STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525630	A. Building B. Wing	02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Glarus Home	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to protect the resident's right to be free from sexual abuse by a resident. This affected 1 of 3 residents (R2) reviewed for abuse. R1 has a documented history of touching other male residents inappropriately. On 4/27/25, a resident woke to R1 in his room with R1 having his hands in the resident's brief, touching his penis. On 4/28/25, it was reported by a resident that R1's hand was in his crotch. This resident reported that R1 touched his genitals but did not hurt him. R1 was placed on 1:1 (one on one) supervision following these incidents. In the following months the facility decreased R1's supervision from 1:1 to 15-minute checks, to one-hour checks, to two-hour checks and finally discontinuing R1's supervision on 12/12/25. On 01/18/26, R1 was found by staff in R2's room inappropriately touching him in his private area. The facility placed R1 on 15-minute checks when in bed or his recliner and 1:1 supervision when out of his room. The facility's failure to provide adequate supervision and protect residents from sexual abuse created a reasonable likelihood for serious psychosocial harm, thus resulting in a finding of Immediate Jeopardy (IJ) that began on 1/18/26. Surveyor notified NHA A (Nursing Home Administrator) and DON B (Director of Nursing) of the Immediate Jeopardy on 2/2/26 at 3:57 PM. The immediacy was removed and corrected on 1/19/26. Evidenced by:The facility's Abuse, Neglect, and Exploitation policy, dated 3/25/25, includes, in part, the following: Policy Statement: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Policy Explanation and Compliance Guidelines:The facility will develop and implement written policies and procedures that:Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property;Establish policies and procedures to investigate any such allegations; andInclude training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse preventions.III. Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship.Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms;D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect;H. Assign responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. VI. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:Responding immediately to protect the alleged victim and integrity of the investigation;Increased supervision of the alleged victim and residents.VII. Reporting and Response: 5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: b. Define how care provisions will be changed and/or improved to protect residents receiving services;c. Training of staff of changes made and demonstration of staff competency after training is implemented;d. Identification of staff responsible for implementation of corrective actions;f. Identification of staff responsible for monitoring the implementation of the plan. R1 admitted to the facility on [DATE]. R1's diagnoses include hemiplegia (paralysis of one side of the body) and hemiparesis (one sided muscle weakness) following a cerebral infarction (stroke), diabetes mellitus, hypertension (high blood pressure), difficulty walking, muscle weakness, pain, history of myocardial infarction (heart attack), atherosclerotic heart disease (plaque buildup in the artery walls), and peripheral vascular disease (narrow or blocked blood vessels).R1's Minimum Data Set (MDS), dated [DATE], indicates R1 has a Brief interview for Mental Status (BIMS) of 10, indicating moderate cognitive impairment. R1's behaviors listed include physical and verbal behaviors directed towards others, occurring 1-3 days in a 7-day period. R1 uses a sit-to-stand lift for transfers but once in wheelchair is able to self-propel.R1's Care Plan includes in part the following:Focus: R1 has an ADL (activities of daily living) self-care performance deficit r/t (related to) admission from ALF (assisted living facility) for increased care needs, CAD (coronary artery disease), A Fib (atrial fibrillation), Type 2 diabetes, HTN (hypertension), GERD (gastroesophageal reflux disease), constipation, hx (history) of CVA (cerebral vascular accident), initiated 4/14/25. Interventions: Walking: unable to walk at this time, revision 10/13/25. Transfer: 1A (1 assist) EZ stand (sit to stand lift), revision 10/13/25. I move about the unit: in w/c (wheelchair) 1A. I can self-propel short distances, no w/c leg rests when self-propelling, revision 11/13/25. Special Precautions: Provide cares in pairs, revision 8/25/25.Focus: The resident has a behavior problem of inappropriate sexual conduct with other residents and inappropriate comments to staff. 