STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525461	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Glacier Valley	1900 American Eagle Drive Slinger, WI 53086

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 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 adequate supervision and staff education were provided for 1 resident (R) (R1) of 10 sampled residents following two incidents of familial abuse. On [DATE], staff heard Family Member (FM)-G yell at R1 and observed them slap R1 on the arm. On [DATE], staff entered R1's room and observed FM-H with a hand in R1's groin. FM-H was arrested and a no contact order was issued. Information was not posted or available at the nursing station on R1's unit to alert staff that FM-H was not allowed in the building and could not visit R1. In addition, R1's care plan was not updated to alert staff of the abuse and no contact order and the incidents were not documented in R1's medical record. Findings include: The facility's undated Abuse Prevention, Identification & Reporting policy indicates: Residents have the right to be free from: Abuse .Types of Physical Abuse: .slapping .Possible indicators: Bruising .Verbal Abuse: Includes spoken .or gestured communication that is degrading, threatening, or offensive .All staff are mandatory reporters. Immediately report: Suspected or witnessed abuse .Inappropriate staff, visitor, or family behavior The facility will: .Implement immediate interventions to protect residents .Documentation should always be: Objective; Timely; Factual .Document: Exact observations; .Notifications made; Interventions initiated; Witnesses and relevant details . R1 was admitted to the facility on [DATE] following a hospitalization for a left hip fracture and had diagnoses including cognitive communication deficit, cerebrovascular accident (CVA) (otherwise known as stroke), insomnia, and depression. R1's Minimum Data Set (MDS) assessment, dated [DATE], stated R1 had a Brief Interview for Mental Status (BIMS) score of 5 out of 10, indicating severely impaired cognition. R1 required moderate to substantial assistance with activities of daily living (ADLs) and had an activated Power of Attorney for Healthcare (POAHC) as of [DATE]. A facility-reported incident (FRI) submitted to the State Agency (SA) on [DATE] indicated Assistant Director of Nursing (ADON)-M heard tense, raised voices coming from R1's room on [DATE] at 12:35 PM and approached the open doorway. ADON-M heard FM-G yell something at R1, and observed FM-G slap R1 on top of the right hand and forcefully grab R1's right upper and lower arm. ADON-M instructed FM-G to stop and separated the two. When ADON-M stated FM-G's behavior was inappropriate, FM-G indicated R1 was their mother and they could do what they wanted. FM-G stated they lightly held R1's upper arm and denied they slapped or roughly handled R1. The police were notified. Supervised visitation was implemented for FM-G pending completion of the facility's investigation. The investigation indicated R1 appeared confused during the incident but felt safe in the facility, denied any abuse, and did not appear to be upset. An initial assessment did not reveal any injuries or bruising; however, an assessment completed at 1:50 PM identified bruising on R1's right upper arm, left arm, and left thumb. A FRI submitted to the SA on [DATE] indicated Speech Therapist (ST)-O entered R1's room on [DATE] at approximately 3:00 PM and observed FM-H lying on R1's bed. R1 was seated in a wheelchair adjacent to the bed. FM-H's hand was in R1's groin area. FM-H appeared startled, removed their hand, and began discussing discharge plans. ST-O removed R1 from the room. The police and Adult Protective Services (APS) were notified. APS reported a no contact order was initiated. FM-H (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not allowed to contact or visit R1 and was prohibited from entering the facility. The investigation included a review of R1's behavioral patterns since admission. Staff reported R1 was usually calm, cooperative, sociable, and easily redirectable when family were not present. Family visits frequently resulted in increased confusion, emotional distress, verbal agitation, and repeated requests for R1's deceased spouse. R1 frequently misidentified FM-H as their spouse and became distressed when family attempted to orient R1 to reality. The investigation indicated the facility was committed to maintaining R1's safety and dignity while cooperating with any ongoing investigations. A care plan, initiated [DATE], indicated R1 had a diagnosis of post-traumatic stress disorder (PTSD)/trauma and was at risk for periods of anxiety, fearfulness, irritability, poor sleep, destructive behavior, nightmares, and flashbacks. (Of note: R1's diagnoses list did not contain a diagnosis of PTSD/trauma.) A goal indicated R1 would have a reduction in unwanted mood or behaviors stemming from the effects of PTSD. The care plan contained the following interventions: Encourage R1 to verbalize feelings and fears; Establish a trusting relationship with R1 and identify PTSD symptoms .; Identify known and/or potential triggers and develop an action