| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525418 | A. Building<br>B. Wing | 03/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Evansville Manor Nursing and Rehab, LLC | 470 Garfield Ave<br>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) |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**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 sexual abuse for 1 of 5 residents reviewed (R1). R2 has a history of making inappropriate comments and inappropriately touching female residents and staff. R2 is care planned to be kept out of arms reach of female residents and to be monitored when out in common areas. On 2/27/26, R2 was left unsupervised and inappropriately touched R1.The facility's failure to provide adequate supervision and protect residents from sexual abuse created a reasonable likelihood for serious psychosocial harm, thus resulting in a finding of immediate jeopardy (IJ) that began on 2/27/26. Surveyor notified NHA A (Nursing Home Administrator) of the immediate jeopardy on 3/12/26 at 12:00 PM. The immediacy was removed and corrected on 2/28/26. The deficient practice is being cited as past noncompliance. Evidenced by:The facility policy, Vulnerable Adult, Abuse and Neglect Prevention, dated 3/25/25, states: .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.All residents are susceptible to maltreatment and exploitation due to their need for nursing home care .Additionally, residents and staff will be protected from abuse, neglect, and harm while they are residing at the facility. There is zero tolerance for abuse or harm of any type. Residents and staff will be monitored for protection. The facility will strive to educate all participants in techniques to protect all parties.R2 was admitted to the facility on [DATE] with diagnoses including stroke, diabetes, kidney disease, impulse disorder, unspecified symptoms and signs involving cognitive functions and awareness, mood disorder, other subjective visual disturbances, and mild cognitive impairment.R2's most recent Minimum Data Set (MDS) indicates R2 has a Brief Interview for Mental Status (BIMS) score of 14 indicating R2 is cognitively intact. R2 has an activated power of attorney.R2's Comprehensive Care Plan states: .When R2 goes to activities he must be escorted to and from and placed at least arms distance away from any/all female residents 7/23/24.R2 exhibits behavior symptoms related to impulse disorder.hits/kicks during cares at times. Taking food items off of other residents trays or snack carts that are not within his diet orders. R2 tends to make sexual comments or attempt to touch staff's behinds. Resident is very honest when he is guilty of making comments and actions.10/2/23 Patient grabbed a female resident chest. 10/20/23 Resident using vulgar language/comments in dining area towards staff and residents, resident is not to have any contact with female resident .1/24/23 room change. 5/3/23 resident concern. 12/4/23 no contact with resident .2/25/24 inappropriate comment to resident .5/15/25 inappropriate behaviors towards females. 9/3/25 Resident has increased negative behaviors with certain staff. 2/27/26 inappropriate behavior toward female resident.R2 will have fewer episodes of making sexual comments or touching staff and other residents private areas/bottoms inappropriately, by the review date.12/4/23 Keep out of arms reach from female residents.Monitoring R2 when he is in a common area.R1 was admitted to the facility on [DATE] with diagnoses including autistic disorder and metabolic encephalopathy (acute confusion, altered mental status.)R1's most recent MDS indicates (continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1 has a BIMS score of 00 indicating R1 is severely cognitively impaired. R1 has an activated power of attorney.R1's most recent Comprehensive Care Plan states in part:.Vulnerability: Limited speech due to Autism Spectrum Disorder, nonverbal. Resident is unable to call out for help or remove self from a situation she feels unsafe in.Provide safe environment.The facility completed a self-report/investigation which states: .2/27/26 6:30PM, RN E (Registered Nurse) notified NHA A (Nursing Home Administrator) that at approximately 6:30PM R2 was observed with R1 in the lounge, with his hand on her, and it appeared he was touching her private area.no negative effects on resident noted at time of assessment.staff separated residents immediately, ensured R1 was safe, implemented 1:1 for R2, reported to NHA, DON (Director of Nursing), DQA (Division of Quality Assurance), Police Department notified, Guardians updated.The facility's brief statement to state agency states: At approximately 6:45PM, RN E notified NHA A that R2 was found with R1 in the hallway lounge with his hand on her, and it appeared he was touching her private area. The facility initiated an investigation, separated the residents, and placed R2 on 1:1 monitoring. RN E performed a full head to toe assessment on the resident, noting no concerns. The resident did not show any psychological distress from the incident, according to RN E. The police, POA, and provider were notified. Accused CNA was sent home. A detailed summary of investigation along with supporting documentation will be submitted.Facility interviewed residents and staff. Facility completed a timeline of events and ensured safety and placed accused CNA G (Certified Nursing Assistant) on administrative leave pending investigation. R1 went to ER for evaluation and returned with no new orders. Accused CNA G reported she did not know R2 was on 1:1 in the lounge and thought he was supervised only during meals. The facility provided CNA G 1:1 education and provided all nursing staff education regarding sexual abuse, following Kardex, what 1:1 means, and specific behavior training for R2.Facility conclusion states: .The facility concluded that R2 should not have been touching R1 as she is unable to consent. It was identified that some staff required additional clarity regarding supervision protocols for certain residents. To prevent such incidents in the future, the facility provided training to nursing staff on supervision requirements for residents and the specific sexual behaviors necessitating close monitoring, especially when in proximity to other vulnerable individuals. Additionally, the facility is actively pursuing alternative placement for R2 and psychosocial support with geri-psych (geriatric psychiatric unit). Resident has been accepted .and will be transferred on 3/5/26. Resident will remain on 1:1 always until this time. Prior to returning to facility, IDT (Interdisciplinary Team) will ensure a safe and proper plan is implemented