STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525418	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evansville Manor Nursing and Rehab, LLC	470 Garfield Ave Evansville, WI 53536

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect the resident's right to be free from verbal abuse by a CNA (certified nursing assistant) for 1 of 3 Residents (R1) reviewed for abuse. R1 and CNA C (certified nursing assistant) had a verbal altercation. The facility did not implement appropriate actions to protect R1. CNA C continued to provide direct care to residents. The facility did not educate all staff on abuse during the abuse investigation. Evidenced by: The facility policy entitled, Policy & Procedure Vulnerable Adult Abuse and Neglect Prevention, dated 3/25/25, states, in part: . Purpose: To provide residents a safe environment that is free from harm. Policy: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, neglect, mistreatment or exploitation. The facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thorough investigations of allegations. The guidelines include compliance with the seven (7) federal components of prevention and investigation. Procedure: . The facility will strive to educate all participants in techniques to protect all parties. 8. Alleged Abuse: is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated. Resident Protection Program Policy & Procedure:The seven elements of the prevention and investigation include: *Screening *Training *Prevention *Identification *Investigation *Protection *Reporting/Response. 3. Identification:a. In the event of suspected maltreatment, the needs of the resident will be immediately assessed, and the safety of the resident will be ensured. The safety and health of the resident(s) will be attended to before any other action is taken. Immediate steps should be taken to ensure that no resident remains in danger of maltreatment. 4 Investigation:a. Upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately and they, the Director of Nursing, or assigned designee, will coordinate an investigation, which will include completion of witness statements.b. When a specific staff member is implicated in the alleged event, the person will be removed from the residents' care area immediately, interviewed by the supervisor assigned, asked to provide a written statement and suspended until the investigation is completed. MUST BE SUSPENDED IMMEDIATELY PENDING INVESTIGATION.h. Education will be provided as needed to all parties involved. 6. Reporting of Incidents:a. All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's designee.b. The facility must report to the State agency immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. R1 admitted to the facility on [DATE] and has diagnoses that include Type 2 Diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R1's MDS (Minimum Data Set) admission Assessment, dated 9/22/25, shows that R1 has a BIMS (Brief Interview of Mental Status) score of 14 indicating R1 is cognitively intact. Note: R1 was out of facility during survey. Surveyor was unable to interview R1. The facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, dated 9/27/25, states, in part: . Allegation Type: Abuse: Hitting, slapping, threats of harm, assault, humiliation.Is the date and time when occurred known? YesDate occurred: 9/27/25Time Occurred: 12:00AMIs occurred date and time estimated? YesDate discovered? 9/27/25 Brief Summary of Incident: R1 and CNA C (certified nursing assistant) were witnessed yelling at each other. R1 and CNA C were immediately separated. Ensured R1 felt safe in facility. CNA C suspended pending investigation. Nurse manager, DON (Director of Nursing) and NHA (Nursing Home Administrator) were notified. [City name] Police Department notified.Report Submitted Date: 12:12:46PM . The facility provided education on Reporting Allegations of Abuse, Neglect and Misappropriation, on 9/29/25 to LPN E (Licensed Practical Nurse). The facility provided education on Policy & Procedure Vulnerable Adult Abuse and Neglect Prevention, on 9/29/25 to LPN E. The facility did not provide abuse education to all facility staff. On 10/8/25 at 11:18 AM, Surveyor interviewed LPN D who indicated on 9/26/25 at the beginning of her shift (third) she had been in the nursing office and overheard CNA C and R1 going back and forth yelling at each other. CNA C was antagonizing R1. R1 was yelling CNA C was lazy and smelled like marijuana, and CNA C was yelling at R1 that she was not lazy and what she did in her spare time was her business. LPN D indicated both R1 and CNA C kept yelling at each other. LPN D stepped out of the nurse office and told both R1 and CNA C to stop. R1 went to his room. LPN C told CNA C she is not to talk to a resident that way, that is retaliation when you confront R1 on a complaint he made

