STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525465	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Lake Health and Rehab Center	5595 Cty Rd Z West Bend, WI 53095

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 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)

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 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 staff and resident interview and record review, the facility did not ensure allegations of abuse/neglect were reported to the State Agency (SA) for 2 residents (R) (R6 and R8) of 8 sampled residents.R6 alleged that staff neglected R6 and left R6 in the bathroom without a call light for 30 minutes. R6 also alleged that staff used inappropriate language, threw a catheter bag across the room, and did not provide assistance when asked. The allegations of abuse/neglect were not reported to the SA.R8 alleged that staff neglected to provide care. The allegation of neglect was not reported to the SA.Findings include: The facility's Patient Abuse, Neglect, Mistreatment, and Misappropriation of Property and Exploitation Policy, revised 4/2025, indicates: .Neglect - An intentional omission or intentional course of conduct by a caregiver, or a nonclient patient, including but not limited to: Restraint, isolation or confinement that is contrary to Cedar Community policies and procedures, is not part of the patient's treatment plan and, through substantial carelessness or negligence, does any of the following: .b. Substantially disregards a patient's rights under either Chapter 50 or 51 Stats., or a caregiver's duties and obligations to a patient .Reporting/Response: A. The facility will have written procedures that include: .c. Upon learning of an injury or incident of misconduct, Cedar Community will immediately review the situation to determine if it fits the definition of misconduct definitions (federal, state). When the situation fits, the Alleged Nursing Home Resident Mistreatment Report (online fillable form) will be completed immediately and sent to the Division of Quality Assurance (DQA)/Office of Caregiver Quality (OCQ) via the online reporting system .1. On 9/29/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including history of stroke, urinary tract infection (UTI), congestive heart failure (CHF), and depression. A Minimum Data Set (MDS) assessment completed on 7/26/25 included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R6 was not cognitively impaired. R6 was responsible for R6's medical decisions.On 9/29/25, Surveyor reviewed a grievance for R6 that was dated 8/21/25. The form indicated Certified Nursing Assistant (CNA)-E asked R6 to do things on the evening of 8/20/25 that R6 could not do for R6's self. CNA-E put R6's pajama bottoms on the floor and asked R6 to put them on and thread the catheter tubing through the leg opening. R6 indicated R6 was unable to do that. CNA-E later told R6 to take off R6's sweater and undershirt and left R6's room. R6 called CNA-E to come back because R6 could not take off the sweater and undershirt independently. CNA-E returned and assisted R6. R6 requested assistance earlier in the evening because R6 was wet and uncomfortable sitting in R6's recliner. CNE-E said CNA-E could not help yet and was busy with other residents. CNA-E eventually returned and assisted R6. R6 stated when R6 tells CNA-E what R6 needs help with, CNA-E will remember and help R6 with those things the next time. On 9/29/25 at 11:48 AM, Surveyor interviewed R6 about the grievance. R6 indicated R6 heard staff members use inappropriate language with cares, including motherfucker and that fuck, on more than one occasion. R6 indicated it did not feel good to overhear inappropriate language but did not cause R6 harm. R6 also indicated CNA-E threw a catheter bag across the room and left R6 on the toilet with R6's pants and call light on the floor. CNA-E told R6 to get dressed and left the room. R6 yelled for assistance for approximately 30 minutes. R6 stated when R6's cares were neglected and R6 was left on the toilet without a call light within reach, R6 felt helpless. R6 indicated the facility was aware of the concerns. (See interview under example 2.)2. On 9/29/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including myasthenia gravis, dementia, and chronic kidney disease. An MDS assessment completed on 7/30/25 included a BIMS score of 12 out of 15 which indicated R8 had moderately impaired cognition. R8 had an activated Power of Attorney for Healthcare (POAHC) for medical decisions. On 9/29/25, Surveyor reviewed a grievance for R8 that was dated 8/20/25. The grievance indicated every time CNA-E waits on R8, CNA-E doesn't do what R8 asks and says R8 can do it by R8's self. R8 asks CNA-E to move the garbage can every night when R8 is in bed and indicated CNA-E should know that R8 wants the garbage can next to the bed at night. When R8 asks CNA-E to take off R8's shirt or move the table closer to the bed, CNA-E says R8 can do it by R8's self. R8 indicated CNA-E has a long, sad look on CNA-E's face. R8 asked if CNA-E ever smiles. When asked if CNA-E is trying to promote R8's independence, R8 didn't think so because R8 can still do things independently, including go to the bathroom during the night. R8 stated when R8 asks staff to do something it's because R8 needs help.On 9/29/25, Surveyor reviewed an interview with Licensed Practical Nurse (LPN)-L dated 8/26/25 that indicated R8 told LPN-L that CNA-E put R8 on the toilet and told R8 to take R8's

