STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525435	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbotsford Health Care Center	600 E Elm St Abbotsford, WI 54405

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	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure an allegation of misappropriation was thoroughly investigated for 1 of 1 resident (R) (R5) reviewed.The facility did not provide evidence of resident interviews and staff training on misappropriation.The facility's policy titled, Abuse/Neglect/Exploitation, read in part, Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Training staff on changes made and demonstration of staff competency after training is implemented.On 02/06/26, the facility reported R5 returned from the hospital on [DATE] and it was reported R5 had $200 missing. Staff had observed a $50 bill in R5's room on 02/05/26.The facility completed an investigation which included: -Interview with R5.-Search for the missing money, which was not found.-Contacting law enforcement.-Staff interviews.-Facility reimbursed R5 $50 that had been verified by staff.-The facility submitted their investigation to the State Agency on 02/12/26.On 03/11/26 at 1:00 PM, Surveyor interviewed R5. R5's Brief Interview for Mental Status (BIMS) was 15/15, indicating intact cognition. R5 stated he was missing $200 and the facility reimbursed him $50. When Surveyor asked him questions about the missing money, R5 was not always clear in his responses and was cursing. R5 stated he had $200, then he stated he asked the transportation driver to stop at the tobacco outlet. When Surveyor asked him if they stopped, R5 stated, I had $200, and they only reimbursed me $50. Surveyor was unable to obtain additional information from R5.On 03/11/26, Surveyor interviewed Certified Nursing Assistant (CNA) I. CNA I was aware of R5's missing money. CNA I stated R5 was offered to keep his money locked and had declined. CNA I confirmed staff searched for the money and were unable to locate it. CNA I stated she did not remember any staff education or training related to misappropriation after R5's money was allegedly missing.On 03/11/26 at 1:27 PM, Surveyor interviewed Social Services Director (SSD) J. SSD J stated she was the grievance officer for the facility. SSD J confirmed the facility was unable to locate any missing money for R5 and staff could not confirm how much was missing, except for $50 that was observed in R5's room. SSD J provided Surveyor with the facility's investigation and evidence of R5 being reimbursed $50 via check.Surveyor asked SSD J if resident interviews were conducted, and SSD J reported the facility conducts daily Angel Rounds. Angel Rounds are where each department head is responsible for checking in with assigned residents on a daily basis and asking specific questions to confirm resident satisfaction or concerns.SSD J provided Surveyor with a blank copy of Angel Rounds. SSD J stated she knows the document is not dated with a revision date, but on 02/07/26, the facility added the question, Do you have any missing money or items? SSD J provided Surveyor with a typed two-page document titled, Resident interviewed about missing items, dated 02/07/26. The document listed a room number, a resident name, and indicated yes or no after the resident name. There were 26 residents listed on the document. R5 was the only resident who reported missing money.Surveyor asked SSD J if staff education was provided, and she stated NHA or DON would provide staff education.Surveyor interviewed R3 and R6, who did not have concerns related to missing items or money. R3 and R6 did not report if the facility had interviewed them after R5's money was allegedly missing.On 03/11/26 at approximately 2:30 PM, Surveyor interviewed Nursing (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Home Administrator (NHA) A. NHA A reported resident interviews were conducted. NHA A stated a staff in-service, and education was completed on misappropriation.On 03/12/26, the facility provided evidence staff training related to misappropriation was completed on 02/12/26, six days after the incident. There was no evidence immediate education was completed to protect residents from misappropriation. Based on the Surveyor's investigation, the facility was unable to determine the amount of money R5 was allegedly missing, and the facility did reimburse R5 for the amount of money that was observed by staff. Surveyor determined the facility did not complete a thorough investigation due to lack of evidence of resident interviews and staff training.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 of 3 residents (R7) reviewed for discharge process received the proper notice of transfer, reason for transfer, location of transfer, appeal rights, and name and address (mailing and email) with telephone number of the Office of the State Long-Term Care Ombudsman. In addition, the facility did not ensure R7 and/or their representative received written information on the duration of the bed hold policy, the reserve bed payment policy, and the right to return to the facility.Based on the Surveyor's investigation, there was no evidence of the following:-R7's admission to the facility.