1/18/26-inappropriately touched another resident, revision 1/18/26. Interventions: 1:1 with staff until back in his room for the evening on 1/18/26, revision 1/21/26. 15-minute checks when in bed or recliner, revision 1/21/26. If you see me in another residents room, stop and intervene remove the resident from the room update the nurse immediately and stay with the resident, initiated 1/20/26. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate locations as needed, initiated 4/29/25. Resident has a sensor alarm on his door and at ground level due to inappropriate sexual behavior, revised 1/23/26. Resident has frequent checks due to inappropriate sexual behaviors, initiated 4/29/25. Staff supervision 1:1 when up in and mobile in his wheelchair. (which includes any part of the facility when resident is in his wheelchair as he can independently propel self), revision 1/21/26. Staff will ensure safety and consent of all residents involved in any sexual activity, initiated 4/29/26.R2 was admitted [DATE]. R2's diagnoses include Acute Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Sepsis, Alzheimer's (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Disease, and Hypertension. R2's MDS with an Assessment Reference Date (ARD) of 1/4/26 includes in part the following: R2 understands and is understood, is cognitively intact, has no behaviors. R2 transfers with a walker independently. Facility Reported Incident from 1/18/26 states in part.On 1/18/26, it was reported to the NHA (Nursing Home Administrator) that R2 was inappropriately touched by R1. It was witnessed by Activity Assistant. R2 stated that the touching was not consensual. R2's skin check was negative, and he reported no injury and no pain. Police notified. Statements are being taken. R1 was placed on 15-minute checks. R2 is alert and oriented and own person. R1 has activated Power of Attorney. MDs and family notifications are being made.R1's progress note dated 1/18/26 at 1830 (6:30 PM) states. Resident witnessed in another resident's room with hand placed towards inner thigh. Resident immediately taken back to his room. Resident remained calm, denied pain or injury. Skin assessment completed, no new concerns noted. Resident agreeable to go back to room. NHA, DON, Charge Nurse, HCPOA (Healthcare Power of Attorney) notified. Resident placed on 15-minute checks. Confirmed room door alarm is functioning properly.R1's Treatment Administration Record (TAR) states in part . January 2026: Progress note on Behaviors and 15min (15-minute) checks when in room and in bed and or recliner, if up and mobile he should be immediate supervision during shift, mood, appetite, behaviors during your shift. Every shift for behavior monitoring mood and appetite add progress note every shift, start 1/21/26. February 2026: Progress note on Behaviors and 15min (15-minute) checks when in room and in bed and or recliner, if up and mobile he should be immediate supervision during shift, mood, appetite, behaviors during your shift. Every shift for behavior monitoring mood and appetite add progress note every shift, start 1/21/26.R1's progress notes from 1/21/26 to present in Electronic Health Record (EHR) indicate that R1 continues on 15-minute checks when in bed and recliner and 1:1 when up in wheelchair.Observations and interviews completed on 2/2/26 by Surveyors show R1 was 1:1 when up in wheelchair and on 15-minute checks when in bed or recliner.Surveyor attempted to contact R2 on 2/2/26 at 1:46 PM without success. Message left for R2 to return call to Surveyor but Surveyor never received a call back.Because this type of inappropriate, unwanted sexual contact would reasonably cause anyone to have psychosocial harm, it can be determined that the reasonable person in the resident's position would have experienced severe psychosocial harm - dehumanization, and humiliation - as a result of the sexual abuse.On 2/2/26 at 9:00 AM, Surveyor interviewed RN H (Registered Nurse). Surveyor asked RN H what the alarm that was sounding at the nurses' station was for. RN H stated the alarm was activated by a motion sensor alarm that was in R1's door. Surveyor asked why R1 needed a motion sensor alarm on his door. RN H stated R1 had a history of touching other residents and the alarm would let staff know if R1 came out of his room or if other residents wandered into R1's room. On 2/2/26 at 9:10 AM, Surveyor interviewed Scheduler K. Surveyor asked Scheduler K where staff document R1's 15-minute checks. Scheduler K showed Surveyor a clipboard with R1's 15-minute check documentation. Surveyor and Scheduler K reviewed R1's documentation, dated 2/2/26. On 2/2/26 at 11:45 AM, Surveyor interviewed RN G. Surveyor asked RN G what she does if there is a report of abuse. RN G stated, I would separate the residents, keep residents safe, report the incident, and assess for any