

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/15/2025
NAME OF PROVIDER OR SUPPLIER  Clark County Rehabilitation & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  W4266 County Highway X Owen, WI 54460	

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 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.  (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did notify the resident representative of a change in condition for 1 of 3 residents (R) reviewed (R1).On 08/12/25, the facility was notified of an allegation of abuse regarding R1. R1's legal guardian was not notified of incident or subsequent investigation findings.This is evidenced by:Facility policy titled, Abuse, Neglect, Mistreatment &amp; Misappropriation of Resident Property Policy &amp; Procedure, with no implemented or reviewed date, states in part: G. Reporting and Response: The Administrator or designee will inform the resident or resident's representative of the report of an incident and that in investigation is being conducted. The Administrator or designee, will inform the resident and/or responsible party the results of the investigation.R1 was admitted to the facility on [DATE] with pertinent diagnoses of anxiety disorder, depression, personality disorder with other symptoms and signs involving cognitive functions and awareness, and unspecified psychosis not due to substance or known physiological condition.R1's most recent significant change Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition. R1 was noted to have physical, verbal, and other behavioral symptoms occurring 1-3 days, delusions present, and rejection of cares occurred 4-6 days. R1 was independent with eating, sit to lying, sit to stand, and chair/bed transfers. R1 was receiving antipsychotic and antianxiety medications. No use of physical restraints.R1's care plan, with an initiated date of 01/28/25 and a target date of 08/04/25, states: Medication non-compliance r/t unspecified schizophrenia spectrum and other psychotic disorder and personality disorder with interventions of If R1 refuses to take medication attempt to determine the reason for refusal; if no response after 1 attempt do not use progressive verbal prompts as it leads to verbal aggression and physical threats, re-approach in a few minutes, notify physician and guardian of change of condition.Surveyor reviewed R1's medical record and noted:04/30/25 - documentation of court appointed permanent guardianship due to incompetency. 05/01/25 - documentation of an Involuntary Order to Treat with Psychotropic Medications ordered by the court.Between 10/13/25 - 10/15/25, Surveyor investigated an anonymous complaint regarding an allegation of facility staff holding R1's arms and face while administering medications. Surveyor reviewed facility's documentation and noted that on 08/12/25, Director of Nursing (DON) B was notified of an allegation of abuse that occurred on 08/05/25 and 08/06/25. The facility completed an investigation and determined on 08/19/25 that the allegation was substantiated. The facility completed staff and resident interviews, re-education with direct care staff, and notified the provider of the incident. No documentation of informing the guardian was noted.On 10/14/25 at 9:22 AM, Surveyor interviewed R1's Guardian (G) H. Surveyor asked G H if she was aware of incident that occurred on 08/05/25 and 08/06/25. G H stated no one in the facility had informed her of this occurring and no details of an investigation or findings of abuse being confirmed were communicated. G H told Surveyor this was the first time hearing of this event.On 10/14/25 at 1:03 PM, Surveyor interviewed DON B regarding incident. DON B stated that she was pretty sure the guardian was notified but would double-check for documentation to provide the surveyor. No additional documentation was provided.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to ensure each resident is free from physical restraints that are not required to treat the resident's medical symptoms for 1 of 3 resident reviewed for restraints (R1). On 08/05/25 and 08/06/25, facility staff used physical restraint to give R1 oral medications. This is evidenced by: Facility policy titled, Restraints, Use of (Physical), with a most recent revised date of 01/09/14, states in part: Policy: The use of any type of physical restraint will be based on evaluation of risk versus benefit of use following a comprehensive assessment and identification of needs and medical symptoms. A physical restraint will be used as a last resort or on a temporary trial following failure of alternative interventions. The choice of physical restraint will be identified as the least restrictive and used only when deemed necessary and appropriate as permitted by regulation. The use of a physical restraint will be an exception. The individual's legal representative will be involved in the decision-making process following education of risk versus benefit of use. Definition of Physical Restraint: Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (SOM, Appendix PP). Requirements for use: A physician order that