-R7's fall and incident at the facility.-R7's discharge from the facility.-Evidence the facility could not meet R7's needs.-R7 was provided with discharge notices and bed hold notice, with appeal rights upon discharge.-Communication with current hospital to assess transfer status and agreement to re-admit R7 to the facility.-A hoyer sling was ordered for R7.The facility's policy titled Transfer and Discharge, read in part,1. The facility will evaluate and determine the level of care needed for the resident prior to admission to ensure the facility's ability to meet the resident's needs.2. Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions:a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.3. When a resident exercises his or her rights to appeal a transfer or discharge, the facility will not transfer or discharge the resident while the appeal is pending, unless failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility.4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge. b. The effective date of the transfer or discharge. c. The location to which the resident is to be transferred or discharged . d. An explanation of the right to appeal the transfer or discharge to the State.e. The name, address, and telephone number of the State entity which receives such appeal hearing requests. f. Information on how to obtain an appeal form.g Information on obtaining assistance in completing and submitting the appeal hearing request.h. The name, address, and phone number of the representative of the Office of the State Long-Term Care Ombudsman.10. For a transfer to another provider, for any reason, the following information must be provided to the receiving provider:a. Contact information of the practitioner who was responsible for the care of the resident;d. All other information necessary to meet the resident's needs.11. Non-Emergency Transfer or Discharges-initiated by the facility, return not anticipate.a. Document the reason for transfer or discharge in the resident's medical record, and in the case of necessity for the resident's welfare and the resident's needs cannot be met in the facility, document the specific resident needs that cannot be met, facility attempts to [NAME] the resident's needs, and the service available at the receiving facility to [NAME] the resident's needs. Document any danger to the health or safety of the resident or other individuals that failure to transfer or discharge would pose.On 02/10/26, Complainant G reported R7 was admitted to the facility, and within 15-30 minutes, R7 fell and was sent to the emergency room for evaluation. Complainant G reported the facility was refusing to re-admit R7, stating they were unable to meet R7's needs.On 03/11/26 at 8:56 AM, Surveyor interviewed Complainant G. Complainant G stated when R7 arrived in the emergency room on [DATE], after falling at the facility, emergency medical services (EMS) told hospital staff the facility would not accept R7 back to the facility as R7's transfer status was not what the hospital had told the facility. Complainant G stated when she spoke with the facility staff she was told the facility did not have the equipment to care for R7, such as bariatric hoyer lift or sling. Complainant G was unaware R7 suffered any injury from the fall. Complainant G stated R7 had been transferred to a different hospital.On (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/11/26, Surveyor reviewed R7's electronic health record in the facility. Surveyor noted R7's record contained pre-admission scanned records, such as Advanced Directives, hospital discharge summary, insurance and payment information, but was unable to find any other documentation to support R7 was in the facility.The facility did not provide evidence of progress notes, assessments, incidents, or documentation of R7's admission or discharge to and from the facility.On 03/11/26 at 11:11 AM, Surveyor called R7. R7 did not answer, and Surveyor received an automated message there was no voicemail set-up on this phone.On 03/11/26 at 11:12 AM, Surveyor attempted to call R7's emergency contact, and received an automated message there was no voicemail set up on this phone.On 03/11/26 at 12:16 PM, Surveyor interviewed Admissions Coordinator (AC) G. AC G reported R7 was not admitted to the facility. AC G stated the referring hospital reported R7 was a pivot transfer and when R7 arrived she could not transfer. AC G stated R7 traveled approximately two hours from the referring hospital to the facility and had been placed in a wheelchair that was too small for R7.AC G stated shortly after R7 arrived, R7 was seated in her wheelchair and reached down to pick up something and slid out of her chair and onto the floor. AC G reported EMS were called, as the facility was unable to get R7 up from the floor. AC G reported she was unsure if R7 suffered any injury. R7 was transported to the emergency