indicated that RN A had completed her shift, left the facility, and was suspended. An untitled, undated document provided by the facility revealed documented evidence that RN A clocked in at the facility after the alleged allegation of abuse, on 10/11/2025 from 5:55 AM to 11:55 AM; 10/12/2025 from 5:49 AM to 10:47 AM; and 10/13/2025 from 5:20 AM to 9:01 AM. During a telephone interview on 01/07/2026 at 11:42 PM, RN A stated she could not remember assisting (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525375	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hebron Oaks	510 Genomic Drive Madison, WI 53719

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 with care on 10/09/2025 at any time during the shift. RN A stated the facility's Former Director of Nursing (FDON) left a message on her answering machine on 10/10/2025, and she tried to call the FDON back but was unable to reach her. RN A stated facility management never told her that she was suspended until 10/13/2025 around 9:00 AM while she was working on the 3rd floor. RN A stated she was called on 10/13/2025 around 3:00 AM by a night shift nurse and asked if she could come in to work, so she picked up a shift on that day from about 5:20 AM to 9:00 AM. RN A stated she saw the IDON and the ADM by the nurses' station on the 3rd floor, and the ADM told her that she was not supposed to be at the facility because she was suspended. RN A stated she was also at the facility on 10/11/2025 to return some keys and complete online computer training and came to the facility on [DATE] to complete online computer training. RN A stated she did not have contact with Resident #1 on 10/13/2025 because the resident was sent to the hospital on the prior shift. During a telephone interview on 01/08/2026 at 2:07 PM, the FDON stated the ADM would have typically been the person who informed the staff member that they were suspended, and RN A was difficult to reach because she did not have a cell phone or email. During an interview on 01/08/2026 at 9:58 AM, the IDON confirmed that RN A came to the facility the weekend following the incident to complete online computer training. During an interview on 01/08/2026 at 10:03 AM, the IDON stated that RN A was removed from the schedule following the incident on 10/09/2025, but RN A was not aware that she had been removed from the schedule. During a telephone interview on 01/08/2026 at 9:59 AM, the ADM stated he was not aware that RN A came to the facility to complete online computer training on 10/11/2025 and 10/12/2025. The ADM stated RN A was not authorized to come into the facility on [DATE] and work a shift. The ADM stated that he saw RN A on the 3rd floor on 10/13/2025 and told her she was suspended. The ADM stated that when a staff member was suspended, they did not have a way to suspend the staff member's timecard, and the rest of the facility staff would not be aware of the staff member's suspension. Facility did not put protections in place to after an allegation of abuse occurred with RN A involving R1.