injury. Surveyor asked RN G about R1's behavior. RN G indicated that R1 had behaviors of being sexually inappropriate with an incident occurring last spring or summer. Surveyor asked RN G if she had any recent education. RN G stated, yes, recent education on abuse, consensual relationships, reporting, and R1's care plan changes for 1:1 and 15-minute checks.On 2/2/26 at 11:45 AM, Surveyor interviewed RN H. Surveyor asked RN H what she does if there is a report of abuse. RN H indicated she would separate residents, assess for injury, and report to administrator and/or DON. Surveyor asked RN H about R1's behavior. RN H stated R1 is known to be sexual with other residents, usually male (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents. Surveyor asked RN H if she knew what interventions are in place for R1. RN H stated R1 is on 1:1 when he is up in his wheelchair. R1 has an alarm on door and is 15-minute checks when in bed or recliner. Surveyor asked RN H who completes the documentation that 15-minute checks are being completed. RN H stated the CNAs and Nurses complete the documentation on 15-minute checks. On 2/2/26 at 12:20 PM, Surveyor interviewed CNA I (Certified Nursing Assistant). Surveyor asked CNA I what she does if she identifies abuse. CNA I stated she would report to the nurse, separate residents, and keep safe. Surveyor asked CNA I about R1's behaviors and what they were. CNA I stated R1 can get handsy with males. Surveyor asked CNA I what interventions are in place for R1. CNA I stated R1 is on 15-minute checks when in his room in his bed or in recliner and 1:1 when up in his wheelchair. On 2/2/26 at 12:45 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B who completes R1's 15-minute check documentation. DON B stated the person assigned to R1 should ensure the 15-minute documentation is completed around the clock. On 2/2/26 at 1:38 PM, Surveyor interviewed CNA C. Surveyor asked CNA C about the incident with R1 and R2. CNA C indicated she was down the hall helping another resident. When I got done with that, I was at the nurses' station when AA F (Activities Assistant) came up to me and said that I might want to check on R1 and R2. I went down to R2's room and when I walked in, I said R1's name and R1 quickly moved his hand away from R2. I then removed R1 from R2's room. Surveyor asked CNA C where R1's hand was when she entered R2's room. CNA C stated R1's hand was in R2's private area under R2's clothing. Surveyor asked CNA C how staff know who the staff is that is designated to be 1:1 with R1. CNA C indicated the master schedule that is located on the 100, 200, and 300 wings list the staff member who is to provide 1:1. Surveyor asked CNA C who is responsible for completing the 15-minute check sheets on R1. CNA C stated all staff who work with R1 are responsible for completing.On 2/2/26 at 1:47 PM, Surveyor interviewed RN/CN D (Charge Nurse). Surveyor asked RN/CN D if she could tell me about the incident involving R1 and R2 on 1/18/26. RN/CN D stated she was called to the unit by the floor nurse. When I came onto the unit, I noticed that R1 was in his room and saw the back of R2 in his room. RN/CN D then went to the nurses' station where I was informed of the incident. I notified the DON and NHA. I went down and made sure R2 was okay and assessed both residents. R2 then requested to come out to the dining room for dinner. I spoke with the AA who provided her account of what happened. I then updated R1's son/POA (Power of Attorney). Surveyor asked RN/CN D how staff know who is the designated 1:1 staff member for R1. RN/CN D stated that the master schedule that is located on the 100, 200, and 300 units has that information. There is also a copy of the schedule located on each unit but unsure if that always has a specific person designated on it. RN/CN D indicated that she only works every other weekend so is unsure of current practice for 1:1. Surveyor asked RN/CN D what interventions are in place for R1. RN/CN D stated R1 is on 15-minute checks when in bed and recliner and 1:1 when up in wheelchair. Surveyor asked RN/CN D if she has had any recent education. RN/CN D stated we had recent education on a lot of things but some of those included residents at risk, reporting, abuse, voicing concerns, and intervening.On 2/2/26 at 2:00 PM, Surveyor interviewed RN E. Surveyor asked RN E if she could describe the events from 1/18/26 between R1 and R2. RN E stated AA F came to the nurses' station to report that R1 was in R2's room, R1 was touching R2's thigh. Myself and the CNAs went down to R2's room, one of the CNAs removed R1 from the room. When I walked into the room, I was unable to see where R1's hand was. R1 was in his wheelchair with his back to me. I then called the RN/CN D to the unit. Surveyor asked RN E who