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law through established procedures for 1 of 3 residents (R1) reviewed for abuse. Facility became aware of an abuse allegation on 9/26/25 at 10:15 PM and did not report to the State Agency until 9/27/25 at 12:12 PM. Evidenced by: The facility policy entitled, Policy & Procedure Vulnerable Adult Abuse and Neglect Prevention, dated 3/25/25, states, in part: . Purpose: To provide residents a safe environment that is free from harm. Policy: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, neglect, mistreatment or exploitation. The facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thorough investigations of allegations. The guidelines include compliance with the seven (7) federal components of prevention and investigation. Procedure: . The facility will strive to educate all participants in techniques to protect all parties. 8. Alleged Abuse: is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated. Resident Protection Program Policy & Procedure:The seven elements of the prevention and investigation include: *Screening *Training *Prevention *Identification *Investigation *Protection *Reporting/Response. 3. Identification:a. In the event of suspected maltreatment, the needs of the resident will be immediately assessed, and the safety of the resident will be ensured. The safety and health of the resident(s) will be attended to before any other action is taken. Immediate steps should be taken to ensure that no resident remains in danger of maltreatment. 4 Investigation:a. Upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately and they, the Director of Nursing, or assigned designee, will coordinate an investigation, which will include completion of witness statements.b. When a specific staff member is implicated in the alleged event, the person will be removed from the residents' care area immediately, interviewed by the supervisor assigned, asked to provide a written statement and suspended until the investigation is completed. MUST BE SUSPENDED IMMEDIATELY PENDING INVESTIGATION.h. Education will be provided as needed to all parties involved. 6. Reporting of Incidents:a. All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's designee.b. The facility must report to the State agency immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. R1 admitted to the facility on [DATE] and has diagnoses that include Type 2 Diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R1's MDS (Minimum Data Set) admission Assessment, dated 9/22/25, shows that R1 has a BIMS (Brief Interview of Mental Status) score of 14 indicating R1 is cognitively intact. Note: R1 was out of facility during survey. Surveyor was unable to interview R1. The facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, dated 9/27/25, states, in part: . Allegation Type: Abuse: Hitting, slapping, threats of harm, assault, humiliation.Is the date and time when occurred known? YesDate occurred: 9/27/25Time Occurred: 12:00AMIs occurred date and time estimated? YesDate discovered? 9/27/25 Brief Summary of Incident: R1 and CNA C (certified nursing assistant) were witnessed yelling at each other. R1 and CNA C were immediately separated. Ensured R1 felt safe in facility. CNA C suspended pending investigation. Nurse manager, DON (Director of Nursing) and NHA (Nursing Home Administrator) were notified. [City name] Police Department notified.Report Submitted Date: 12:12:46PM . The facility's Risk Management Assessment/Incident, dated 9/26/25, at 10:15PM, states, in part: . Verbal Aggression InitiatedResident: R1Incident Location: Reception/LobbyPerson Preparing Report LPN D (Licensed Practical Nurse) . Agencies/People Notified:LPN E 9/27/25 9:21PM On 10/8/25 at 11:18 AM, Surveyor interviewed LPN D who indicated on 9/26/25 at the beginning of her shift (third) she had been in the nursing office and overheard CNA C and R1 going back and forth yelling at each other. CNA C was antagonizing R1. R1 was yelling CNA C was lazy and smelled like marijuana, and CNA C was yelling at R1 that she was not lazy and what she did in her spare time was her business. LPN D indicated both R1 and CNA C kept yelling at each other. LPN D stepped out of the nurse office and told both R1 and CNA C to stop. R1 went to his room. LPN C told CNA C she is not to talk to a resident that way, that is retaliation when you confront R1 on a complaint he made

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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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, that all alleged violations are thoroughly investigated, and that steps were taken to prevent further abuse for 1 or 3 residents reviewed (R1). On 9/27/25, the facility became aware of an abuse allegation regarding R1. The facility failed to provide evidence to prevent further abuse to R1 and other residents. The facility allowed the staff member identified in the abuse allegation to continue working with residents. Evidenced by: The facility policy entitled, Policy & Procedure Vulnerable Adult Abuse and Neglect Prevention, dated 3/25/25, states, in part: . Purpose: To provide residents a safe environment that is free from harm. Policy: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, neglect, mistreatment or exploitation. The facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thorough investigations of allegations. The guidelines include compliance with the seven (7) federal components of prevention and investigation. Procedure: . The facility will strive to educate all participants in techniques to protect all parties. 8. Alleged Abuse: is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated. Resident Protection Program Policy & Procedure:The seven elements of the prevention and investigation include: *Screening *Training *Prevention *Identification *Investigation *Protection *Reporting/Response. 3. Identification:a. In the event of suspected maltreatment, the needs of the resident will be immediately assessed, and the safety of the resident will be ensured. The safety and health of the resident(s) will be attended to before any other action is taken. Immediate steps should be taken to ensure that no resident remains in danger of maltreatment. 4 Investigation:a. Upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately and they, the Director of Nursing, or assigned designee, will coordinate an investigation, which will include completion of witness statements.b. When a specific staff member is implicated in the alleged event, the person will be removed from the residents' care area immediately, interviewed by the supervisor assigned, asked to provide a written statement and suspended until the investigation is completed. MUST BE SUSPENDED IMMEDIATELY PENDING INVESTIGATION.h. Education will be provided as needed to all parties involved. 6. Reporting of Incidents:a. All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's designee.b. The facility must report to the State agency immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. R1 admitted to the facility on [DATE] and has diagnoses that include Type 2 Diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R1's MDS (Minimum Data Set) admission Assessment, dated 9/22/25, shows that R1 has a BIMS (Brief Interview of Mental Status) score of 14 indicating R1 is cognitively intact. The facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, dated 9/27/25, states, in part: . Allegation Type: Abuse: Hitting, slapping, threats of harm, assault, humiliation. Is the date and time when occurred known? YesDate occurred: 9/27/25Time Occurred: 12:00AMIs occurred date and time estimated? YesDate discovered? 9/27/25 Brief Summary of Incident: R1 and CNA C (certified nursing assistant) were witnessed yelling at each other. R1 and CNA C were immediately separated. Ensured R1 felt safe in facility. CNA C suspended pending investigation. Nurse manager, DON (Director of Nursing) and NHA (Nursing Home Administrator) were notified. [City name] Police Department notified. Report Submitted Date: 12:12:46PM . On 9/27/25, at 12:12:46 PM, the facility submitted an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report to the state. The facility's investigation did not include providing protection to R1 and residents in the facility. CNA C continued to provide direct care to residents after the abuse incident occurred. The facility provided education on Reporting Allegations of Abuse, Neglect and Misappropriation, on 9/29/25 to LPN E. The facility provided education on Policy & Procedure Vulnerable Adult Abuse and Neglect Prevention, on 9/29/25 to LPN E. The facility did not provide education to all staff on abuse. On 10/8/25, at 11:18AM, Surveyor interviewed LPN D who indicated on 9/26/25 at the beginning of her shift (third) she had been in the nursing office and overheard CNA C and R1 going back and forth yelling at each other. CNA C was antagonizing R1. R1 was yelling CNA C was lazy and smelled like marijuana, and CNA C was yelling at R1 that she was not lazy and what she did in her spare