

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Prairie Maison		STREET ADDRESS, CITY, STATE, ZIP CODE 700 South Fremont Prairie Du Chien, WI 53821	
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 to report an allegation of verbal abuse to the State Agency (SA) within five working days for one resident of six sampled residents (Resident (R) 4) reviewed for abuse in a total sample of eight. Findings include: Review of the facility abuse policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, updated 02/26 revealed, .Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or the families.Yelling is considered verbal and/or mental abuse.The administrator or designee or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies.The state licensing/certification agency responsible for surveying/licensing the facility.Immediately is defined as.Within two hours of an allegation involving of abuse or result in serious bodily injury. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R4 was admitted to the facility on [DATE] and discharged on 02/19/26 with a diagnosis of a fractured humerus (the long bone from the shoulder to the elbow). Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date of 02/05/26 revealed R4 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R4 was cognitive. Review of the February 2026 Grievance Log provided by the Administrator revealed a Complaint/Grievance from R4 regarding abuse submitted to the Director of Nursing (DON) by Certified Nurse Aide (CNA)7. Review of the written statement by CNA7, dated 02/16/26 at 11:01 PM revealed, .I just wanted you to be aware that CNA1 is making residents feel horrible. When I was washing up R4 for bed tonight, she sat on the toilet for about 10 minutes. When I asked her if everything was okay, she said, I'm just trying to get it all done. When I told her that if she wasn't done for the night, she can always ring later if she has to go. She said, Well, some girl was yelling at me for going to bathroom so much at night. CNA1 told her that she needs to stop ringing so much at night because it wakes everyone else up, is (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	an inconvenience to CNA1 and she needs to start going to the bathroom more during the day, so she does not go so much at night. I just thought this was completely not okay and wanted you to be aware ASAP [as soon as possible]. Review of the Facility Investigation provided by the Administrator revealed the allegation of verbal abuse was not reported to the SA until 03/04/26 (13 working days late). During an interview on 07/22/26 at 2:36 PM, the Administrator was asked why this allegation of verbal abuse was not reported to the SA within five working days. The Administrator stated, It was not recognized as abuse however, I was told later that yelling is a form of verbal abuse and should have been reported.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure a thorough investigation was completed for allegations of verbal and physical abuse for three residents (Residents (R)4, R5, and R6) of four sampled residents reviewed for abuse in a total sample of eight. This failure placed residents at risk of further abuse and lack of safety. Allegations of abuse were not thoroughly investigated for R4, R5 or R6. Findings include: Review of the facility abuse policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 02/26 revealed, .All allegations are thoroughly investigated. The administrator or designee initiates investigations. The administrator or designee provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation.The individual conducting the investigation as a minimum, if appropriate.Interviews the person(s) reporting the incident.Interview any witnesses to the incident.Interviews the resident.Interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident.Interviews the resident's roommate, family members, and visitors.Interview other residents to whom the accused employee provides care or services.Reviews all events leading up to the alleged incident.Documents the investigation completely and thoroughly. 1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R4 was admitted to the facility on [DATE] with a diagnosis of left humerus fracture (the long bone from shoulder to elbow). R4 discharged from the facility on 02/19/26 Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/05/26 revealed R4 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R15 was cognitive. Review of the Facility Investigation provided by the Administrator, dated 03/04/26 revealed, . On 02/17/26, Director of Nursing [DON] received a grievance from Certified Nurse Aide [CNA]7. DON immediately notified Administrator. Grievance stated that [R4] informed CNA7 that another CNA [CNA1], yelled at resident R4 for going to the bathroom so much at night and that she needs to stop ringing [call light] so much at night because it wakes everyone else up, is an inconvenience to the CNA, and that she needs to start going to the bathroom more during the day so she doesn't go so much at night. According to the Facility Investigation the Administrator spoke with R4 on or around 02/17/26 and documented the interview, however, the Administrator did not interview or provide any written statements from staff on all shifts who had contact or