STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525516	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Badger Prairie Hcc	1100 E Verona Ave Verona, WI 53593

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving misappropriation of resident funds/personal property are reported immediately to the administrator of the facility, the State agency, and to other officials, including local law enforcement, in accordance with State law through established procedures for 1 of 1 supplemental residents (R27) reviewed for abuse. Facility did not report R27's allegation of a staff member hitting her/physical abuse to local law enforcement.Evidenced by:Facility policy, title Abuse, Neglect, Mistreatment, Exploitation, Misappropriation of Property, or Injuries of Unknown Origin, and Mandatory Reporting of a Crime, dated 7/22/25, includes: Any employee, manager, agent, volunteer, or contractor of the facility must report any reasonable suspicion of a crime committed against a resident of the facility to both law enforcement and the state agency.Facility policy, titled Nursing Home Reporting, undated, includes: Immediately protect the resident, call Administrator, notify law enforcement. Must call even if resident or family prefer not to. When to notify law enforcement: If events that cause the allegation involve abuse or result in serious bodily injury. If there is reasonable suspicion of a crime: murder, rape, assault, robbery, drug diversion, identity theft, fraud. If there has been nonconsensual sexual contact. If there has been a resident to resident willful action that results in physical injury, mental anguish, or pain. Call Police Immediately but no later than two hours. If the events that caused allegation do not involve abuse and do not result in serious bodily injury. If there is suspicion of neglect exploitation mistreatment or misappropriation of property. If there are requests from residents/ family to report to police. call police or use police department reporting no later than 24 hours.R27 admitted to the facility on [DATE] with the following diagnoses: Paranoid schizophrenia (mental illness with paranoia and delusions), dementia, depression, and anxiety.R27's Nurse Notes, dated 8/27/25, include: 1:25 PM Resident accusatory 1 time asking CNA, Are you going to hit me like you did this morning? Reported to nurse manager. Self transferred 6 times, kept getting stuck and unable to move further. No other behaviors noted this shift.(It is important to note the allegation by R27, that a staff member hit her.)Facility Self Report, dated 8/27/25, includes:Wednesday, 8/27/25, at 12:45 PM RN C (Registered Nurse) informed me (Nurse Manager E). during nursing report at 12:30 PM CNA D (Certified Nursing Assistant) reported that R27 accused her of hitting her. I immediately visited the neighborhood, removed CNA D from the floor, at 12:55 PM. DON B (Director of Nursing) was notified of allegations. Now in my office, CNA D provided a statement of events that occurred. She stated the incident occurred around 10:30 AM. CNA D said R27 was in a pleasant mood earlier, but when she approached to assist, R27 asked, Are you here to hit me again? CNA D responded, No, I would never do that. I'm here to help you with your cares. When asked CNA D stated she reported the incident to the nurse immediately. I confirmed with the nurses on duty, who stated the report was received at 12:30 PM. CNA D was asked to leave the facility pending an investigation. CNA D departed the facility immediately. At approximately 2:12 PM R27's group sheet was updated to require two CNAs for all cares. At 3:19 PM an education reminder was sent out to all staff to report incidents immediately to their supervisor. At approximately 2:30 PM I (Nurse Manager E) visited R27 in her (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. She was calm, drinking a pepsi, and not in distress. She described her day as good but noted her CNAs were rough with her, though she could not recall who or what happened. When asked if she was harmed, she first said no, then yes, but could not provide details and changed the subject to her sister's visit. I reassured her of our commitment to safe care and encouraged her to reach out if she recalled more. At 3:00 PM Social Worker F followed up with R27, finding her in her room, sitting in a recliner, drinking a soda, in a positive mood, and mentioning it's always a good day when her sister visits. When asked about her care, R27 said it was good but described her morning CNAs as not so good, without clarifying why. When asked if she was having trouble remembering or was nervous, she said yes but couldn't explain what happened with the CNA despite prompting. At 3:56 PM CNA D was placed on paid administrative leave pending the investigation. At 4:00 PM the floor nurse conducted a comprehensive skin assessment, finding R27 alert, with a 2x2 cm dark purple bruise on her left calf that did not appear new or suspicious. R27 reported right hip pain and has a diagnosis of primary generalized osteoarthritis and other chronic pain, but no redness or bruising was noted. Her range of motion was intact and strong in all four extremities. She showed no distress and her vital signs were stable. During the assessment, the nurse asked R27 is she was hit. R27 denied being hit. At 5:20 PM, I notified R27's guardian about the allegation and our follow up actions. At 5:30 PM, I notified the Medical Director of the allegations of abuse. On Thursday, August 28, 25 a nursing order was placed to chart an internal progress note monitoring R27's psychosocial well being; conducted every shift for three days. On Thursday, August 28, 25 Social Worker F conducted a climate survey asking residents the following questions: Do you have any concerns about your care, do you have any concerns about staff and so you feel safe at this facility. On Tuesday, September 2, 25 the floor nurse conducted an additional comprehensive skin assessment concluding the integument was intact, not with standing the bruise noted to the left calf. CNA D statement: Good morning, up and shower. Bathroom after breakfast, stuck in bathroom, started to sit, CNA D pulled resident up and back onto toilet. Stood back up, to remove pants. Resident went to the bathroom, up back onto chair. Toileted again around 10:30 ish. Resident was walking in room, CNA D came into assist with resident. Resident stated, Are you back in here to hit me again? CNA D said, No, I would never do anything like that. Resident replied with a look. CNA D assisted resident to bathroom. Resident made no further comments regarding being hit. Activities of Daily Living went on as usual. Nurse Manager E statement: At approximately 2:30 PM Writer went to speak with R27. R27 was in her room sitting at her recliner having a pepsi. R27 did not appear to be in any distress. Writer asked how her day went and she replied, Really good. Writer asked how things were going with her CNAs, she stated they were going well, but no sooner stated, They were rough with me today. Writer asked who they were and if she could elaborate on what occurred. Writer asked if she could explain what had happened and she replied, I can't remember. R27 began talking about her sister visiting and asked if I had any siblings. Writer assured R27 that our goal is to provide safe care giving and if at any time she had remembrance of what may have occurred, to reach out as to discuss further. Writer also stated I will come to visit later this evening. Social Worker F statement: Writer was asked to check in with R27 following a reported allegation. Resident was in her room sitting in her recliner drinking soda. Resident was in a positive mood stating, It is always a good day when (sister) visits. Writer asked resident how her care has been, to which she responded, Good. Writer asked how things have been with core morning CNA, who reported resident's allegation against her. R27 responded, Not so good but was unable to clarify why. R27 would say 1 to 3 words and become quiet. Writer asked if she was having trouble remembering or if she was nervous to discuss it, which R27 replied, Yes. R27 was unable to vocalize what had happened with CNA and did not respond to prompting. R27 appeared drowsy and stated she was feeling tired because she had a busy morning and had been outside. Writer asked if resident would prefer to rest, which she agreed to. During conversation, resident had significant hand tremors and often brought her hand to her forehead and said, I can't when asked a question. She appeared to be drowsy and kept her eyes closed for most of the interaction, which not typical when speaking with (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	writer.On 9/10/25 at 1:52 PM DON B (Director of Nursing) indicated the facility did not notify local law enforcement of R27's allegation of staff hitting her. DON B indicated the policy states, When to notify law enforcement: If events that cause the allegation involve abuse. DON B indicated a concern of a staff member hitting a resident is an allegation of abuse. DON B indicated the facility should have called local law enforcement per facility policy and because local law enforcement is one of the residents' resources.