STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525560	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shorehaven Hlth & Rehab Ctr	1305 W Wisconsin Ave Oconomowoc, WI 53066

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 2 (R1 and R3) of 2 residents with allegations of abuse were reported to the State Agency and one or more law enforcement entities. *On 2/9/26, R3 alleged Certified Nursing Assistant (CNA)-D pushed R3 against the wall and slapped R3 on the face with a wet rag. The facility did not report the allegation of abuse within 2 hours to the State Agency as required and the facility did not report the allegation of abuse to law enforcement as required. *On 1/25/26, R1 and R2 were involved in a resident-to-resident altercation. R1's allegation of abuse was not submitted to the State Agency timely and law enforcement was not notified. Findings include: The facility's policy titled F600 Freedom from Abuse, Neglect, Exploitation and Misappropriation dated 8/30/1999, last revised 11/2024, documents the following: Reporting and reasonable suspicion of a crime in a long-term care facility: If anyone is observed or suspected to be attempting to hurt or threaten a resident, intervention will be done to stop him or her. Make sure the resident is safe. Immediately report this in a nursing supervisor. The supervisor will report to the Director of Nursing (DON) and the Nursing Home Administrator (NHA) immediately. If neither is available, the Assistant Director of Nursing (ADON) or house charge Registered Nurse (RN) will be contacted. Supervisors should interview staff person(s), family member(s), or visitor(s) as to what they had witnessed. This information will be shared with the NHA and DON. The accused person will be asked to leave the property until an investigation is concluded. If it is a staff member, he/she will be suspended until an investigation is concluded. Social Services should be involved with the family and resident. Recording of abuse will also be done to State licensing and credentialing department when alleged suspect is in position licensed by the State. Investigation of known incidents when abuse, neglect, exploitation or misappropriation is known, (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	steps may consist of: After the resident is deemed safe and the accused individual is removed from the room/household a supervisor or team leader will notify the NHA and DON. Interview all the accused individual(s) allegedly responsible for act, resident, witness, family members and other residents as deemed necessary. May need to involve other regulatory authorities i.e. Reporting to the office of caregiver quality, law enforcement and adult protective services. The NHA to report to state within the allowed time frame and complete the appropriate paperwork depending on the situation. Protecting residents during investigation: When a staff member in a suspected, the staff member will be sent home and not be able to return to work unless the investigation demonstrates the employee is not guilty of abuse or misappropriation. 1.) R3 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R3's diagnoses include Vascular Dementia (decline in mental function caused by reduced blood flow to the brain), generalized anxiety disorder, weakness, and legal blindness. R3's Quarterly Minimum Data Set (MDS) completed on 12/23/25, documents that R3 experiences delusions and has verbal behaviors towards others that occur 1-3 days of the week. R3 was assessed as having a Brief Interview for Mental Status (BIMS) score of 9 indicating that R3 has moderate cognitive impairment. R3's care plan documents: Impaired thought process: (R3) gets mixed up at times and forgets where (R3) is or what is going on. (R3) has a diagnosis of vascular dementia and is forgetful, due to this (R3's) daughter in law, is my activated power of attorney and helps me make decisions (start date 10/1/25, last reviewed 2/10/26). Interventions include: Support and reassure (R3) when in new situations (start date 2/10/26). Encourage (R3) to verbalize feelings, concerns and fears. Help (R3) clarify misbeliefs and provide support (start dated 2/10/26). Respect (R3's) right to make decisions (start dated 2/10/26). Give (R3) options to make decisions regarding daily tasks that need to be completed (start date 2/10/26). Activities of Daily Living (ADL)s Functional Status/Rehabilitation Potential Restorative Nursing Programs: (R3) is in need of skill training and practice in transfers, walking and dressing/grooming. Interventions include: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Transfers: Staff will assist (R3) with transfers in and out of bed, in and out of chair and onto and off the toilet using a [NAME] Steady by providing verbal cues for proper hand and foot placement as well as encouragement to stand tall at least three times daily (start date 9/15/25). Bed mobility: staff will assist (R3) with repositioning and sitting at edge of bed as needed (start date 9/15/25). On 3/5/26, Surveyor reviewed the facility self-report which documents the following: *On 2/9/26, at approximately 12:30 AM, CNA-D performed cares for R3. R3 alleged CNA-D pushed