plan if traumatic feelings are triggered; Assure R1 of their safety as needed; Avoid unnecessary touching. (Of note: The care plan did not mention familial abuse, supervised visits, or that FM-H was prohibited from contacting R1 or visiting the facility.) R1's medical record did not contain mention of the incidents on [DATE] and [DATE]. On [DATE] at 9:05 AM and 11:29 AM, Surveyor interviewed Registered Nurse (RN)-I who was working on R1's unit. When asked about family visitation for R1, RN-I indicated R1 and FM-G usually visit in the dining room and staff prefer to have them visit in common areas. RN-I was not sure if R1 and FM-G required supervision during visits or if they could visit in R1's room with the door closed. RN-I indicated there used to be a posting at the nursing station that indicated FM-H could not visit but it must have been removed. When asked how staff are aware of the family abuse allegations and know that FM-H can't contact or visit R1, RN-I stated the information is passed on in report. RN-I verified the facility uses agency staff. RN-I stated family was visiting with R1 in the dining room at that time. When asked if R1 was visiting with FM-G, RN-I wasn't sure and stated FM-G had a twin and it was difficult to tell them apart. (Of note: Surveyor did not observe a posting or any visible information related to FM-H at the nursing station on R1's unit.) On [DATE] at 11:27 AM, Surveyor interviewed RN-L who was working at the nursing station on R1's unit. RN-L stated they were training and weren't aware of any restricted visitation for R1. On [DATE] at 11:40 AM, Surveyor interviewed Receptionist (RCP)-E who stated there is a staff member at the front desk from 8:00 AM-7:00 PM on weekdays and 8:00 AM-4:00 PM on weekends. RCP-E showed Surveyor a posting at the desk that contained FM-H's name and picture and stated FM-H is not allowed in the building and cannot go past the lobby. The posting instructed staff to ask FM-H to leave immediately and to call the police and Nursing Home Administrator (NHA)-A if FM-H refused. RCP-E was not sure if the information was posted anywhere else in the facility. (Of note: Surveyor entered the facility at approximately 8:00 AM that morning and waited for staff at the reception desk for approximately 1 minute before walking down the hall to Assistant Director of Nursing (ADON)-M's office which was near the nursing station for the 400-600 units.) On [DATE] at 11:45 AM, Surveyor observed the nursing station on the 400-600 units which did not contain a posting or visible information related to FM-H. On [DATE] at 11:45 AM, Surveyor interviewed Housekeeper (HSK)-P who was cleaning the unit across the dining room from R1's unit. HSK-P was not aware of anyone who could not visit the facility and did not receive related education. (Of note: The facility provided an education sheet signed by HSK-P on [DATE] (which was before the incident with FM-H) that indicated HSK-P received education on abuse prevention and identification.) On [DATE] at 11:52 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-K who recently started on R1's unit and was orienting with staff. CNA-K was not aware of any restricted visitation for R1. On [DATE] at 11:57 AM, Surveyor interviewed ADON-M who stated the front desk is staffed from 8:00 AM-6:00 PM seven days per week. ADON-M stated FM-H was registered in the facility's electronic visitor sign-in system which would alert designated staff if FM-H (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempted to sign in. Surveyor informed ADON-M there wasn't a posting or information at the nursing stations to indicate FM-H cannot visit. When asked how staff know FM-H cannot not visit if FM-H enters the facility when staff are away from the reception desk, ADON-M stated multiple stafff would recognize FM-H. ADON-M verified R1's care plan did not indicate why R1 had PTSD/trauma and did not indicate R1 had been abused by family and there was a no contact order in place for FM-H. The care plan also did not contain information related to monitoring family visits or encouraging visits in common areas. ADON-M indicated supervised visits for FM-G were discontinued but was not sure when they were discontinued. On [DATE] at 12:08 PM, Surveyor interviewed NHA-A and Director of Nursing (DON)-B via phone. DON-B indicated Social Services Director (SSD)-N initiated a trauma care plan for R1. NHA-A indicated they discussed posting information related to FM-H at the nursing station on R1's unit so staff were aware if FM-H attempted to enter the unit, however, they didn't want R1 or their family to get upset if they saw the posting. NHA-A indicated FM-H hadn't attempted to visit since the incident and was still detained. Regarding supervised or monitored visits for FM-G, NHA-A indicated they ended shortly after the facility's investigation of the incident on [DATE]. NHA-A stated R1's family members didn't trust the facility and would rather meet in a common area. NHA-A verified the abuse incidents weren't documented in R1's medical record or on R1's care plan so staff, especially newly hired staff and agency staff, were aware. On [DATE] at 12:30 PM, Surveyor interviewed SSD-N who verified R1's PTSD/trauma care plan did not indicate why R1 had PTSDS or trauma and did not provide an accurate representation of R1 or their family dynamics. On [DATE] at 1:05 PM, ADON-M approached Surveyor and indicated SSD-N posted information related to FM-H at the nursing station on R1's unit and updated R1's care plan. In addition, a progress note was added to R1's medical record regarding the incident on [DATE] and indicated FM-H was prohibited from contacting R1.