STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525553	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shell Lake Health Care Center	802 E Cty Hwy B Shell Lake, WI 54871

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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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 record review, facility document, policy review and interviews, the facility failed to ensure allegations of physical abuse by a staff member against two of five residents (Resident (R)1 and R2) reviewed for abuse were reported immediately for timely follow up and prevention of further potential abuse and failed to submit the five-day follow up investigation report to the State Agency in a timely manner. These failures had the potential to lead to further physical abuse of residents.Findings include:1. Review of R1's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with a diagnosis of dementia.Review of R1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/19/25 and located under the MDS tab of the EMR, revealed she had a Brief Interview for Mental Status (BIMS) score of four out of 15, indicating severely impaired cognition. She did not exhibit mood or behavioral symptoms.Review of R1's Care Plan, dated 04/24/24 and located under the Care Plan tab of the EMR, revealed, I am a vulnerable adult r/t [related to] compromised medical health as evidenced by need for care in SNF [skilled nursing facility]. I have difficulty with decision-making. The approaches included: Any situation identified as abuse/potential abuse/neglect/misappropriation/exploitation will be reported per facility protocol . Staff are aware of my vulnerability (including, but not limited to physical, verbal, financial, sexual, emotional abuse/neglect).2. Review of R2's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE] with a diagnosis of subarachnoid hemorrhage.Review of R2's quarterly MDS, with an ARD of 12/02/25 and located under the MDS tab of the EMR, revealed she had a BIMS score of eight out of 15, indicating moderately impaired cognition. She did not exhibit mood or behavioral symptoms.Review of R2's Care Plan, dated 06/17/25 and located under the Care Plan tab of the EMR, revealed, I am a vulnerable adult r/t compromised medical health as evidenced by need for care in SNF. The approaches included: Any situation identified as abuse/potential abuse/neglect/misappropriation/exploitation will be reported per facility protocol . Staff are aware of my vulnerability (including, but not limited to physical, verbal, financial, sexual, emotional abuse/neglect).Review of the facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, (the facility's initial report to the State Agency), dated 08/26/25 and provided on paper by the Social Services Director (SSD), revealed nursing staff reported to the Director of Nursing (DON) at 10:45 PM on 08/25/25 that Certified Nurse Aide (CNA) 1 had concerns that CNA2 had physically abused R1 and R2 on 08/23/25 based on noises she heard from R1's room behind the door. The report documented, [CNA1] alleged that 'when she was going down south hall to assist [CNA2] she heard a thud and R1 was yelling. Also, she said that [CNA2] was rough with R2 and something about her arm'. The facility suspended CNA2 pending investigation.Review of the facility's Misconduct Incident Report, (the facility's follow-up investigation report to the State Agency), dated 09/08/25 and provided on paper by the SSD, revealed the facility reported the allegations to the police and residents' physicians and representatives. The facility initiated body checks on all residents with no unexplained injuries found. Resident and staff interviews revealed no concerns with abuse or rough treatment. The facility's investigation did not substantiate that abuse occurred. CNA1 terminated her employment shortly after this incident and CNA2 was reinstated.Review of CNA2's Time Card, provided on paper by the DON, revealed CNA2 worked in the facility on 08/23/25 from 9:53 PM to 2:43 AM, on 08/24/25 from 3:18 AM to 6:47 AM and from 9:53 PM to 12:49 AM, and on 08/25/25 from 9:54 PM to 11:03 PM, at which time she was suspended pending the investigation. During an interview on 12/22/25 at 2:49 PM, the DON stated the allegations of abuse by CNA2 against R1 and R2 were not substantiated. The DON stated education was done with all staff to report any potential allegation immediately. The DON stated CNA1 received this education but terminated her employment before working again. The DON stated she expected staff to report any allegation immediately to their supervisor or to administration to ensure the alleged perpetrator was removed from the floor right away in order to prevent further potential abuse.During a telephone interview on 12/22/25 at 3:03 PM, CNA1 stated on 08/23/25, she heard R1 shouting from behind a closed door and heard a thud in the room while CNA2 was providing care. She also stated she overheard R2 saying, quit being so rough to CNA2 while CNA2 was assisting her with dressing. CNA1 stated she did not report her concerns until she came back to work on her next shift, which was 08/25/25. CNA2 stated since there was nobody around at the time to report to at the end of her shift on 08/23/25, she could not report her concerns that night.During a telephone interview on 12/22/25 at 3:24 PM, the Administrator stated