STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525403	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark County Rehabilitation & Living Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, interviews, and review of the facility reported incidents (FRI) the facility failed to protect the resident's right to be free from physical abuse by other residents for four residents (R3, R5, R10, and R2) of eight residents reviewed for abuse out of a total sample of 23 residents. The facility's failure to protect residents from abuse placed residents at continued risk of harm. Findings include:1. Review of the facility's reported incident (FRI) revealed that on 01/21/26 R4 struck R3 on both arms after R3 attempted to intervene when R4 got upset at a certified nurse aide who was redirecting R4 after attempting to take a meal tray that was for another resident. The FRI revealed that R4 and R3 were separated and R4 went to his room. The FRI also revealed that R4 was put on a one-to-one with staff and R3 moved to a different unit. Review of R4's electronic medical record (EMR) revealed an admission record located under the Profile tab of the EMR with an admission date of 07/06/25. The quarterly minimum data set (MDS) with an Assessment Reference Date (ARD) of 01/13/26 revealed a Brief Interview for Mental Status (BIMS) of 10 out of 15 indicating moderately impaired cognition. Review of R4's care plan located under the Care Plan tab of the EMR, dated 01/21/26, revealed that R4 had an impaired cognitive deficit and impulse disorder, had a motion activated doorbell above the door and was receiving one-on-one related to impulsive behaviors. During an interview on 04/09/26 at 1:25 PM, Certified Nurse Aide (CNA) 4 stated that R3 was helping place trays on the tables when R4 attempted to remove a tray that was not his. CNA4 stated that when I attempted to redirect R4 he became agitated. CNA4 stated that when R3 saw what was happening R3 confronted R4. The CNA stated that R4 struck R3 in the upper arm at the time R3 confronted R4. CNA stated that she separated the residents and reported the incident. During a follow-up interview on 04/10/26 at 9:05 AM, R3 stated that the altercation happened because R4 tried to take a food tray that did not belong to him and CNA4 was attempting to redirect R4. R3 stated that's when R4 got mad and was yelling at the CNA. R3 stated at that point R3 said something to R4 about being mean to the CNA so R4 then hit R3 in the arm. R3 stated that he started laughing at R4 and R4 hit R3 in the other arm before the CNA4 could get to R4. R3 stated that R4 was removed from the area and they put a guy to watch R4 all the time. During an interview on 04/10/26 at 10:05 AM, the Nurse Practitioner (NP) stated that R4 received a medication review and medication changes to help with the uncontrolled impulses. The NP also stated that R4 was seen by psychiatry for behaviors. During an interview on 04/10/26 at 10:30AM the Director of Nurses (DON) stated that after the resident-to-resident altercation R3 was asked if he wanted to change rooms and he agreed. The DON (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 - Some	stated that we had R4 seen by psychiatry and they made some medication changes to help with impulse control. The DON also stated that R4 remained on one-to-one supervision during the investigation. The DON stated that interventions were put in place to alert staff when R4 leaves his room. 2. Review of R5's admission Record in the EMR under the Census tab revealed R5 was re-admitted to the facility on [DATE] with the diagnosis of dementia. Review of R5's quarterly MDS, in the EMR under the MDS tab with ARD of 02/17/26, indicated that R5 has a BIMS four out of 15, meaning that R5 is cognitively impaired. Further review indicates that R5 has a history of wandering. During observation and attempted resident interview on 04/08/26 at 4:31 PM, R5 was sitting quietly in his wheelchair, alert yet stared when approached by others. R5 was unable to answer any questions. Review of R4's admission Record in the EMR under the Census tab revealed R4 was re-admitted to the facility on [DATE] with the diagnosis of conduct disorder. Review of R4's admission MDS, in the EMR under the MDS tab with ARD of 01/13/26, indicated that R5 has a BIMS 10 out of 15, meaning that R4 is moderately cognitively impaired. Further review indicates that R4 has a history of behavior toward others. Review of R4's Care Plan dated 10/27/25 and revised 02/17/26 revealed no concerns. During observation on 04/09/26 at 8:33 AM, R4 was in the hallway, when surveyor attempted to speak, and R4 refused to answer and kept walking. Review of facility provided, Misconduct Incident Report, (initial report), dated 02/16/26, indicated, R5 walking around unit and walked into R4's room. CNA6 could not redirect R5. R4 yelled and R5 kept entering so R4 got