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility did not post required direct care staffing levels in a timely or accurate manner. This practice had the potential to affect all 67 residents residing in the facility.The 6/11/26 daily direct care staff was not posted in a timely manner. In addition, daily direct care staff postings did not list the hours worked per shift or correct shift times. Findings include:The facility's Posting of Licensed and Unlicensed Direct Care Staff policy, revised 11/1/17, indicates: The Director of Nursing (DON) or designee shall post the direct care staffing on a daily basis .1. Direct care staffing for licensed and unlicensed staff is posted on a daily basis. 2. Data requirements for posting include the following information: .C. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: 1) Registered Nurses (RNs); 2) Licensed Practical Nurses (LPNs) or Licensed Vocational Nurses (LVNs); 3) Certified Nurse Aides (CNAs); .A. The facility must post the nurse staffing data specified in the above section on a daily basis at the beginning of each shift .On 6/11/26 at 8:42 AM, Surveyor observed the direct care staff posting at the reception desk which was dated 6/10/26. Receptionist (RCP)-E was at the desk but did not know when the staffing information for 6/11/26 would be posted. RCP-E confirmed Staff Coordinator (SC)-C posts the daily schedule and works from 8:00 AM-3:00 PM. Surveyor noted the 6/10/26 posting listed the AM shift as 6:00 AM-2:30 PM, the PM shift as 2:00 PM-10:30 PM, and night (NOC) shift as 10:00 PM-6:30 AM. Direct care staff titles were listed as RN, LPN, Certified Medication Tech (CMT), and CNA with a handwritten number behind each title that indicated how many staff were working for each of the 3 shifts. The column titled actual hours worked for each discipline was not completed.On 6/11/26 at 9:11 AM, Surveyor observed the 6/11/26 direct care staff posting at the reception desk. The posting included the census and number of staff working per shift per discipline, however, the actual hours worked column was not completed. Shift times were the same as the 6/10/26 posting. On 6/11/26 at 9:30 AM, Surveyor compared the posting to the nursing department schedule. The numbers on the posting matched the names on the schedule, however, the schedule indicated one of the AM shift CNAs was scheduled until 10:00 AM versus the full shift. The direct care staff posting did not reflect the actual hours worked by nursing staff, including whole and partial shifts.On 6/11/26 at 9:45 AM, Surveyor interviewed SC-C who was responsible for the nursing department schedule and completed the direct care staffing posts. SC-C indicated the hours staff work is based on the census. SC-C stated the facility uses a patient per day (PPD) calculation which may reduce the hours worked in a shift. SC-C provided examples of having a CNA work from 6:00 AM-10:00 AM, 2:00 PM-6:00 PM, or 6:00 PM-10:00 PM. SC-C indicated staff hours are cut when the census is lower and added when the census is higher. When Surveyor indicated the posting did not indicate the actual hours, SC-C was not aware the posting should include actual hours worked. SC-C indicated they do not complete the actual hours worked until the day is over, therefore, it is not reflected on the daily posting for residents or visitors to see. On 6/11/26 at 1:31 PM, Surveyor reviewed direct care staffing posts with Human Resources Representative (HRR)-D from the last 12 months which contained the actual hours worked. HRR-D indicated the actual hours worked are entered after the posting is taken down and used as a tool for tracking purposes. HRR-D stated staff education will be completed to ensure actual hours are listed on the posting for residents and family to see in real time. On 6/11/26 at 2:00 PM, Surveyor observed AM shift nursing staff on the long-term care unit and expected to see PM staff starting at 2:00 PM. Surveyor interviewed Certified Nursing Assistant (CNA)-F who indicated the PM shift starts at 2:30 PM. Between 2:12 PM and 2:25 PM, Surveyor observed PM shift staff enter the unit to begin their shift. On 6/12/26 at 3:21 PM, Nursing Home Administrator (NHA)-A indicated the current shift times are as follows: CNAs: AM shift: 6:00 AM-2:30 PM; PM shift: 2:15 PM-10:45 PM; NOC shift: 10:30 PM-7:00 AM; Nurses: AM shift: 6:00 AM-2:30 PM; PM shift: 2:00 PM-10:30 PM; NOC shift: 10:00 PM-6:30 AM. Surveyor noted the PM and NOC shift times for CNAs were different than the times (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	listed on the direct care staffing post which indicated the PM shift was from 2:00 PM-10:30 PM and the NOC shift was from 10:00 PM-6:30 AM.