room.AC G stated she did receive a phone call from the emergency room discharge planner asking if the facility would re-admit R7. AC G stated, Our lifts only hold so much and we did not have the appropriate sling.AC G stated she has been in contact with hospital discharge planners, and the facility had agreed to re-admit R7. AC G stated, I believe she [R7] is still in the hospital.On 03/11/26 at 12:46 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A stated the facility had accepted R7 as an admission to the facility on [DATE]. NHA A reported the facility was told R7 could pivot transfer, and when R7 arrived at the facility staff were unable to transfer her out of her wheelchair as R7 could not pivot transfer. NHA A stated she asked for therapy to assess R7 and when returning to R7's room, R7 had fallen out of the wheelchair. NHA A stated no admission paperwork for R7 had been done.NHA A stated the facility called an ambulance to have R7 transferred to the emergency room. NHA A stated R7's wheelchair was too small and there was a long travel time, and asked, Is that why she couldn't pivot transfer? NHA A stated she called the referring hospital and was told R7 should be sent to the referring hospital's sister hospital, which was located approximately 30 minutes away from the facility. NHA A reported the sister hospital called the facility asking the facility what they wanted them to do with R7. NHA A reported the facility did not have the equipment to care for R7 as she could not pivot transfer.The facility did not provide evidence they communicated with the receiving hospital the reason for R7's discharge.NHA A reported she had been in contact with Bureau of Nursing Home Resident Care (BNHRC) Interim Regional Field Operations Director (RFOD) and was told to remain in contact with the current hospital. NHA A stated she had been in contact with the discharge planner at the current hospital and stated, We will take her back when she can pivot transfer. I haven't heard anything back.Surveyor asked if R7 suffered any injury and NHA A was not sure as staff were unable to move R7 from the floor.Surveyor asked why R7 was transferred to the hospital and NHA A stated because staff were unable to get R7 off the floor and R7 was unable to pivot transfer.Surveyor asked if R7's transfer status has been assessed at the current hospital and if R7's transfer status was a mechanical (hoyer) lift, and NHA A stated, That is a good question.The facility did not provide evidence R7 was assessed at the facility to determine what her transfer status was. The facility did not provide evidence of communication with current hospital to determine R7's transfer status and re-admission to the facility.Surveyor spoke with BNHRC Interim RFOD. BNHRC Interim RFOD stated the facility stated they would be ordering the correct hoyer sling for R7 and once received would be re-admitting R7.On 03/11/26 at approximately 2:30 PM, Surveyor asked NHA A if they had ordered and received hoyer lift sling for R7. NHA A was unsure and asked other staff. Staff reported the former Director of Nursing (DON) had been working on that and they would have to check to see.The facility did not provide evidence that a hoyer sling was ordered for R7.Surveyor requested documentation to verify contact with the hospital and agreement to re-admit (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7.The facility provided the Surveyor with an email chain of communication between the facility's admission coordinator and the referring hospital discharge planner, which read as follows:-02/09/26, AC G, Yes we will accept her on [MCO]. Could you have her get here by noon tomorrow?-02/10/26, AC G, So we had issues when [R7] got here. She could not transfer like we were told and then slid onto the floor. Was taken down to hospital via ambulance. We were under the understanding that [R7] was pivot transferring, but she said she couldn't.The facility did not provide evidence of communication with the hospital after R7 was discharged from the facility.The facility provided Surveyor with a discharge summary from the receiving hospital dated 02/10/26. The discharge summary read in part, Resume normal activity. PT/OT eval and treat. Post-hospital discharge follow-up deconditioning, weakness, ankle and knee instability, bariatric management, and UTI.The facility did not provide evidence of R7's pre-admission assessment indicating her transfer status.The facility was unable to provide evidence the discharge process was followed for R7's discharge.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure 1 resident (R1) of 3 residents reviewed for accidents received adequate supervision and assistance devices to prevent accidents in a sample of 7 residents. The facility did not have a Wanderguard alarm bracelet placed on R1 to notify staff of R1's attempts to elope from facility which could cause potential for harm if R1 left facility unsupervised. Findings include:The facility policy, titled Elopement, not dated, states in part, An elopement risk assessment should be conducted at time of admission.develop a specific elopement prevention care plan at time of admission for residents identified at risk for elopement.use an alarm system that notifies staff when an exit door is opened.The facility policy, titled Accidents and Supervision, not dated, states in part, Using specific interventions to try to reduce a resident's risk from hazards in the environment.ensuring that the interventions are put into action.Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents.R1 was admitted to the facility on [DATE] and has diagnoses that include altered mental status, history of falling, alcohol dependence with withdrawal delirium, age-related physical debility and metabolic encephalopathy (a brain dysfunction resulting in acute confusion, delirium, or coma).R1's Minimum Data Set (MDS) assessment, dated 03/05/2026, indicated that R1 has a Brief Interview for Mental Status (BIMS) of 00 which means severe cognition. R1 has an activated power of attorney for healthcare.R1's baseline care plan, dated 03/05/2026, with a target date of 06/02/2026, states in part: At risk for elopement related to wandering. Interventions include.Wanderguard to right wrist. Redirect patients from doors.On 03/11/2026 at 9:00 AM, Surveyor asked Nursing Home Administrator (NHA) A for a list of residents determined to be at risk of elopement who utilize the Wanderguard alarm notification system. NHA provided names of 2 residents currently residing at facility, which included R1. On 03/11/2026 at 9:33 AM, Surveyor observed R1 sitting in wheelchair alone in room. Surveyor did not see any evidence of a Wanderguard bracelet located on R1's wrists or ankles. R1 was fidgeting in wheelchair and speaking incoherently about having to meet up with my kids at the Hartwigs. Attempts by Surveyor to interview R1 were unsuccessful due to R1's severe cognitive status.On 03/11/2026, at 9:35 AM, Surveyor interviewed Certified Nursing Assistant (CNA) E if R1 was to have a Wanderguard bracelet in place. CNA E affirmed there was to always be a Wanderguard bracelet on R1. Surveyor asked CNA E to show surveyor where the Wanderguard bracelet was located on R1. CNA E could not find a Wanderguard bracelet on R1. On 03/11/2026 at 9:36 AM, Surveyor observed Registered Nurse (RN) F place a Wanderguard bracelet onto R1's left ankle. RN F stated R1 had a fall incident the night prior and was sent to the emergency department for evaluation because R1 told staff he hit his head. RN F stated no injuries were found and R1 returned to the facility early the morning of 03/11/2026. RN F was unable to determine how long R1 had gone without a Wanderguard bracelet in place. RN F confirmed a Wanderguard bracelet needed to always be in place.On 03/11/2026 at 9:39 AM, while standing outside of R1's room, Surveyor observed R1 independently exit out of his room (205-B) at a fast walk, cross the hallway and enter another resident's room. CNA E, who was down the hallway approximately 20 feet, also observed R1 exit room and immediately intervened by stopping and redirecting R1 into a wheelchair with the assistance of 2 other staff members. R1 was visibly agitated and initially resisted staff attempts to redirect him. Staff were able to console R1, and a staff member took R1 to a therapy session. Surveyor observed there was no chair alarm in place on R1's wheelchair. On 03/04/2026, record review indicated an elopement evaluation was done, and R1 was determined to have wandering behaviors. Nursing documentation stated in part, Resident began wandering in wheelchair attempting to go through doors looking for beer.RN placed Wanderguard on right wrist due to elopement risk.On 03/11/2026, record review indicated R1 had a fall on 03/11/2026 at 11:45 PM and was sent to the emergency department (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for evaluation. There is no documentation if Wanderguard was in place on R1 prior to fall, or upon discharge to the emergency department. There is no documentation on R1's return to the facility post emergency department visit, including whether an assessment was done to determine if Wanderguard was in place upon return to facility. Surveyor was not able to find any documentation in R1's medical record by CNAs or nursing for monitoring to ensure Wanderguard bracelet was in place daily or per shift.On 03/11/2026, at 12:40 PM, Surveyor asked CNA D and CNA E how staff identified residents who were at risk for elopement. CNA D stated there is a binder with names of residents who require Wanderguard bracelets to be in place at the nurse's station. Surveyor asked CNA D and CNA E whose responsibility is to ensure R1 had a Wanderguard bracelet in place and CNA D stated everyone who interacts with R1 should make sure Wanderguard is in place. On 03/11/2026 at 2:35 PM, NHA A stated the Wanderguard bracelet must have been removed from R1's ankle when R1 was at the emergency department. NHA A confirmed staff should do assessment anytime upon a resident's return to the facility and ensure Wanderguard bracelets are in place.