identifies the medical symptom(s) supporting the use of the physical restraint. Verbal followed by a written consent for the use of the restraint by the legal representative. Completion of a pre-restraining assessment to determine possible contributing factors to the identified behavior and to identify all other alternative that have been tried and failed or may need to be tried prior to use of a physical restraint. The care plan must focus on: preventing adverse effects (i.e. ADL decline, increased patterns of incontinence, skin breakdown) of physical restraint use, identification of when the restraint is to be used and how long, a process in place for systematic and gradual restraint reduction or elimination, a tracking mechanism must be in place to identify when a restraint was applied and when it was removed. Facility policy titled, Medication Administration, with no date, states in part: 14. B. Court-Ordered Medications: If a court order for involuntary medication is in place, medications may be administered without the resident's consent. Medications may be administered in resident food or fluid without their knowledge or by means of restraint. Restraints may only be completed by individuals properly trained in restraint techniques. 15. The nurse is aware of the repercussions of misconduct or unprofessional conduct as it relates to medication administration per Rules of Conduct, Chapter N 7.04, Wisconsin Statutes and Administration Code for the Board of Nursing. R1 was admitted to the facility on [DATE] with pertinent diagnoses of anxiety disorder, depression, personality disorder with other symptoms and signs involving cognitive functions and awareness, and unspecified psychosis not due to substance or known physiological condition. R1's most recent significant change Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition. R1 was noted to have physical, verbal, and other behavioral symptoms occurring 1-3 days, delusions present, and rejection of cares occurred 4-6 days. R1 was independent with eating, sit to lying, sit to stand, and chair/bed transfers. R1 was receiving antipsychotic and anti-anxiety medications. R1's care plan, with an initiated date of 01/28/25 and a target date of 08/04/25, states: Medication non-compliance r/t unspecified schizophrenia spectrum and other psychotic disorder and personality disorder with interventions of: -Document refusal, -If [R1] refuses to take medication: -Attempt to determine the reason for refusal; if no response after 1 attempt do not use progressive verbal prompts as it leads to verbal aggression and physical threats, re-approach in a few minutes, -Wait a few minutes and then offer again, -Provide education as to why the need of the medication, -If refusals continue, explore other options with primary care physician, -Questions to ask to try to determine the reason for refusal: Does [R1] experience unpleasant side effects from the medication? Does [R1] have difficulty swallowing? Is [R1] afraid for some reason? Special Instructions: *COURT ORDERED PSYCHIATRIC MEDICATIONS - Psychiatric medications should be disguised in food or drink. Court ordered psychotropic medications is in place so do not need to tell him medication is in food). -Of note: R1's care plan does not include interventions associated with the use of physical restraints to administer psychotropic medications. R1's physician orders: -Haloperidol Lactate Oral Concentrate 2 MG/ML (Haloperidol Lactate) Give 2.5 ml by mouth one time a day for Behavior/agitation/mood. -Valium Oral Tablet 5 MG (Diazepam) Give 1 tablet by mouth every 8 hours as needed for anxiety. -Of note: no physician order for use of physical restraints to administer psychotropic medications was noted. Surveyor reviewed R1's medical record and</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not implement policy and procedure to protect residents following a known incident of abuse, report and investigate allegations of abuse, and complete required training of staff. This has the potential to affect all the facility's 134 residents. The facility did not implement its abuse policy and procedures by the following: Certified Nursing Assistant (CNA) G was instructed to physically restrain Resident (R) 1 while CNA F administered medication. CNA G did not immediately report to Director of Nursing (DON) or Nursing Home Administrator. Accused staff continued to work in the facility until the incident was reported a week later. The facility did not submit to the state agency a facility reported incident for 2 abuse allegations. The facility did not report the abuse of R1 to law enforcement. The facility did not notify R1's representative of the incident of abuse. The facility did not complete a full investigation of allegations of abuse for R1 and R3. The facility did not ensure staff upon hire and annually completed abuse, neglect, mistreatment and misappropriation of resident property. This is evidenced by the facility's policy titled Abuse, Neglect, Mistreatment &amp; Misappropriation of resident property policy &amp; procedure, which is not dated, states in part: Each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion. The resident will also be free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements. Staff and volunteers will receive education about resident mistreatment, neglect, and abuse, including injuries of unknown source, exploitation and misappropriation of property upon first employment and annually after that. When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The Administrator will keep the resident or his/her resident representative informed of the progress of the investigation. All reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated. The follow-up investigative notes will be submitted via email or fax to DQA within five working days of the initial report. Employees accused of alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation. The facility will ensure that all alleged violations involving abuse, neglect exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made. Example 1R1 was admitted to the facility on [DATE] with pertinent diagnoses of anxiety disorder, depression, personality disorder with other symptoms and signs involving cognitive functions and awareness, and unspecified psychosis not due to substance or known physiological condition. R1's most recent significant change Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition. R1 was noted to have physical, verbal, and other behavioral symptoms occurring 1-3 days, delusions present, and rejection of cares occurred 4-6 days. R1 was independent with eating, sit to lying, sit to stand, and chair/bed transfers. R1 was receiving antipsychotic and anti-anxiety medications. The facility's investigation dated 08/12/25 documented on 08/12/25 Registered Nurse (RN) C reported RN D received a concern from CNA G regarding inappropriate medication administration to R1 by CNA F. CNA G stated that on that day, both CNA F and RN E asked CNA G to assist in giving R1 his medication. CNA G was instructed to stand behind R1 and hold his arms to his side. CNA G observed CNA F placing her hands on both sides of R1's cheeks to open his mouth and placing medication into his mouth. RN E then handed CNA F a bottle of Gatorade, which CNA F poured into R1's mouth to assist with swallowing. RN E handed CNA F a syringe of Haldol, to administer. CNA F reported that someone would hold R1's hands while CNA F squirted the syringe of Haldol medication into the side of his cheek. CNA G acknowledge placing her hands under his chin while administering Haldol. CNA F and RN E were placed on paid administrative leave on 08/12/25. On the same day all CNA and nursing staff received re-education on identifying and reporting abuse, following court-ordered medication care plans, and the prohibition of physical holds unless properly trained. Facility's conclusion, CNA F engaged in inappropriate medication administration practices and was terminated. On 10/14/25 at 11:50 AM, Surveyor interviewed CNA G about the abuse with R1. CNA G stated between 9:00 - 9:30 PM, CNA F and RN E instructed CNA G to assist holding R1's hands to give medication. CNA G held R1's hands and CNA F placed CNA F's hand on R1's face to open mouth and gave medication. CNA G stated this also occurred the</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</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 - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility did not implement policies and procedures for ensuring the reporting of physical abuse in accordance with section 1150B of the Act when an allegation of physical abuse was not reported immediately, but no later than 2 hours to the administrator and local law enforcement in accordance with state law through established procedures for 2 of 3 residents (R) reviewed (R1 and R3). On 08/08/25, the facility was notified by local law enforcement that an allegation was reported of abuse regarding R3. The facility did not investigate or report this allegation to the State Agency (SA). On 08/12/25, the facility was made aware of an allegation of abuse regarding R1. The facility did not report this allegation to the SA. This is evidenced by: Facility policy titled, Abuse, Neglect, Mistreatment &amp; Misappropriation of Resident Property Policy &amp; Procedure, with no implemented or reviewed date, states in part: G. Reporting and Response: It is the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the event that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Example 1R3 was admitted to the facility on [DATE] with pertinent diagnoses of mild cognitive impairment of uncertain or unknown etiology, personality disorder, delusional disorders, unspecified psychosis not d/t a substance or known physiological condition, and depression. On 08/08/25 at 2:45 PM, local law enforcement was contacted by R3's sister reporting an allegation of abuse. On 08/08/25 at 3:31 PM, law enforcement arrived at facility and informed staff purpose of visit was related to allegation of abuse concerning R3. The facility did not submit a Facility Reported Incident (FRI) concerning allegation of abuse to the State Agency. On 10/14/25 at 1:10 