R3 against the wall and bar of the Sara Steady. R3 alleged CNA-D also hit R3 with a wet rag 6 times across R3's face. *Statement from the Director of Social Services (DOSS)-F documenting DOSS-F met with R3 on 2/9/26. R3 notified DOSS-F of an allegation of abuse from a staff member last night. DOSS-F notified the Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the allegation. *Statement from DOSS-F documenting R3's Power of Attorney (POA) was notified of the allegation. *Statement from DON-B documenting DON-B contacted Registered Nurse (RN)-E by phone to discuss RN-E's progress note dated 2/9/26. RN-E documented R3 alleged abuse during cares with CNA-D. RN-E stated CNA-D was assisting R3 with cares when R3 alleged CNA-D pushed and slapped R3. RN-E assessed R3 who reported pain. RN-E documented no signs of swelling, redness or bruising during R3's assessment. *Statement from DON-B documenting DON-B contacted CNA-D by phone who stated R3 alleged CNA-D was performing cares on R3 when R3 alleged CNA-D hit R3. CNA-D stated she attempted to get the nurse after R3's abuse allegations and CNA-D could not leave R3 due to R3 attempting to self-transfer. CNA-D assisted R3 back to bed and reported the abuse allegation to the RN-E. *Resident interviews were performed with 6 residents on the unit R3 resides on. No concerns of abuse or safety were documented during resident interviews. *Summary of investigation by NHA-A which documents CNA-D was providing cares to R3 on 2/9/26, at approximately 12:30 AM when R3 alleged CNA-D hit and grabbed R3. CNA-D notified RN-E who assessed R3. RN-E stated R3 alleged CNA-D pushed R3 against a wall and the bar of the Sara Steady and CNA-D slapped R3 6 times in the face with a wet rag. Resident interviews were performed with no concerns identified. DOSS-F notified R3's POA of abuse allegations. R3's care plan was reviewed and updated. Surveyor notes, RN-E did not report allegations of abuse to NHA-A or DON-B. Surveyor notes CNA-D continued to work and completed her shift after allegation of abuse with R3. Surveyor notes the facility did not contact law enforcement with allegations of abuse with R3. On 3/5/26, at 11:07 AM, Surveyor interviewed DOSS-F who stated she talked with R3 at breakfast time on 2/9/26 and R3 expressed allegations of abuse from the prior night. R3 alleged a staff member hit R3 with a rag. DOSS-F stated she immediately reported the allegation to NHA-A and DON-B. On 3/5/26, at 11:40 AM. Surveyor interviewed CNA-D who stated R3 alleged CNA-D hit R3. CNA-D (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she attempted to walk out of R3's room after R3 alleged abuse but could not leave the room due to R3 attempting to self-transfer and CNA-D did not feel it was safe for CNA-D to leave R3 to self-transfer. CNA-D stated she notified RN-E of the abuse allegations. CNA-D stated she continued to work her shift but had no further interactions with R3 and that RN-E cared for R3 the rest of the shift. On 3/5/26, at 12:15 PM, Surveyor interviewed RN-E who stated CNA-D notified her that R3 alleged abuse with CNA-D. RN-E stated she continued cares for R3 for the remainder of the shift and CNA-D no longer cared for R3. RN-E stated she reported the incident to the day shift nurse during rounds (change of shift). RN-E stated she also reported it to the night shift supervisor but was not clear with the night shift supervisor that it was an allegation of abuse. RN-E stated she took it as R3 being confused rather than looking at it from and abuse allegation. RN-E then stated she should have removed CNA-D and report the allegation to administration right away. On 3/5/26, at 12:47 PM, Surveyor interviewed DON-B who stated DOSS-F found out about the allegation of abuse with R3 while doing her morning rounds on 2/9/26. DON-B stated an investigation was immediately started. DON-B stated police were not notified due to R3 not having any injuries. Surveyor notified DON-B of concerns with RN-E not notifying administration of allegation of abuse and the facility not reporting R3's abuse allegation to law enforcement. DON-B acknowledged these concerns. 2.) R1 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R1's quarterly Minimum Data Set (MDS) completed on 12/6/25, documents R1 as having a Brief Interview for Mental Status (BIMS) score of 14, indicating that R1 is cognitively intact. R2 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R2's diagnoses include Alzheimers disease with late onset, and dementia with psychotic disturbance. R2's annual Minimum Data Set (MDS) completed on 12/15/25, documents R2 as having a Brief Interview for Mental Status (BIMS) score of 4, indicating that R2 is severely impaired. On 3/5/26, Surveyor reviewed the Facility self-report which documents the following: On 1/25/26 at dinner, R2 was seated at a table across from R1 in a common area. R2 moved to the opposite side of the table, pulled R1's hair, and shook R1's wheelchair. R1 called out, and staff who were present in the room immediately intervened and separated the residents. RN assessed R1 and found no injuries. One on one support was provided. R2 returned to R2's baseline behavior. R2 has a diagnosis of dementia with psychotic disturbance and a known history of grabbing and striking out at staff, which is typically managed with redirection, one on one support, calming touch, and environmental changes. R1 stated R1 feels safe and did not express ongoing concerns. R2 was placed on frequent checks following the incident. Police were not contacted as no injury occurred and both residents were successfully redirected. Care plans have been updated. R2 was placed on frequent checks for 3 days and will continue to be monitored closely for any behavioral incidents; no further incidents have occurred to date. R1's statement was obtained. Staff statements were obtained. R2's care plan was updated on 1/26/26 addressing behavior problems and interventions. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 and R2's Power of Attorney's notified. Director of Nursing and physicians notified. Surveyor notes the Facility did not contact law enforcement. On 3/5/26, Surveyor reviewed the Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report, Misconduct Incident Report. This report was submitted on 1/26/26 at 9:10 AM. The incident occurred 1/25/26 at 12:00 PM. Allegations of abuse must be reported within 2 of the suspected abuse to DQA (Department of Quality Assurance). The Facility submission was 19 hours and 10 minutes late. On 3/5/26, Surveyor reviewed the Misconduct Incident Report. This report was submitted on 1/28/26, meeting the timeline of report completion within 5 days. Report indicates the police were not contacted. On 3/5/26 at 10:44 AM, Surveyor interviewed R1 and R1's [daughter] who was visiting R1 at the time. R1 stated R1 recalls the incident and R1 is just fine. R1 stated R2 had never shown any signs of aggression before the incident and R2 has never shown any signs of aggression following the incident. Surveyor asked R1 if the staff provided care and monitoring following the incident and R1 stated, Oh yes, they looked me over and took care of me. Surveyor asked R1 if R1 was injured during this incident and R1 stated, no but R1 did not expect it. R1 stated staff continued to follow up with R1 many times to see how R1 was doing. R1 stated R1 is very comfortable at the Facility and R1 feels safe and secure. R1's [daughter] stated the Facility immediately contacted the family and stated this Facility is the very best place for R1. [Daughter] has no concerns and stated the incident was handled appropriately. On 3/5/26, at 12:51 PM Surveyor met with Director of Nursing (DON)-B. Surveyor asked DON-B if Facility contacted the police regarding the resident to resident altercation between R1 and R2 that occurred on 1/26/26 and DON-B replied, No. Surveyor notified DON-B of concerns with the late reporting of the initial Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report, Misconduct Incident Report and not calling the police with abuse allegation. No additional information was provided at this time.

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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 interview and record review, the facility did not ensure 1 (R3) of 3 residents reviewed for allegation of abuse were provided a thorough investigation after the alleged violation. The facility's self-report dated 2/9/26 indicated Certified Nursing Assistant (CNA)-D pushed R3 against the wall and slapped R3 on the face with a wet rag. CNA-D continued to work with other residents after abuse allegations on 2/9/26. Findings include: The facility's policy titled F600 Freedom from Abuse, Neglect, Exploitation and Misappropriation dated 8/30/1999, last revised 11/2024, documents the following:Reporting and reasonable suspicion of a crime in a long-term care facility:If anyone is observed or suspected to be attempting to hurt or threaten a resident, intervention will be done to stop him or her.Make sure the resident is safe.Immediately report this in a nursing supervisor.The supervisor will report to the Director of Nursing (DON) and the Nursing Home Administrator (NHA) immediately. If neither is available, the Assistant Director of Nursing (ADON) or house charge Registered Nurse (RN) will be contacted. Supervisors should interview staff person(s), family member(s), or visitor(s) as to what they had witnessed. This information will be shared with the NHA and DON. The accused person will be asked to leave the property until an investigation is concluded. If it is a staff member, he/she will be suspended until an investigation is concluded. Social Services should be involved with the family and resident.Recording of abuse will also be done to State licensing and credentialing department when alleged suspect is in position licensed by the State.Investigation of known incidents when abuse, neglect, exploitation or misappropriation is known, steps may consist of:After the resident is deemed safe and the accused individual is removed from the room/household a supervisor or team leader will notify the NHA and DON.Interview all the accused individual(s) allegedly responsible for act, resident, witness, family members and other residents as deemed necessary.May need to involve other regulatory authorities i.e. Reporting to the Office of Caregiver Quality, law