is responsible for completing the 15-minute check sheets on R1. RN E indicated that the CNAs fill them out or whomever is doing 1:1, it is everyone's responsibility. Surveyor asked RN E if she had recently received any education. RN E stated she had education within the last couple of weeks on (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	abuse, reporting, consensual relationships, the plan for R1's 1:1 and 15-minute checks, and intervening.On 2/2/26 at 2:16 PM, Surveyor interviewed CNA J via telephone and asked CNA J to describe what occurred on 1/18/26 between R1 and R2. CNA J stated AA F came to the nurses' station and stated R1 was in R2's room. R1 was sitting next to R2 who was sitting in the recliner with his feet up. CNA J went immediately to R2's room and observed R1 sitting next to R2. R1's hand was inside R2's pants, R1 was touching R2's penis and upper thigh. CNA J immediately removed R1 from R2's room and took R1 to his room. CNA J returned to R2's room, asked R2 if he was alright. R2 stated he was alright and that he had not consented to have R1 touch him under his pants. CNA J state a nurse assessed R1 and R2 following the interaction.Surveyor asked CNA J if she was educated after the incident between R1 and R2. CNA J stated there was written education on abuse at the nurses' station that she read and signed. The education included what to do if seeing abuse or inappropriate interactions between residents including separating immediately, making the residents safe, and reporting the incident to the nurse. Surveyor asked CNA J what staff is doing to ensure no further resident to resident interactions occur with R1. CNA J stated R1 is on 15-minute checks when in his room in bed or recliner and is 1:1 when in his wheelchair. CNA J stated the 15-minute documentation is to be completed by the staff who is assigned to R1.On 2/2/26 at 4:35 PM, Surveyor interviewed AA F. Surveyor asked AA F if she can tell Surveyor about the incident on 1/18/26 between R1 and R2. AA F stated that she had gone by R2's room a couple of times on her way to do a resident's nails and then again on her way to do an activity. R1 was in R2's room and they appeared to be talking both times. AA F stated that when she was returning to the unit from the activity, she noted that R1 was close to R2 and then noticed R1 had his hand between R2's thighs. AA F stated that when she saw this she immediately went to report to the nurse. Surveyor asked AA F if she had received any recent education. AA F stated that HR (Human Resources) provided her with education and instructed her to immediately intervene, separate the residents, and ensure they are safe. AA F stated that she had just finished completing her Relias training prior to this interview on abuse.The facility's failure to provide adequate supervision and protect residents from sexual abuse by R1 created a reasonable likelihood for serious psychosocial harm, thus leading to a finding of immediate jeopardy which began on 1/18/26. The facility removed and corrected the immediate jeopardy on 1/19/26 when it completed the following:Residents were separated and it was reported to the NHA on 1/18/2026Staff that were working on 1/18/2026 gave statements. If further information was needed, staff were interviewed.An officer came to the facility and interviewed R1 and R2 on 1/18/2026.Both R1 and R2's mood, behavior, and appetite were monitored.Both R1 and R2 had skin assessments completed.Both R1 and R2 MDs were updated. R2's POA was updated. R1 was his own decision maker and declined notification.All residents on the 500 with a BIMS of less than 7 had a skin check-started and completed by the 5 day.All residents with a BIMS greater than 7 were interviewed-started and completed by the 5 day. R1 was placed on 1:1 when up in wheelchair which started on 1/18/2026. This is ongoing.R1 is on 15 minute checks when in bed or recliner which started on 1/18/2026. This is ongoing.R1 has alarms on his door and at ground level to alert staff. R1 and R2's psychosocial well being care plans were updated.R1 and R2 had a resident relationship, intimacy and sexuality history completed. Both deny wanting a relationship.Education began with staff regarding abuse with an emphasis on sexual abuse, 1:1 definition/expectations, individual interventions for R1, and 15 minute checks. The charge Nurse made sure staff were educated prior to the start of their next shift. Facility Leadership team ensured their staff were educated prior to the start of their shift.1/19/2026R1 and R2 were interviewed by the social worker and both state they feel safe.R2 was interviewed by DON and VP of Nursing and states he feels safe.Both R1 and R2 were offered BCS services (continued on next page)

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