PM, Surveyor interviewed Director of Nursing (DON) B regarding incident. DON B stated that R3 and his sister have called the police and reported numerous allegations of abuse that were unfounded. DON B stated that on 08/08/25, R3 had been threatening to call 911 numerous times for being held against his will and had notified the police that R3 might call to report this. Surveyor asked why this allegation was not reported. DON B stated the facility already knew this allegation was not true due to the multiple prior reports and did not think it should be reported or investigated. Example 2R1 was admitted to the facility on [DATE] with pertinent diagnoses of anxiety disorder, depression, personality disorder with other symptoms and signs involving cognitive functions and awareness, and unspecified psychosis not due to substance or known physiological condition. On 08/12/25, DON B was notified of an allegation of abuse regarding R1 that occurred on 08/05/25 and 08/06/25 and began an investigation. On 08/05/25, between 9:00-9:30 PM, Certified Nursing Assistant (CNA) G was asked to assist CNA G and Registered Nurse (RN) E administer R1's medications. CNA G was told by CNA F and RN E to hold R1's hands/arms while CNA F held R1's chin and squirted the syringe of medication into R1's mouth. As CNA F administered R1's medications using physical restraint, RN E would supervise. CNA G did not immediately report this to a supervisor. On 08/06/25 between 9:00-9:30 PM, CNA G observed CNA F throw R1 into a recliner in the day room and told R1 that CNA F will sit on you (R1) if you don't take your meds. CNA G then observed CNA F squat over R1 to act like CNA F was going to sit on R1. CNA G heard R1 state 'no, no' during this encounter. The following day, CNA G reported concerns to the unit nurse manager, RN D. RN D stated to CNA G that this is bad and is abuse. RN D did not immediately report this to Director of Nursing (DON) B. On 08/12/25, DON B was notified and began an investigation. On 08/19/25, facility investigation determined abuse occurred and terminated CNA F. A FRI was not submitted to the State Agency to report allegation of abuse. No documentation was noted demonstrating local law enforcement was contacted to report allegation of abuse. On 10/14/25 at 1:10 PM, Surveyor interviewed DON B regarding reporting allegation of abuse. DON B stated this was not reported to State because it was late being reported to DON and State survey agency would be giving them a cite for reporting late so decided not to report.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 1 of 3 (R3) residents reviewed. On 08/08/25, an allegation of abuse was reported to local law enforcement regarding R3. The facility did not investigate this allegation. This is evidenced by: Facility policy titled, Abuse, Neglect, Mistreatment &amp; Misappropriation of Resident Property Policy &amp; Procedure, with no implemented or reviewed date, states in part: E. Investigation: It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. Procedure: The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. R3 was admitted to the facility on [DATE] with pertinent diagnoses of mild cognitive impairment of uncertain or unknown etiology, personality disorder, delusional disorders, unspecified psychosis not d/t a substance or known physiological condition, and depression. On 08/08/25 at 2:45 PM, local law enforcement was contacted by R3's sister reporting concerns that R3 was being abused at the facility and R3 does not feel safe. On 08/08/25 at 3:31 PM, law enforcement arrived at facility and informed staff purpose of visit was related to allegation of abuse concerning R3. Surveyor reviewed R3's progress notes and noted: On 08/08/25, R3 stated desire to call 911 for being held prisoner at facility and upset about guardianship and protective placement. At 2:45 PM, facility called local police to inform them that R3 may call and was told that R3's sister had already called to report brother being abused at facility. At 3:10 PM, R1's guardian and county APS SW, DON, and supervisor notified of events and police involvement via email. No additional documentation of investigating allegation of abuse noted. On 10/14/25 at 1:10 PM, Surveyor interviewed Director of Nursing (DON) B regarding incident. DON B stated that R3 and his sister have called the police and reported numerous allegations of abuse that were unfounded. DON B stated that on 08/08/25, R3 had been threatening to call 911 numerous times for being held against his will and had notified the police that R3 might call to report this. Surveyor asked why this allegation was not reported. DON B stated the facility already knew this allegation was not true due to the multiple prior reports and did not think it should be reported or investigated.