

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Newcare		STREET ADDRESS, CITY, STATE, ZIP CODE 903 Main Ave Crivitz, WI 54114	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 resident (R) (R1) of 4 sampled residents.</p> <p>On 5/23/25, staff witnessed R2 strike R1 in the chest with an open hand multiple times. The facility did not report the incidence of abuse to local law enforcement.</p> <p>Findings include:</p> <p>The facility's Resident Abuse, Neglect and Misappropriation/Exploitation policy, dated 8/2024, indicates: .3. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: a. Ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation/exploitation of resident property, are reported immediately, but not later than 2 hours after the allegations is made, if the event that causes the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the event that causes the allegation does not involve abuse and does not result in serious bodily injury, to the Administrator of the facility and to other officials (including the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures .</p> <p>On 6/18/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure, disorder of psychological development, diabetes, and anxiety. R1's Minimum Data Set (MDS) assessment, dated 6/3/25, included a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R1 had severe cognitive impairment. R1 had a legal Guardian for healthcare decisions.</p> <p>On 6/18/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia with agitation, unspecified mood disorder, anxiety, and major depression. R2's MDS assessment, dated 3/18/25, included a BIMS score of 6 out of 15 which indicated R2 had severe cognitive impairment. R2 had an activated Power of Attorney for Healthcare (POAHC) for medical decisions.</p> <p>(continued on next page)</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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/25, Surveyor reviewed a facility-reported incident (FRI) that indicated on 5/23/25 at approximately 9:15 PM, a Certified Nursing Assistant (CNA) saw R2 standing above R1. R1's blankets were off and R1 was lying on the ground. R2 looked up at the CNA and then looked down at R1 and stuck R1 on the chest with an open hand four to five times. The CNA immediately removed R2 from the vicinity and then brought R1 to R1's room. R1 cried and expressed fear after the incident. R1 was interviewed the next day and indicated an incident occurred that made R1 scared.</p> <p>Surveyor noted the facility's investigation of the altercation between R1 and R2 did not indicate the facility notified local law enforcement of the abuse.</p> <p>On 6/18/25 at 12:02 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed one resident hitting another resident was considered abuse and verified law enforcement was not notified.</p>		

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<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>**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 abuse was thoroughly investigated for 1 resident (R) (R1) of 4 sampled residents.</p> <p>On 5/23/25, staff witnessed R2 strike R1 in the chest multiple times. Following the altercation, staff were not provided education to prevent further abuse among residents.</p> <p>Findings include:</p> <p>On 6/18/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure, disorder of psychological development, diabetes, and anxiety. R1's Minimum Data Set (MDS) assessment, dated 6/3/25, included a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R1 had severe cognitive impairment. R1 had a legal Guardian for healthcare decisions.</p> <p>On 6/18/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia with agitation, unspecified mood disorder, anxiety, and major depression. R2's MDS assessment, dated 3/18/25, included a BIMS score of 6 out of 15 which indicated R2 had severe cognitive impairment. R2 had an activated Power of Attorney for Healthcare (POAHC) for medical decisions.</p> <p>On 6/18/25, Surveyor reviewed a facility-reported incident (FRI) that indicated on 5/23/25 at approximately 9:15 PM, a Certified Nursing Assistant (CNA) saw R2 standing above R1. R1's blankets were pulled off and R1 was lying on the ground. R2 looked up at the CNA and then looked down at R1 and struck R1 on the chest with an open hand four to five times. The CNA immediately removed R2 from the vicinity and then brought R1 to R1's room. R1 cried and expressed fear after the incident. R1 was interviewed the next day and indicated an incident occurred that made R1 afraid. The investigation did not include and the facility did not provide documented staff education to ensure all staff were educated to prevent further altercations.</p> <p>Surveyor reviewed R2's nursing progress notes. Documentation on 5/26/25 at 7:00 PM indicated R2 became erratic and took a butter knife from R2's tray and held it in the air as though R2 was going to use it for something other than cutting food. A staff member redirected R2 and removed the knife from R2's hand. After supper, R2 tried to enter R1's room. Staff held the door shut so R2 could not enter, however, R2 then attempted to enter R1's room from the shared bathroom. Staff redirected and toileted R2 and brought R2 back to the dining room to watch TV. R2's fifteen minute checks were extended for two weeks after the incident and continued until 6/10/25. Kitchen and dietary staff were notified of the incident. It was decided that R2 would not receive a butter knife on R2's tray which did not affect R2's ability to eat independently.</p> <p>On 6/18/25 at 11:08 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated LPN-D had not witnessed R2 be aggressive toward other residents, however, R2 was aggressive toward staff during cares and needed redirection. LPN-D indicated R2 attempted to get in R1's room after the initial incident between R1 and R2. LPN-D indicated R2's treatment plan contained an intervention to keep R2 and R1 separated but denied staff education was provided on abuse or aggression prevention.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/25 at 11:17 AM, Surveyor interviewed Registered Nurse (RN)-C who indicated education was not provided to staff on abuse or aggression prevention, however, RN-C knew to keep R1 and R2 separated.</p> <p>On 6/18/25 at 12:47 PM, Surveyor interviewed CNA-E who indicated CNA-E was not present when the altercation between R2 and R1 occurred. CNA-E denied receiving education on abuse or aggression prevention but knew to keep R1 and R2 separated.</p> <p>On 6/18/25 at 12:54 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated following the incident between R1 and R2, a sign was posted at the nursing station and a treatment plan was updated to keep R1 and R2 separated. DON-B denied providing staff education on abuse or aggression prevention.</p>		