STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525558	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burnett Medical Center	257 W St George Ave Grantsburg, WI 54840

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 record review and interview, the facility did not implement policies and procedures for ensuring the reporting of physical abuse in accordance with section 1150B of the Act when an allegation of physical abuse was not reported immediately, but no later than 2 hours to the State Agency and local law enforcement in accordance with state law through established procedures for 1 of 3 residents (R) reviewed (R1).On 03/22/26, the facility was made aware of R1's allegation of abuse. The facility did not report this allegation to the State Agency (SA) or to local law enforcement within 2 hours. This is evidenced by:Facility policy titled, Abuse, neglect, Mistreatment and Misappropriation of Resident Property, with revised date of 07/10/25, states: G. Reporting and Response Components.The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.to the administrator of the facility and the DQA in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility.R1 was admitted to the facility on [DATE] with diagnoses including adult failure to thrive, type 2 diabetes mellitus, emphysema, bipolar disorder, depression, and generalized anxiety. Minimum Data Set, dated [DATE] documented a Brief Interview for Mental status (BIMS) score of 3/15, indicating severe cognitive impairment, behaviors of inattention fluctuate, and a PHQ-9 score of 5, meaning mild depression.R1's progress note dated 03/22/26 documented .At 0115, writer responded and observed resident attempting to stand unassisted next to bed. Writer and CNA guided resident to a safe seated position. Resident made repeated accusations toward staff, stating, You're beating me. and used profane language. Staff provided reassurance that care was for resident's safety and attempted to de-escalate by reducing stimulation and giving resident space. Resident continued yelling, kicking, and making accusations toward staff .Writer notified DON (Director of Nursing) at 0250 to report incident and resident's statements/behavior. DON acknowledged report and stated she would follow-up with resident on Monday.On 04/29/26 at 12:31 PM, Surveyor interviewed Registered Nurse (RN) C about R1's abuse allegation. RN C stated R1 was agitated and tried to ensure R1 was safe when R1 was trying to self-transfer. R1 started making allegations of staff beating R1. RN C stated she immediately reported the incident to DON B and wrote out statements and had staff write statements. RN C stated RN C and the Certified Nursing Assistants (CNA)s continued to work the remainder of their shift.On 04/29/26 at 2:33 PM, Surveyor interviewed DON B regarding R1's allegation of abuse by staff. DON B stated DON B got notified around 2:30 AM that day and staff stated R1 was agitated and was calm now. DON B told staff DON B will look at this on Monday [3/23/26]. DON B stated DON B did not report the allegation to the State Agency (SA), police, or remove staff from working with residents until the investigation was complete. DON B stated on Monday 3/23/26, R1 recanted R1's statement.

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 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 observation, interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 1 of 3 residents (R) reviewed (R1).On 03/22/26, the facility was made aware of R1's allegation of abuse by staff. The facility did not complete a full body assessment of R1, complete interviews with staff and other residents to ensure a thorough investigation into the allegation. This is evidenced by: Facility policy titled, Abuse, neglect, Mistreatment and Misappropriation of Resident Property, with revised date of 07/10/25, states in part: The facility will immediately begin a thorough investigation of any reported incident, collect information that corroborates or disproves the incident and document the findings for the incident.Collecting and preserving physical and documentary evidence.interviewing the alleged perpetrator.Identifying and interviewing other staff or resident in the immediate area at the time of the incident who may have witnessed what occurred. Interviewing staff who worked previous shifts to determine if they were aware of an injury or incident.Injuries present including a resident assessment.R1 was admitted to the facility on [DATE] with diagnoses including adult failure to thrive, type 2 diabetes mellitus, emphysema, bipolar disorder, depression, and generalized anxiety. Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental status (BIMS) score of 3/15, indicating severe cognitive impairment, behaviors of inattention fluctuate, and a PHQ-9 score of 5, meaning mild depression.R1's progress note dated 03/22/26 documented .At 0115, writer responded and observed resident attempting to stand unassisted next to bed. Writer and CNA guided resident to a safe seated position. Resident made repeated accusations toward staff, stating, You're beating me. and used profane language. Staff provided reassurance that care was for resident's safety and attempted to de-escalation by reducing stimulation and giving resident space. Resident continued yelling, kicking, and making accusations toward staff .Writer notified DON (Director of Nursing) at 0250 to report incident and resident's statements/behavior. DON acknowledged report and stated she would follow-up with resident on Monday.On 04/29/26 at 8:45 AM, Surveyor observed R1 in his wheelchair in the dining room during breakfast and R1 appeared calm. R1 did not show signs of physical abuse. On 04/29/26 at 9:10 AM, Surveyor interviewed R2 regarding abuse by staff or if R2 has observed staff abusing other residents. R2 denied being abused by staff and felt safe in the facility. R2 had no concerns about abuse. R2's Power of Attorney (POA) was present during interview with R2. R2's POA stated they had no concerns about abuse by staff. On 4/29/26 at 9:40 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D about resident abuse. Surveyor asked CNA D if CNA D had knowledge of R1's allegation of abuse. Surveyor asked CNA D what CNA D would do if CNA D witnessed abuse occurring in the facility. CNA D replied that CNA D had no knowledge of abuse occurring in the facility and would report to charge nurse and Director of Nursing (DON) immediately. Surveyor asked CNA D regarding abuse education. CNA D stated CNA D receives abuse education as needed and yearly.On 04/29/26 at 9:57 AM, Surveyor observed R1 in his wheelchair in the dining room during activities and R1 appeared calm.On 04/29/26 at 11:28AM, Surveyor interviewed R3 regarding abuse by staff or if R3 observed staff abusing other residents. R3 denied being abused by staff and felt safe in the facility. R3 had no concerns about any type of abuse.On 04/29/26 at 12:00 PM, Surveyor observed R1 in his wheelchair in the dining room during lunch and R1 was calm and interactions with staff were appropriate.On 04/29/26 at 12:03 PM, Surveyor interviewed CNA E about resident abuse. Surveyor asked CNA E if CNA E had knowledge of R1's allegation of abuse. Surveyor asked CNA E what CNA E would do if CNA E witnessed abuse occurring in the facility. CNA E stated having no knowledge of abuse occurring in the facility and would report to charge nurse and DON immediately. CNA E stated CNA E receives abuse education as needed and yearly.On 04/29/26 at 12:10 PM, Surveyor interviewed R4 and R4's spouse regarding abuse by staff or if R4 or R4's spouse observed staff abusing other residents. R4 and R4's spouse denied R4 being abused by staff and felt (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safe in the facility. R4 and R4's spouse had no concerns about any type of abuse. On 04/29/26 at 12:15 PM, Surveyor interviewed Licensed Practical Nurse (LPN) F about resident abuse. Surveyor asked LPN F if LPN F had knowledge of R1's allegation of abuse. Surveyor asked LPN F what LPN F would do if LPN F witnessed abuse occurring in the facility. LPN F stated having no knowledge of abuse occurring in the facility and would report to charge nurse and DON immediately. LPN F stated LPN F receives abuse education as needed and yearly.Surveyor reviewed R1's medical record; there is no evidence documented in R1's medical record of a skin assessment on R1 after R1 alleged abuse occurred by staff. There is no documentation regarding an investigation of the allegation in R1's record.On 04/29/26 at 2:33 PM, Surveyor interviewed DON B about investigating R1's allegation of abuse by staff. DON B stated DON B interviewed R1 on Monday [3/23/26] and R1 recanted R1's statement. R1 stated staff did not hurt R1 and R1 wanted to be left alone. DON B stated no other interviews were conducted with other residents or staff only the written statements from the staff involved. After speaking with R1 it was determined the allegation did not occur.