enforcement and adult protective services.The NHA to report to state within the allowed time frame and complete the appropriate paperwork depending on the situation.Protecting residents during investigation:When a staff member in a suspected, the staff member will be sent home and not be able to return to work unless the investigation demonstrates the employee is not guilty of abuse or misappropriation. R3 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R3's diagnoses include Vascular Dementia (decline in mental function caused by reduced blood flow to the brain), generalized anxiety disorder, weakness, and legal blindness. R3's Quarterly Minimum Data Set (MDS) completed on 12/23/25, documents that R3 experiences delusions and has verbal behaviors towards others that occur 1-3 days of the week. R3 requires partial/moderate assistance with rolling left to right and going from sitting to standing. R3 requires substantial/maximal assistance when going from sitting to lying position. R3 is dependent on staff for toileting hygiene and transfers. R3 is frequently incontinent of urine and always incontinent of bowels. R3 was documented as having a Brief Interview for Mental Status (BIMS) score of 9 indicating that R3 has moderate cognitive impairment. On 3/5/26, Surveyor reviewed the facility self-report which documents the following:*On 2/9/26, at approximately 12:30 AM, CNA-D performed cares for R3. R3 alleged CNA-D pushed R3 against the wall and bar of the Sara Steady. R3 alleged CNA-D also hit R3 with a wet rag 6 times across R3's face.*Statement from the Director of Social Services (DOSS)-F documenting DOSS-F met with R3 on 2/9/26. R3 notified DOSS-F of an allegation of abuse from a staff member last night. DOSS-F notified the Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the allegation.*Statement from DOSS-F documenting R3's Power of Attorney (POA) was notified of the allegation.*Statement from DON-B documenting DON-B contacted Registered Nurse (RN)-E by phone to discuss RN-E's progress note dated 2/9/26. RN-E documented R3 alleged abuse during cares with CNA-D. RN-E stated CNA-D was assisting R3 with cares when R3 alleged CNA-D pushed and slapped R3. RN-E assessed R3 who reported pain. RN-E (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented no signs of swelling, redness or bruising during R3's assessment.*Statement from DON-B documenting DON-B contacted CNA-D by phone who stated R3 alleged CNA-D was performing cares on R3 when R3 alleged CNA-D hit R3. CNA-D stated she attempted to get the nurse after R3's abuse allegations and CNA-D could not leave R3 due to R3 attempting to self-transfer. CNA-D assisted R3 back to bed and reported the abuse allegation to the RN-E.*Resident interviews were performed with 6 residents on the unit R3 resides on. No concerns of abuse or safety were documented during resident interviews.*Summary of investigation by NHA-A which documents CNA-D was providing cares to R3 on 2/9/26, at approximately 12:30 AM when R3 alleged CNA-D hit and grabbed R3. CNA-D notified RN-E who assessed R3. RN-E stated R3 alleged CNA-D pushed R3 against a wall and the bar of the Sara Steady and CNA-D slapped R3 6 times in the face with a wet rag. Resident interviews were performed with no concerns identified. DOSS-F notified R3's POA of abuse allegations. R3's care plan was reviewed and updated.Surveyor notes, CNA-D continued to work with other residents after abuse allegations on 2/9/26. On 3/5/26, at 11:07 AM, Surveyor interviewed DOSS-F who stated she talked with R3 at breakfast time on 2/9/26 and R3 expressed allegations of abuse from the prior night. R3 alleged a staff member hit R3 with a rag. DOSS-F stated she immediately reported the allegation to NHA-A and DON-B. On 3/5/26, at 11:40 AM. Surveyor interviewed CNA-D who stated R3 alleged CNA-D hit R3. CNA-D stated she attempted to walk out of R3's room after R3 alleged abuse but could not leave the room due to R3 attempting to self-transfer and CNA-D did not feel it was safe for CNA-D to leave R3 to self-transfer. CNA-D stated she continued to work her shift but had no further interactions with R3 and that RN-E cared for R3 the rest of the shift. On 3/5/26, at 12:15 PM, Surveyor interviewed RN-E who stated CNA-D notified her that R3 alleged abuse with CNA-D. RN-E stated she continued cares for R3 for the remainder of the shift and CNA-D no longer cared for R3. RN-E stated she reported the incident to the day shift nurse during rounds (change of shift). RN-E stated she also reported it to the night shift supervisor but was not clear with the night shift supervisor that it was an allegation of abuse. RN-E stated she took it as R3 being confused rather than looking at it from and abuse allegation. RN-E then stated she should have removed CNA-D and report the allegation to administration right away. On 3/5/26, at 12:47 PM, Surveyor interviewed DON-B who stated DOSS-F found out about the allegation of abuse with R3 while doing her morning rounds on 2/9/26. DON-B stated an investigation was immediately started. Surveyor notified DON-B of concerns with CNA-D continued to work her shift after R3 alleged abuse with CNA-D. DON-B acknowledged these concerns.