

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/13/2025
NAME OF PROVIDER OR SUPPLIER  Maplewood of Sauk Prairie		STREET ADDRESS, CITY, STATE, ZIP CODE 245 Sycamore St Sauk City, WI 53583	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the appropriate agencies for 1 of 1 abuse allegations involving a resident (R1). On 11/6/25, an allegation of sexual abuse toward R1 from a staff member was reported to the facility and the facility did not report the allegation of abuse to the State Agency. The facility's abuse policy states, in part: *An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.* The facility will have written procedures that include: reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a.) Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b.) Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.* The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: increased supervision, room or staffing changes, and protection from retaliation. R1 was admitted to the facility on [DATE]. She discharged from the facility on 10/14/25. On 11/6/25, the facility received an allegation of sexual abuse from an outside agency providing care to R1. R1 alleged that a CNA (Certified Nursing Assistant), described as bald, brown-skinned man with a black beard was assisted [sic] her after dinner one evening. R1 stated she was naked in the tub and the male nurse was washing only her breasts. R1 stated the CNA did not touch any other area of her body, only her breasts, then left the room. On 11/13/25 at 1:08 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing). DON B stated that because the allegation came in nearly a month after R1 discharged from the facility, had only one bath with a male CNA on 9/23/25 and no person perfectly fit the description of the alleged perpetrator, she and NHA A did not feel they could do anything about it. NHA A stated that, in hindsight, the facility should have reported the incident to the State Agency.</p>

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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NAME OF PROVIDER OR SUPPLIER  Maplewood of Sauk Prairie		STREET ADDRESS, CITY, STATE, ZIP CODE  245 Sycamore St Sauk City, WI 53583	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are thoroughly investigated for 1 of 3 residents (R1) reviewed for abuse. On 11/6/25, an allegation of sexual abuse toward R1 from a staff member was reported to the facility and the facility did not investigate the allegation. The facility's abuse policy states, in part: "An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur." The facility will have written procedures that include: reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a.) Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b.) Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.* The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: increased supervision, room or staffing changes, and protection from retaliation. R1 was admitted to the facility on [DATE]. R1 discharged from the facility on 10/14/25. On 11/6/25, the facility received an allegation of sexual abuse from an outside agency providing care to R1. R1 alleged that a CNA (Certified Nursing Assistant), described as bald, brown-skinned man with a black beard was assisted [sic] her after dinner one evening. R1 stated she was naked in the tub and the male nurse was washing only her breasts. R1 stated the CNA did not touch any other area of her body, only her breasts, then left the room. On 11/13/25 at 1:08 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing). DON B stated that because the allegation came in nearly a month after R1 discharged from the facility, had only one bath with a male CNA on 9/23/25 and no person perfectly fit the description of the alleged perpetrator, she and NHA A did not feel they could do anything about it. DON B and NHA A indicated that they did not investigate the allegation. They indicate they did not gather interviews of residents or staff to determine who the alleged perpetrator could have been. DON B and NHA A indicated they did not interview or assess other residents to ensure other residents' safety. NHA A stated that, in hindsight, the facility should have reported the incident to the State Agency and questioned staff and residents.</p>		