for residents. Also, actively working with MCO (Managed Care Organization) to seek placement in a smaller setting/male group home. Facility will ensure through education that all staff assigned on R2's hallway have documented education on proper 1:1 with residents assigned to it. Close monitoring and collaboration with the local law enforcement will continue. Follow up with all residents that were at risk prior in the facility occurred with no further concerns. Staff education will continue. Care plan was updated for R2. R1 had a planned discharge for 3/1/26 and has since been discharged from facility. Follow up occurred with R1's guardian on 3/2/26 and 3/4/26.Surveyor confirmed R1 was discharged on 3/1/26 to her group home and R2 was discharged on 3/5/26 to a geriatric psychiatric facility.On 3/11/26 at 1:50 PM, Surveyor interviewed CNA C, who indicated she has received education recently on sexual abuse, 1:1 supervision, and specific behaviors for R2. CNA C indicated she is aware of the incident from 2/27/26 and after R2 was placed on 1:1. CNA C indicated before the incident, R2 needed to be in staff line of sight at all times when out of his bedroom and at arm's length from all female residents. CNA C indicated R2 is very quick and has touched CNA C and said inappropriate things to her as well.On 3/11/26 at 2:06 PM, Surveyor interviewed CNA D, who indicated she is always down R2's hallway, but was not working on 2/27/26. CNA D indicated prior to the incident on 2/27/26, R2 needed to be in line of sight when out of room and at arm's length from all female residents. After the incident, R2 was 1:1 at all times. CNA D indicated she received education after the incident. CNA D indicated R2 talked about the incident when she came back to work the following Monday and that R2 laughed<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | about the incident.On 3/11/26 at 2:30 PM, Surveyor interviewed RN E, who indicated she was the nurse that was working on 2/27/26. RN E indicated around 6:30 PM, CNA G reported to her that CNA G was returning trays to the cart, came back and saw R2 touching R1 in her abdomen area. CNA G immediately separated the two residents and reported the incident. RN E completed a full head to toe skin check on R1, R2 was put on 1:1 staffing, and all notifications were made. RN E indicated before this incident, R2 was care planned to be in line of sight if out of room, not be left around female residents, and staff had to escort him to and from activities. RN E indicated he needed extra supervision when out of his room. RN E indicated CNA G was agency staff and she was under the impression that the extra supervision was just for mealtimes. RN E indicated everyone received education after the incident.On 3/11/26 at 2:12 PM, Surveyor interviewed FM F (Family Member), who indicated she is R1's activated power of attorney. FM F indicated R1 is not able to use words to communicate. FM F indicated she came to the facility after the incident and R1 was not acting like herself. FM F indicated R1 did not make eye contact. FM F indicated she went with R1 to the emergency room. FM F indicated she has no concerns with how the facility investigated and handled the incident.On 3/12/26 at 11:30 AM, Surveyor interviewed DA H (Dietary Aide), who indicated she is aware of the incident that occurred on 2/27/26 between R2 and R1. DA H indicated she received education after the incident. DA H indicated R2 cannot be left alone, never can be alone. DA H indicated if she ever saw R2 without staff by R2's side she would stay with him until she got a nursing staff to assist him. DA H indicated if she ever witnessed any issues between R2 and another resident she would intervene and report the incident immediately.On 3/12/26 at 11:45 AM, Surveyor interviewed AA I (Activity Aide), who indicated she received education after the incident on 2/27/26. AA I indicated R2 is a 1:1 at all times. AA I indicated if she witnessed R2 being inappropriate with another resident she would separate the two residents and report immediately.On 3/11/26 at 3:02 PM, Surveyor interviewed NHA A. NHA A indicated the incident took place on 2/27/26 around 6:30 PM. NHA A indicated RN E called and reported the incident. NHA A indicated both residents were separated, R2 was placed on 1:1, and R1 was assessed and went to the emergency room. NHA A indicated CNA G was placed on administrative leave and all notifications were made. NHA A indicated care plans were updated, audits completed, staff and residents interviewed, and education was provided to all nursing staff. NHA A indicated they identified a break in communication between the nurse/aide, care plan and supervision were not followed, and they began working on past noncompliance. The facility implemented that only the facility CNAs could work down R2's hallway and if agency had to, then there would be documentation of the training with that agency staff. The facility completed audits to ensure this was being followed. The facility also completed audits on ensuring the 1:1 was in place, 1:1 documentation was completed, and this matched the schedule for the day. The facility also made the decision to not have residents who are unable to verbally communicate be admitted down R2's hallway and Admissions received training on this. NHA A indicated before this incident R2 needed to stay arm's length from all female residents and supervision when out of bedroom.The facility's failure to provide adequate supervision and protect residents from sexual abuse by R2 created a reasonable likelihood for serious psychosocial harm, thus leading to a finding of immediate jeopardy which began on 2/27/26. The facility removed and corrected the immediate jeopardy on 2/28/26 when it completed the following:R2 and R1 immediately separated. R2 placed on 1:1 staffing. A full head to toe assessment completed for R1.CNA G Nursing Assistant placed on administrative leave.Ensured all residents in facility were safe and expressed no concerns regarding safety.Police guardians, state agency, and Medical Director notified.Behavioral Care was sought for R2 to review medications and increased sexual behavior.emergency room evaluation was provided to R1 with no new orders.The facility provided training to the nursing staff on supervision requirements and the specific sexual behaviors necessitation close monitoring, especially when in proximity to other vulnerable individuals and ensuring Kardex is utilized every shift and CNAs review binder for any additional changes to resident care.Agency staff will not be assigned to R2's<br>(continued on next page) |

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