possible knowledge of the incident(s) with CNA1. The Facility Investigation showed an email to CNA1 by the Administrator, dated 02/19/26 revealed, (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[CNA1] R4 stated that the other day you told her, 'You should pee more during the day, so you don't have to go at night' and the 'buzzer woke everyone up' meaning pressing her call light. Did you make those statements to that resident. A reply email by CNA1, dated Today (unknown date/time) revealed, No, I did not make those statements to the resident. The Administrator responded to the email (unknown date/time) which stated, Okay, thank you for responding. Just to cover my basis on providing education regardless of if you made those statements or not, please do not ever make those comments to residents as that is inappropriate and can cause emotional distress and make them no want to use their call light. Thank you. Review of an email provided by the Administrator, dated Today (unknown date/time) to unknown person(s) revealed, .Hello, reminder that if you have concerns of a staff member yelling at a resident, that needs to be reported to Management immediately. Yelling is considered verbal and/or mental abuse. The email did not show if all staff were educated about reporting verbal abuse. The Facility Investigation did not show any documentation if R4 was assessed for emotional distress or trauma related to verbal abuse. During an interview on 07/22/26 at 8:22 AM, Social Worker (SW) was asked if she had evaluated R4 for any emotional distress related to verbal abuse by CNA1. The SW stated, No, I did not evaluate this resident for any emotional distress. The SW was asked if she had been asked to evaluate R4 by management. The SW stated, No, I wasn't. 2. Review of the admission Record located in the Profile tab of the EMR revealed R5 was admitted to the facility on [DATE] with diagnosis which included atrial fibrillation (irregular heart rhythm), diabetes, and chronic kidney disease. Review of the Facility Investigation provided by the Administrator, dated 06/04/26 revealed, Resident's son brought a concern to the Administrator at approximately 3:30 PM today, 6/4. Son stated resident told him he had a rough night last night and his body is sore. Resident told son a Hispanic CNA was rough with him last night, threw the blanket on him, and walked out of his room shaking her head after he requested help. Skin check was completed on resident with no concerns. The Facility Investigation further revealed that the accused was CNA1 who had worked on R5's hall the night of 06/04/26. CNA1 was interviewed and denied being rough and throwing a blanket at or on this resident. CNA1 stated that she was never in there (R5's room) alone, due to having a trainee with her all night. The CNA trainee [CNA9] was interviewed and had no concerns. R5 was not interviewed for the investigation. There was no documentation to show staff were educated on abuse. Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 07/02/26 revealed R5 had a BIMS score of 15 out of 15 which indicated R5 was cognitive. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/22/26 at 10:41 AM, R5 was asked if he remembered CNA1. He stated, Yes, I remember her. R5 was asked if she had hurt him in anyway. R5 stated, She hurt my feelings. R5 was asked what he meant by 'hurt my feelings.' He stated in a very loud voice and pointed at the door to his room, She was not a very nice person and I want her gone. Per the investigation, R5 had asked that CNA1 not care for him any longer. During an interview on 07/22/26 at 10:55 AM, CNA9 stated, It was my first day [on the job] and I was just getting used to how every thing works. I can't remember anything being said to him R5 does get mad if we don't answer his call light quick enough and he will be loud but does not yell. I think its more miscommunication as English was not CNA1's first language and she might be hard to understand. Review of CNA1's employee file revealed that on 06/09/26 CNA1 was instructed to not go into R5s room anymore per his request. You acknowledged that request and stated, I will not go to his room anymore then. On 06/18/26 the DON was informed that you had been going into his room and providing care for him. Upon review of documentation, you had documented on R5 multiple times on 06/18/26 and 06/13/26. CNA1 was terminated from employment on 06/19/26. 3. Review of the admission Record located in the Profile tab of the EMR revealed R6 was admitted to the facility on [DATE] with a diagnosis of dementia. Review of a quarterly MDS located in the MDS tab of the EMR with an ARD of 03/13/26 revealed R6 had a BIMS score of 11 out of 15 which indicated R6 was moderately impaired in cognition. Review of the Facility Investigation, dated 05/09/26 revealed, Received a grievance from CNA2 stating that R6 did not want CNA1 in her room because she is rough. The Administrator interviewed R6 who stated that not too long ago, [CNA1] pulled on R6's shoulder when moving her in bed. The Facility Investigation only showed that the Administrator conducted three resident interviews with only two of the residents residing on the same unit as R6. There was no documentation to show staff were educated on abuse. R6 had requested that CNA1 not care for her anymore. Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 06/04/26 revealed R6 had a BIMS score of six out of 15 which indicated she is severely impaired in cognition. During an interview on 07/22/26 at 5:09 PM, CNA2 stated, I did not witness the incident. [R6] told me about it. I messaged the DON right away. CNA1 was scaring her [R6] and she was crying because she was scared. There was no documentation in the investigation that R6 was assessed for emotional distress or trauma related the allegation. During an interview on 07/22/26 at 1:07 PM, the Administrator was asked if she felt that her investigations were complete and thorough. She stated, Yes, I do. The Administrator was asked how (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she provided education on abuse to all staff as it was not documented in the investigations. The Administrator stated, I will put up the education on the time clock for them to read. She was asked how do you know that staff has read the information such as a sign-in sheet. The Administrator stated, No, I guess they just read it.		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, the facility failed to notify the State Mental Health Authority of a significant change in status for one resident (Resident (R)1) in a total sample of eight who was previously identified as having a serious mental illness. Findings include: Review of the facility policy titled, Mood, Behavior, and PASRR, dated 03/26 revealed, .It is the policy of the facility that each resident must receive and the facility must provide the necessary behavioral health care and services and medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility will report any changes as identified via the screen to the state mental health authority or state intellectual disability authority promptly. A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with diagnosis that included end-stage renal disease, was dialysis dependent and had an anxiety disorder. Review of the 03/08/23 Preadmission Screening and Resident Review (PASARR) Level 1 (a mandatory preliminary identification process) located in the Miscellaneous tab of the EMR revealed that R1 had serious mental illness and was on psychotropics without symptomology. Review of the 03/21/23 PASSAR level II (a more in-depth screening) revealed that R1 was appropriate for nursing home placement, however, did not require any specialized or psychiatric rehabilitative services. Review of the 03/09/23 Psychotropic Medication Care Plan located in the Care Plan tab of the EMR revealed, The resident uses anti-depressant medications due to resident's diagnosis of Generalized Anxiety Disorder, insomnia, and pain. Interventions include: 1. Document/Record individualized target behaviors: agitation, profanity towards staff, picks at his skin, fingers, and scabs, anti-social, not wanting to talk as much, refusing to talk to certain staff. Dated 07/17/24 and revised on 01/17/25. 2. R1 will refuse to talk to certain staff members and say he never wants to talk to them again or allow them in his room. Later on, he will request to talk to those staff members or say it is ok if they come into his room. When he gets upset, he will be upset for a little bit then say sorry for acting that way or yelling at staff. Sometimes resident does not have a reason why he is upset, may just be having a bad day or is tired. Dated 01/17/25. 3. Resident was seeing a counselor when he went to dialysis at [clinic], but this counselor is no (continued on next page)		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	longer employed at [clinic]. Resident has been offered counseling and psychotropic medication management through [behavioral services], but resident has declined this service and any other offer to set up behavioral health services. Dated 04/03/24. 4. Resident will state he is lonely and people do not like to talk to him but refuses Behavioral Health, refuses to talk to certain people. Dated 06/19/26. 5. When this resident is having a down mood, he likes to talk it out with staff; it helps him get his feelings out. Dated 07/17/24. Review of the 12/15/25 Behavior Care Plan located in the Care Plan tab of the EMR revealed, The resident has a behavior problem (Verbal Aggression) r/t [related to] having frustrations with his family. Intervention, dated 12/15/25, Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Review of the annual Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 06/18/26 revealed R1 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R15 was cognitive. In addition, the assessment documented that R1 had little interest in doing anything and feeling down, depressed, hopeless almost daily. He had rejection of care for one to three days out of seven days and these behaviors have worsened since his last assessment. There was no documentation on the assessment that included any delusions or hallucinations. During an interview on 07/21/26 at 1:30 PM, the Director of Nursing (DON) stated, [R1] has made comments about other dependent residents, he refuses medication, offered behavioral health, refuses insulin and at times dialysis. There is a recent progress note, this week for self-mutilating behaviors. During an interview on 07/22/26 at 8:22 AM, the Social Services Director (SSD) stated, I just