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure allegations of abuse/neglect were thoroughly investigated for 4 residents (R) (R1, R2, R8, and R6) of 8 sampled residents. R1 reported an allegation of abuse involving Certified Nursing Assistant (CNA)-C. During the investigation, staff reported an allegation of abuse involving CNA-C and R2. The facility did not thorougly investigate the allegations of abuse.The facility's grievance file contained grievances from R8 and R6 that included allegations of abuse/neglect involving CNA-E. The facility did not provide staff education in an attempt to prevent further abuse or neglect.Findings include: The facility's Patient Abuse, Neglect, Mistreatment, and Misappropriation of Property and Exploitation Policy, revised 4/2025, indicates: .Reporting/Response: .5. Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following: .c. Training of staff on changes made and demonstration of staff competency after training is implemented . 1.On 9/29/25, Surveyor reviewed a facility-reported incident (FRI) regarding allegations of abuse by CNA-C. The initial report was submitted to the State Agency (SA) on 9/7/25. The five-day report was submitted on 9/12/25. The report indicated at approximately 8:30 PM on 9/6/25, R1 reported to staff that CNA-C assisted R1 with cares during the night and called R1 a bitch when R1 asked for a different shirt. R1 requested that CNA-C not care for R1 in the future. The investigation included an interview with CNA-D that indicated on 9/7/25 at 9:00 AM, CNA-C completed cares for R2 and stated to CNA-D in front of R2, That shirt was pretty fucking tight. CNA-C was suspended pending the results of the investigation. The investigation did not indicate the facility provided staff education to prevent further verbal abuse. On 9/29/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including malignant neoplasm of colon, malignant neoplasm of liver and intrahepatic bile duct, and diabetes. A Minimum Data Set (MDS) assessment completed 8/21/25 included a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R1 had moderately impaired cognition. R1 had an activated Power of Attorney for Healthcare (POAHC).On 9/29/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including dementia, multiple sclerosis, edema, and stage 3 pressure injury. An MDS assessment completed 9/6/25 included a BIMS score of 10 out of 15 which indicated R2 had moderately impaired cognition. R2 had an activated POAHC.(See interview under example 2).2. On 9/29/25, Surveyor reviewed the facility's grievance file and noted grievances submitted by R8 on 8/20/25 and R6 on 8/21/25. The grievances indicated CNA-E asked residents to complete cares independently that residents were unable to complete and left residents' rooms without providing assistance. R8 and R6 asked that CNA-E not provide care for them in the future. On 8/22/25, CNA-E was educated on communication and resident care and that residents' capabilities can fluctuate daily. The grievance resolutions indicated email education was sent to all CNAs on 7/21/25 (which was a month prior to the grievances) that stated if a resident's care plan indicates the resident is independent, staff should still check on the resident, ensure necessary items are within reach, and be aware the resident may require assistance on certain days. Staff should complete rounds for independent residents no differently than for residents who require total care. On 9/29/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including myasthenia gravis, osteoporosis, and dementia. An MDS assessment completed 7/30/25 included a BIMS score of 12 out of 15 which indicated R8 had moderately impaired cognition. R8 had an activated POAHC. On 9/29/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including history of stroke, urinary tract infection (UTI), and depression. An MDS assessment completed 7/26/25 included a BIMS score of 15 of 15 which indicated R6 was not cognitively impaired. R6 did not have an activated POAHC.On 9/29/25 at 11:48 AM, Surveyor interviewed R6 who indicated R6 heard staff used inappropriate language during cares, including motherfucker and that fuck, on more than one occasion. R6 indicated it did not feel good to hear inappropriate language but it did not cause R6 harm. R6 also indicated CNA-E threw a catheter bag across the room and left R6 on the toilet with R6's pants and call light on the floor. CNA-E told R6 to get dressed and left the room. R6 yelled for assistance for approximately 30 minutes. R6 indicated R6 felt helpless when CNA-E neglected R6's cares and left R6 on the toilet without a call light within reach. R6 indicated the facility was aware of the concerns.On 9/29/25 from 1:25 PM to 1:40 PM, Surveyor interviewed CNA-F, CNA-G, and CNA-H who verified they last received abuse/neglect education in June of 2025.On 9/29/25 at 2:12 PM, Surveyor interviewed Director of Nursing (DON)-B who