

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525630	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER New Glarus Home		STREET ADDRESS, CITY, STATE, ZIP CODE 600 2nd Ave New Glarus, WI 53574	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to protect 1 of 3 sampled resident's (R1's) right to be free from sexual abuse by a resident. Staff witnessed R2 touch R1 on the breast. As a result of the incident, the facility placed interventions on R2's care plan to prevent further incidents from occurring. These interventions were observed not to be in place and staff were not aware of the care planned interventions. This is evidenced by: R1 admitted to the facility on [DATE]. R1 has a BIMS (Brief Interview for Mental Status) of 1, indicating severe cognitive impairment. R1's diagnoses include in part, dementia, severe, with other behavioral disturbance, hypertension, dorsalgia, and muscle weakness. R2 admitted to the facility on [DATE]. R2 has a BIMS of 3, indicating R2 has severe cognitive impairment. R2's diagnoses include in part, vascular dementia with other behavioral disturbance, diabetes mellitus type 2, cerebral atherosclerosis, depression, muscle weakness, and history of TIA (transient ischemic attack). The facility completed an initial Incident Report on 9/15/25. The report indicated that R2 had been witnessed by staff touching R1 on the breast. Staff initially interviewed R2 at the time of the incident at which time R2 admitted that he had touched R1 on the breast. R2's care plan states in part. Focus: The resident has a psychosocial well-being problem actual r/t (related to) inappropriately touching another resident, initiated 9/15/25. Interventions: 1:1 supervision 9/15/25, initiated 9/15/25, revised 9/21/25. 9/16/25-Motion sensor alarm placed on doorway to room and bathroom to alert staff of whereabouts. Note: R2's Kardex (CNA care plan) does not include the interventions from the care plan. Nurses Note in R2's chart from 9/15/25 at 16:46 (4:46 PM), states: This resident was seen touching another resident inappropriately in the dining room, they were separated and educated but this resident was mad that this writer stopped him. The Nurse Manager was notified. Nurses Note from R1's chart from 9/16/25 at 16:34 (4:34 PM), states: Resident's POA (Power of Attorney) husband [name] requested to meet with writer. [POA name] asked for the name of the resident from the incident involving his wife on 9/15/25 so he could just observe when he is around. Writer explained that we cannot share that info (information) for HIPPA (Health Insurance Portability and Accountability Act) reasons. Writer had DON (Director of Nursing) join our conversation and she explained the same thing to him. DON stated that the male resident is currently on 15 mins (minute) check when in his room and 1:1 with staff when out of his room and has a door sensor on his door. DON also stated they ordered an alarm pad for bed and chair in his room. [POA name] was good with those things and stated this is a great facility and I know you guys are doing the right things. Facility telephone interview with RN on 9/15/25 at 16:40 (4:40 PM) states: RN was asked if there was an incident between two residents on 400. RN said yes there was, so I asked her to let me know what happened. I was at the Nurses station between 12:30pm and 1:00pm when I noticed R2 was close to R1. R1 was in the recliner facing the Nurses station and R2 was in his wheelchair. R2 moved his left hand toward R1 and with an open hand touched her left breast. I told him to stop, and he did. There was no fondling or other touching of the breast. I told R2 it was inappropriate. Reminded R1 that she was married, and she said right. There were no other witnesses to this. I did tell the CNAs, but they told me they didn't know if I had to report it or not. The residents had been separated immediately since that incident. When I was giving report to the oncoming Nurse, she told me I had to report this. At around 4:00pm, I reported it to the Nurse Manager, [name]. On 10/1/25 at 11:50 AM, Surveyor observed R2 to be sitting at the dining room table. CNA C (Certified Nursing Assistant) was sitting at the next table assisting a resident with eating. R1 was standing at a table kitty corner from R2 with an activities assistant. Note: R2's plan of care indicates he is 1:1 supervision. On 10/1/25 at 12:20 PM, Surveyor observed CNA C and CNA/Med Tech D (Medication Technician) picking up trays at the nurses station and in the kitchenette with their backs to R2. On 10/1/25 at 12:27 PM, Surveyor interviewed CNA C. Surveyor asked CNA C how long she has worked for the facility. CNA C stated she had only been back from FMLA (Family Medical Leave Act) for around 2 weeks but has worked in the facility for 7 years. Surveyor asked CNA C if she had received any education since returning from FMLA. CNA C stated, none that I can think of. Surveyor asked CNA C if R1 has any behaviors. CNA C stated, R1 does have behaviors with dressing and toileting. R1 can get physical with staff but only during those times. Surveyor asked CNA C about R2's behaviors. CNA C stated, R2 can be very behavioral at times. R2 is resistive of care. R2 has an alarm in his room on the doorframe so we know when R2 is on the move. We check on him every 15 minutes and more frequent checks. I think before I returned on 9/16/25, R2 may have been 1:1. Surveyor asked CNA C if she has ever witnessed R2 be inappropriate with other</p>		