make frequent, nonchalant visits, just checking in with him. I think what he really wants is to be noticed. He does act out and since I have come back from maternity leave, the acting out seems to be getting worse. During an interview on 07/22/26 at 2:30 PM, the Administrator stated, R1 is aggressive absolutely, but it's his home. The Administrator was asked if the facility can meet his behavioral needs. She stated, He is not willing to talk about another placement, he does not want to move. We always discuss him during our QAPI [quality assurance and performance improvement] meetings, we tried counseling, we tried family, but he has burned too many bridges. In a follow-up interview on 07/23/26 at 9:17 AM, the DON was asked about R1's worsening verbal behaviors and other types of behaviors including rejection of care however, in reading the progress notes, there seems to be some delusional thoughts. Why was the significant change PASARR not completed. The DON stated, He had no behaviors on his previous annual assessment, and we did not want to deny his accusations with a history of anger/anxiety. As for the delusions, the staff are not documenting the delusions themselves. I probably should have completed a significant change (continued on next page)		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR. We just don't know what else to do, and I agree that there is not a lot of documentation to show a pattern. The DON further stated, His behaviors have increased as well as the self-mutilating behaviors. Cross reference F742		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility policy, the facility failed to ensure that appropriate treatment and services were provided to correct or assist 1 of 8 sampled residents (R1) in achieving his highest practicable mental well-being. Findings include: Review of the facility policy titled, Mood-Behavior-PASARR, dated 03/26 revealed, It is the policy of the facility that each resident must receive and the facility must provide the necessary behavioral health care and services and medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.If warranted, Mood and Behavior tracking documentation will be completed by front line staff, based upon comprehensive assessment outcomes, to identify any mood and behavior patterns, interventions attempted and outcome of approaches.If a resident displays behaviors or mood changes that are a potential danger to the safety, health, or welfare of themselves or others, the interdisciplinary team will assess the resident's current status and in conjunction with the discharge policy, make appropriate intervention or placement decisions. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with diagnoses that included but not limited to a stroke, generalized anxiety disorder, and mild neurocognitive disorder with behavioral disturbance. Review of the 12/15/25 Behavior Care Plan located in the Care Plan tab of the EMR revealed, The resident has a behavior problem (Verbal Aggression) r/t [related to] having frustrations with his family. Intervention, dated 12/15/25, Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Review of the annual Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 06/18/26 revealed R1 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R15 was cognitive. In addition, the assessment documented that R1 had little interest in doing anything and feeling down, depressed, hopeless almost daily. He had rejection of care for one to three days out of seven days and these behaviors have worsened since his last assessment. There was no documentation on the assessment that included any delusions or hallucinations. Review of an 03/03/26 Order Summary located in the Orders tab of the EMR revealed, Monitor/record occurrence of target behavior symptoms increase drowsiness, increased risk of suicidal risks/actions, feeling agitated, anxious, angry, irritable, trouble sleeping, nausea, dry mouth, fatigue, blurred vision, rash, itching, dizziness, trouble breathing, and loss of appetite, weight gain or loss. (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 06/14/26 Progress Note located in the Progress Notes tab of the EMR revealed, . [R1] was upset that no one had answered his call light for 15 minutes. He said all he wanted was a bottle of lotion to use on his hands. Resident then complains that staff take care of other residents that are making up behaviors to manipulate the staff's time. Today it was regarding another resident who always sounds like he is coughing up a lung and wondering why he just doesn't get it done or why we don't put the other resident out in the street so he can cough up his lung outside. He is tired of listening to this coughing up a lung at every meal. Review of a 06/17/26 Progress Note located in the Progress Notes tab of the EMR revealed, . Was informed by life enrichment director that resident was upset that visitor [name withheld] stopped by his room again and tried to talk to him. [R1] was using multiple profanity words and stating he was going to beat him with his cane if he keeps trying to say 'hi' to him. Informed [R1] that if he hits anyone that police will be notified immediately and violence is not tolerated. Again, [R1] began to say, 'you guys don't do anything, you just lie to my face and cover everything