out of bed and punched R5 three times with a closed fist on the left upper arm. After the last punch, R5 turned around and exited the room. R5 walked down the hallway and sat down in a chair. On 04/10/26 at 1:58 PM, surveyor attempted to contact CNA6; however, CNA6 was not available. During interview on 04/10/26 at 3:20 PM, the Director of Nursing (DON) confirmed that R5 was punched three times in the arm by R4 when R5 could not be redirected out of R4's room. 3. Review of the provider's reported investigative summary titled Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report with a report submitted date of 01/22/26 provided by the Administrator revealed, On 1/16/26 [CNA5] heard yelling coming from [R10's] room. CNA5 immediately responded and found R9 in R10's room. R9 thought it was his room and took R10's blanket off his bed. R10 was upset and tried to get R9 out of his room and take his blanket back causing R9 to starting hitting R10 in the chest and shoulder. CNA5 redirected R9 out the R10's room. CNA5 immediately intervened and separated R9 and R10. The report states that R10 continues with his daily routine per usual. Behaviors, demeanor, appetite, and function remain unchanged, and no other residents were affected. The facility listed the following steps the entity took upon learning of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the incident to protect the affect person(s) from further potential misconduct. Residents were separated. Law enforcement notified. R9 has a door alarm to alert staff when he is out of his room and will be in line of site when out of his room. Review of R9's undated Face Sheet located in the resident's EMR under the Resident tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia in other diseases classified elsewhere, unspecified severity, with agitation. Review of R9's comprehensive assessment MDS with an ARD of 12/27/25 revealed R9 had a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating severe cognitive impairment. This assessment also identified R9 as having physical, verbal and wandering behaviors occurring one to three days of the assessment period. During an observation on 04/09/26 at 10:04 AM on the 3W unit, R9 was observed sitting in a recliner in the common area of the unit in the area where the television was on. R9 acknowledged the surveyor was on the unit by waving at the surveyor. When attempting to talk with R9, he could not tell the surveyor what show was playing on the television or carry on a conversation with the surveyor. Review of R10's undated Face Sheet located in the resident's EMR under the Resident tab revealed R10 was admitted to the facility on [DATE] with diagnoses which included neurocognitive disorder with Lewy bodies, cerebrovascular disease, and during his stay was diagnosed with vascular dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of R10's 11/20/25 quarterly MDS with an ARD of 11/05/25 revealed R10 had a BIMS of two out of 15, indicating severe cognitive impairment with no behavioral symptoms during the assessment period. An interview was conducted with CNA12 on 04/09/26 at 10:00 AM on the 3W locked unit. CNA12 was asked if he knew of any situations where R9 and R10 had any altercations. CNA 12 said that they do not really like each other but confirmed he did not witness any altercations between the residents. During an interview with CNA5 on 04/09/26 at 2:10 PM she stated she usually worked this unit and stated that the residents need the consistency. CNA5 was asked if she recalled an incident between R9 and R10 when R9 went into R10's room and R9 tried to take R10's blanket. CNA5 recalled the incident stating that she heard yelling and it was coming from R10. She said that she saw R9 in R10's room and R9 was trying to take R10's blanket away. She recalled that R9 hit R10 and R10 hit R9. She stated that she placed her arm around R9 and they backed up out of R10's room. CNA5 stated there was an investigation into the incident and R9 was placed on every 15-minute checks and R10 on every 30-minute checks. When asked if there have been any other altercations between the two residents, she said it has been only verbal. An interview was attempted with R10 on 04/10/26 at 9:05 AM, R10 did not respond to the surveyor when attempting to converse with him. 4. Review of R2's undated Face Sheet located in the resident's EMR under the Resident tab revealed R2 was admitted to the facility on [DATE] with diagnoses including other specified chronic obstructive pulmonary disease and type 2 Diabetes Mellitus. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R2's admission MDS with an ARD of 10/28/25 revealed R2 had a BIMS of 11 out of 15 indicating moderate cognitive impairment and did not display any behavioral symptoms during the assessment period. Review of R4's undated Face Sheet located in the resident's EMR under the Resident tab revealed R4 was readmitted to the facility on [DATE] with diagnoses including unspecified symptoms and signs of cognitive functions and awareness and degenerative disease of the nervous system. Review of R4's admission MDS with an ARD of 10/13/25 revealed R4 had a BIMS of two out of 15 indicating severe cognitive impairment. The assessment indicated R4 had wandering behaviors. Review the facility's report titled, Alleged Nursing Home Resident Misconduct, Neglect and Abuse Report dated 01/08/26, revealed the facility reported to the Department of Health Services Division of Quality Assurance, State of Wisconsin an incident involving R2 and R4. The Brief Summary of Incident states, R2 was watching TV when R4 came out picked up the remote and changed the channel, then set it back down. R2 got up, grabbed the remote, changed the channel and R4 grabbed his R2's wrist and yelled at him. R2 yelled back. R4 let go and went to his room with caregiver. The incident was reported to have occurred at 5:00 PM and the report was completed by the RN on the unit. The facility's investigation stated, R2 was involved in a resident-to-resident altercation with another R4. R4 grabbed the tv remote and changed the tv channel off the program R2 was watching. When R4 put the tv remote down R2 went to grab it and that's when R4 grabbed R2's wrist and swore at R2 telling him to leave it alone. Staff immediately separated residents. Review of the facility's investigation conducted by the Assistant Director of Nursing (ADON) and attached to the facility's reported incident revealed there have been no further issues between the two residents. The action taken was to put a TV schedule into place on the unit for residents to see and the remote control for the TV in the dayroom would be placed in the cabinet. During an interview on 04/08/26 at 9:00 AM, R2 was asked if he recalled an incident he and R4 had involving a remote for the TV. R2 stated that he was watching TV and R4 got the remote and changed the channel and put the remote back down. R2 said he then picked up the remote and R4 grabbed his wrist. He said that that is what happened. R2 said he lived on another unit before and this one and that is where the incident happened. When asked what happened as a result, R2 said the facility talked to him about it. He said he was moved to the room he is currently in and at first did not like it but was okay with his room today. On 04/09/26 at 10:00 AM, an attempt to see R4 to interview him about the incident was made. R4 was in his room and was not allowing anyone to come in to speak to him. Review of the facility's undated Abuse Policy, indicated, It is the policy of [NAME] County Rehabilitation & Living Center that each resident will be free from 'Abuse'. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties.

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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 observations, record review, interviews, and policy review, the facility failed to ensure staff members involved in allegations of abuse were removed from resident care while the investigation was ongoing for three of nine abuse allegations involving Resident (R) R5, R14, and R16. In addition, the facility failed to ensure that a complete and thorough investigation was conducted for investigations of alleged abuse for two of nine investigations involving R4 and R16. Findings include:1.Review of R14's admission Record in the electronic medical record (EMR) under the Census tab revealed R14 was admitted to the facility on [DATE] with the diagnosis of schizoaffective disorder-bipolar type. Review of facility provided, Misconduct Incident Report, (initial report), dated 02/20/26, indicated, R14 making allegation of abuse towards Certified Nursing Assistant (CNA) 2 and R15. During interview on 04/10/26 at 10:50 AM, the Director of Nursing (DON) confirmed that CNA2 was not taken off the schedule during the investigation process and indicated that she should have been. During interview on 04/10/26 at 1:00 PM, CNA2 confirmed that she only took R14 into her room when R14 wanted to be taken into her room. CNA2 denied ever making R14 stay in her room. Confirmed that R15 never spoke with R14 and/or never followed her around. In addition, CNA2 stated that R14 had delusions that various staff on various shifts were giving her enemas, which was not true. Review of facility provided CNA3's Timecard, February 2026, indicated the following dates and times that CNA2 worked: 02/20/26: 2:00 PM-10:00 PM and 6:00 AM-2:00 PM; 02/21/26:2:00 PM-10:00 PM and 6:00 AM-2:00 PM; 02/22/26: 2:00 PM-10:00 PM and 6:00 AM-2:00 PM; 02/23/26: 2:00 PM-10:00 PM and 6:00 AM-2:00 PM; 02/25/26: 2:00 PM-10:00 PM, 10:00 AM-2:00 PM, and 6:00 AM-2:00 PM; 02/26/26: 2:00 PM-10:00 PM, 10:00 AM-2:00 PM, and 6:00 AM-2:00 PM; and 02/2/26: 2:00 PM-10:00 PM, and 6:00 AM-2:00 PM. 2. Review