</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care by qualified persons according to each resident's written plan of care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not ensure prescription medications were administered by qualified staff for 1 of 3 residents (R1) reviewed. R1's medications were administered by a Certified Nursing Assistant (CNA). This is evidenced by: Facility policy titled, Medication Administration &amp; Treatment by Certified Nursing Assistants, with no date, states in part: Policy: This facility will comply with all state and federal guidelines related to medication administration in order to ensure the safety of resident. Nursing assistants may NOT administer any medications or perform any treatments with the following exception as delegated by the nurse: 1. Nursing assistants can apply prescription and nonprescription topical creams and ointments to UNBROKEN skin during daily cares. 2. Nursing assistants can provide oral care with mouthwashes. Facility policy titled, Medication Administration, with no date, states in part: Policy: Medication administration will adhere to all federal and state regulations. All medications shall be administered by a licensed nurse or nurse technician per physician order. R1 was admitted to the facility on [DATE] with pertinent diagnoses of anxiety disorder, depression, personality disorder with other symptoms and signs involving cognitive functions and awareness, and unspecified psychosis not due to substance or known physiological condition. R1's physician orders: -Haloperidol Lactate Oral Concentrate 2 MG/ML (Haloperidol Lactate) Give 2.5 ml by mouth one time a day for Behavior/agitation/mood. -Valium Oral Tablet 5 MG (Diazepam) Give 1 tablet by mouth every 8 hours as needed for anxiety. On 08/12/25, Director of Nursing (DON) B was made aware of an allegation of abuse regarding R1 and began an investigation. Interviews were completed with Certified Nursing Assistant (CNA) F, CNA G, and Registered Nurse (RN) E, who were identified in the complaint. Facility's documentation noted CNA F admitted administering R1's medications using food, ice cream, and a syringe. CNA F stated that someone would hold R1's hand while CNA F held R1's chin and squirted the syringe of medication into R1's mouth. While CNA F administered R1's medications using physical force, RN E would supervise. Surveyor reviewed CNA F's personnel file and noted no medication administration training completed. On 10/14/25 at 1:10 PM, Surveyor interviewed DON B regarding facility's investigation and the noted medication administration by CNA F. DON B stated it was common practice for the facility to allow CNAs to administer medications while under direct supervision of a nurse. Surveyor asked DON B if CNAs received additional training or competency evaluation to administer medications. DON B stated, no, that no competency would be needed if the nurse prepares the meds and directly observes the administration by the CNA. DON B further stated that as long as the nurse delegated the medication administration task to the CNA, it was completely acceptable for unlicensed staff to administer medications as long as the RN directly supervised.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/15/2025
NAME OF PROVIDER OR SUPPLIER  Clark County Rehabilitation & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  W4266 County Highway X Owen, WI 54460	

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 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>Based on interview and record review, the facility did not ensure staff received training regarding abuse, neglect, and exploitation and what activities constitute abuse, procedures for reporting and dementia management and resident abuse prevention. This has to potential to affect all 134 residents. This is evidenced by: The facility's policy titled Abuse, Neglect, Mistreatment &amp; Misappropriation of resident property policy &amp; procedure, which is not dated, states in part: .Staff and volunteers will receive education about resident mistreatment, neglect, and abuse, including injuries of unknown source, exploitation and misappropriation of property upon first employment and annually after that. Surveyor reviewed Certified Nursing Assistant (CNA) G, CNA F, and Registered Nurse (RN) E's education for abuse. CNA G completed abuse education on 07/05/23, and RN E completed abuse education on 01/30/24. CNA F did not have recorded abuse education training. On 10/14/25 at 11:50 AM, Surveyor interviewed CNA G about the abuse training. CNA G stated had received abuse education when they first took the CNA class at the facility in 2022. On 10/15/25 at 10:00 AM, Surveyor interviewed Director of Nursing (DON) B asking about monitoring for completion of staff education on abuse, neglect and misappropriation at time of hire and annually. DON B stated CNA F's abuse training upon hire was not completed. DON B stated it is the expectation new hire training to be completed before working with residents. Currently working on a system to ensure all staff are assigned training in the computer and to be completed by 10/31/25. DON B stated understanding there may be staff with a lapse in annual training since trying to put this new system in place. CNA G's training was missed since CNA G was casual. RN E will be scheduled to complete trainings. No additional information was provided.</p>