up. Review of a 06/18/26 Progress Note located in the Progress Notes tab of the EMR revealed, . While asking BIMS and PHQ [patient health questionnaire] questions discussed potential for behavioral health interventions and how this could potentially help this resident. The resident denied the need for behavior health services, despite his admitting that it could benefit him in some ways he ultimately stated, 'he doesn't need that shit. Review of an 06/18/26 Progress Note located in the Progress Notes tab of the EMR revealed, .Resident noted to have a fluid filled intact blister measuring 4 cm [centimeters] by 4.5 cm on his right lower leg. Resident said it happened because a nurse put something in his water. Review of an 06/22/26 Progress Note located in the Progress Notes tab of the EMR revealed, . [R1] entered office he had requested door be shut and started yelling stating, 'I am sick of this bullshit. Why can't any of you just fire her a-s. [Administrator] called my sister and called her a liar saying she brought me pills. This is bullshit it's been going on for over 3 months. Her drug sniffing ass is a liar. I want a meeting with everyone because you are all covering up her lying and wiping under the rug. I want the cops, a lie detector test and I want all of you so that statements can be made and this can be put to rest. My family disowned me, his brother stole me baseball cards, my other brother can't come very often because of his heart condition. It's because she [Licensed Practical Nurse (LPN)] does everything for you guys, double shifts, picking up when needed or working other halls. It's always, 'Oh, [LPN1]. F---king bullshit. They are just trying to push it under the rug and hope it goes away. [Administrator] just wants to wait until she has her kid so know [sic] one else remembers. One way or another she's going to jail, she is a liar. I will get a lawyer and call the police.' Resident stood up and left mumbling under his breath as he left. During an interview on 07/21/26 at 11:31AM, R1 stated, .I don't want to move and I don't have to. LPN1 feels like she runs this place. She is a 'bitch' and I think she is doing drugs. She rules everything. During an interview on 07/21/26 at 1:30 PM, the Director of Nursing (DON) stated, I considered moving LPN1 to another floor but there are a lot of residents on her unit that favor her. We designated (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Prairie Maison		STREET ADDRESS, CITY, STATE, ZIP CODE 700 South Fremont Prairie Du Chien, WI 53821	
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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another to give R1 his medications and dialysis treatments.He has made other comments about other dependent residents. He refuses medications, offered behavioral health, refuses insulin and at times refuses dialysis. There has been recent documentation due to his ongoing self-mutilating behaviors. During an interview on 07/22/26 at 8:32 AM, the Social Services Director (SSD) was asked if she was involved in any behavior management with R1. The SSD stated, No, not really. I do the BIMS and the PHQ [personal health questionnaire]. The SSD further stated, I have a pretty good report with R1. I make frequent, nonchalant visits just checking in with him. I think he just wants to be noticed. He does act out and since I have come back from maternity leave, the acting out seems to be getting worse. During an interview on 07/22/26 at 10:30 AM, LPN1 stated, .I don't know where to begin.The Restorative Aide [RA1]reported that he was cursing me up and down. I went down there and he started screaming at me, it was horrible. This is not my first go around with him but, this was the most vicious, vile and abuse towards me. He needs to be number one priority above anyone else. At this point it is hurting me. It all stems down that I didn't make him a priority that morning.I wanted to call law enforcement but didn't, I don't want to lose my job. I was told by an unnamed staff person that he wanted a gun to shoot his family. During an interview on 07/22/26 at 2:30 PM, the Administrator stated, He [R1] is aggressive absolutely, but it's his home. The Administrator was asked if the facility can meet his behavioral needs. She stated, He is not willing to talk about another placement, he does not want to move. We always discuss him during our QAPI [quality assurance and performance improvement] meetings, we tried counseling, we tried family, but he has burned too many bridges. In a follow-up interview on 07/23/26 at 9:17 AM, the DON was asked about R1's worsening verbal behaviors and other types of behaviors including rejection of care however, in reading the progress notes, there seems to be some delusional thoughts. Why was the significant change PASARR not completed. The DON stated, He had no behaviors on his previous annual assessment, and we did not want to deny his accusations with a history of anger/anxiety. As for the delusions, the staff are not documenting the delusions themselves. I probably should have completed a significant change PASARR. We just don't know what else to do, and I agree that there is not a lot of documentation to show a pattern. The DON further stated, His behaviors have increased as well as the self-mutilating behaviors.		