of R16's admission Record in the EMR under the Census tab revealed R16 was admitted to the facility on [DATE] with the diagnosis of paraplegia with thoracic spinal cord injury at T7-T10, and anxiety disorder. Review of facility provided Inventory of Clothing, dated 1/8/24, indicated, Red long sleeved [NAME] shirt (blue [NAME] on sleeve), 2XL. Review of facility provided, Misconduct Incident Report, (initial report), dated 2/13/26, indicated, R16 is upset and is expressing harm to CNA3 because R16 feels CNA3 stole his shirt. Nobody else was affected by this situation. The facility has no evidence of any resident interviews during investigation. (The red [NAME] shirt.) During interview on 04/09/26 at 5:15 PM, the DON confirmed that CNA3 is a floating staff member; however, during the investigation, CNA3 was reassigned to another unit. Further interview on 04/10/26 at 11:00 AM, the DON confirmed that there were no residents interviewed during the investigation. During interview on 04/09/26 at 6:09 PM, CNA3 stated that about a month or so ago, he was contacted by Assistant Director of Nursing (ADON) and was told to stay away from R16; however, that is not easy because R16 has an electric wheelchair and he can go anywhere in the building. R16 confirmed that he was moved to another unit and was not removed from resident care during the facility's investigation. Review of facility provided CNA3's Timecard, February 2026, indicated the following dates and times that CNA3 worked: 02/13/26: 6:00 PM-10:00 PM and 10:00 PM-6:00 AM; 02/14/26: 10:00 PM-6:00 AM and 6:00 PM-10:00 PM; 02/15/26: 6:00 PM-10:00 PM, and 10:00 PM-6:00 AM; and 02/20/26: 6:00 PM-10:00 PM, and 10:00 PM-6:00 AM. 3. Review of R5's admission Record in the EMR under the Census tab revealed R5 was re-admitted to the facility on [DATE] with the diagnosis of dementia. Review of R5's quarterly Minimum Data Set (MDS), in the EMR under the MDS tab with Assessment Reference Date (ARD) of 02/17/26, indicated that R5 has a Brief Interview for Mental Status (BIMS) four out of 15, meaning that R5 is cognitively unaware. Further review indicates that R5 has a history of wandering. During observation and attempted resident interview on 04/08/26 at 4:31 PM, R5 was sitting quietly in his wheelchair, alert yet stared when approached by others. R5 was unable to answer any questions. Review of R4's admission Record in the EMR under the Census tab revealed R4 was re-admitted to the facility on [DATE] with the diagnosis of conduct disorder. Review (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of R4's admission MDS, in the EMR under the MDS tab with ARD of 01/13/26, indicated that R5 has a BIMS 10 out of 15, meaning that R4 is moderately cognitively aware. Further review indicates that R4 has a history of behavior toward others. During observation on 04/09/26 at 8:33 AM, R4 was in the hallway, when surveyor attempted to speak, and R4 refused to answer and kept walking. Review of facility provided, Misconduct Incident Report, (initial report), dated 2/16/26, indicated, R5 walking around unit and walked into R4's room. CNA6 could not redirect R5. R4 yelled and R5 kept entering so R4 got out of bed and punched R5 three times with a closed fist on the left upper arm. After the last punch, R5 turned around and exited the room. R5 walked down the hallway and sat down in a chair. On 04/10/26 at 1:58 PM, attempted to contact CNA6; however, CNA6 was not available. During interview on 04/10/26 at 3:20 PM, the DON confirmed that there was only one staff interview, and that staff interview was from CNA6. The DON indicated that all staff should have been interviewed during the investigation. Review of the facility's undated policy titled, Abuse, Neglect, Mistreatment & Misappropriation of Resident Policy and Procedure states, Purpose: It is the policy of [NAME] County Rehabilitation and Living Center that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion . F. Protection Abuse Policy Requirements: It is the policy of this facility that the resident(s) will be protected from the alleged offender(s). Procedure: Immediately upon receiving a report of alleged abuse, the Administrator and or designee will coordinate delivery of appropriate medical and/or psychological care and attention. Ensuring safety and well-being for the vulnerable individual are of utmost priority. Safety, security and support of the resident, their roommate, if applicable and other residents with the potential to be affected will be provided. This should include as appropriate: a. Procedures must be in place to provide the resident with a safe, protected environment during the investigation: i. The alleged perpetrator will immediately be removed and resident protected. Employees accused of alleged abuse will immediately be removed from the facility and will remain removed pending the results of a thorough investigation.