STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525572	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Center for Health & Rehab Inc	410 N Main St Dousman, WI 53118

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and staff interviews, the facility did not ensure they conducted a thorough investigation of 1 of 2 facility reported incidents (FRIs) involving R2 and R1.On 1/4/26, at approximately 2:00 pm, R2 was observed to have his hand on top of the brief of another resident (R1) while they were sitting, watching television in the living room area. Review of the facility's investigation did not provide evidence of a thorough investigation of the incident. The investigation did not include interviews with additional residents and staff members who may have had knowledge of this incident or any previous interactions and to ensure no other residents may have experienced similar abuse.Findings include:Review of the facility policy titled Freedom from Abuse, Neglect and Exploitation Policy and Procedure (undated) indicates:Investigation componentsAbuse Policy requirements: It is the policy of the facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated.Procedure: The facility will immediately protect the resident(s) and begin a thorough investigation of any reported incident, collect information that corroborates or disproves the incident and document the findings for the incident. The investigation is the process to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. A thorough investigation is an investigation that adequately addresses the circumstances of the allegation. The investigation will include the facts necessary to form a reasoned (sic) conclusion as to what happened. The facility will document the investigation and the reasons for conclusion.iv. Involved staff and witness statements of events1. Identifying and interviewing other staff or residents in the immediate area at the time of the incident who may have witnessed what occurred.2. Interviewing staff who worked previous shifts to determine if they were aware of an injury or incident.On 1/29/26, Surveyor conducted a review of a facility reported incident (FRI) involving R1 and R2. The FRI documented the incident occurred on 1/4/26 at 2:00 PM. Details of the incident include, (R2), who has a diagnosis of Alzheimer's dementia, was seen (sic) to have his hand on the top of the brief of (R1), who also has dementia, in a resident living room. Per witness statement, (R1) did not seem to be aware of what was happening and (R2) responded what? when witness asked what he was doing. (R1) and (R2) were immediately separated, and law enforcement was contacted.Surveyor conducted further review of the facility's investigation. The investigation contained 1 staff interview from Activities Director- C who witnessed (R2) touching (R1) and immediately separated the 2 residents. The statement documented that Activity Director- C was gathering residents for an activity when she noticed (R2's) hand was partially down the top of (R1's) pants/ brief and moving back and forth. (R1's) shirt had been partially lifted as well. Activity Director- C documented she gently lifted (R2's) hand and placed it on his own lap in which (R2) replied what? Activity Director- C stated, you need to keep your hands here. Activity Director - C stated she brought (R1) with her and separated from (R2) and reported the incident to the nurse on duty.The facility's investigation did not include additional (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	interviews from staff or other residents who may have had knowledge of or also witnessed the incident. The facility did not interview other individuals (residents or staff) to determine if they had ever witnessed R2 touching other peers inappropriately before this incident, if there were any other behaviors or statements of a sexual nature demonstrated by R2, or if there was a pattern of behavior or interactions to help determine the extent of the interaction between R2 and R1 and how long it may have been going on. The facility also did not determine if any other residents may have been effected by R2's behavior as part of their investigation.On 1/29/26 at 12:38 PM, Surveyor interviewed Administrator- A and Director of Nursing- B regarding the investigation of the 1/4/26 incident involving R2 and R1. Surveyor asked if the facility had interviewed any other potential witnesses to the incident on 1/4/26. Administrator- A stated they got a statement from the Activities Director who witnessed the incident and separated R2 and R1. Surveyor asked Administrator- A if she was aware if any other staff had witnessed the incident, as they were found in a common living area. Administrator- A was unable to answer. Surveyor asked Administrator- A if there were any other residents in the living area at the time of the incident. Administrator- A was unable to provide an answer. Surveyor asked if R2 had ever been inappropriate with any other peers. Director of Nursing - B stated that this was the first time and that they monitor all the residents for changes in their behavior so they would know if something happened to them. After Surveyor and Administrator- A and Director of Nursing - B spoke with Surveyor, Administrator- A did conduct interviews with staff who were working on 1/29/26. Staff were asked have you ever seen (sic) any residents inappropriately touch one another, if so, what would you do and who would you report to if you did?As of the time of exit on 1/29/26, the facility was not able to provide any additional evidence that they had conducted a thorough investigation by interviewing additional staff and residents regarding the incident that took place on 1/4/26 between R1 and R2.On 2/3/26 the facility submitted additional documentation to review regarding the 1/4/26 incident regarding R2 and R1. The facility information confirms any interviews with facility residents and staff occurred on 1/29/26, during or after the survey regarding the incident. The facility provided details of staff training regarding abuse, reporting, and investigating incidents on 2/2/26, following the survey.