STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525712	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care and Rehab - Cumberland	1100 7th Ave Cumberland, WI 54829

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and policy review, the facility did not ensure a thorough investigation for 1 of 1 (R1) resident reviewed for safety concerns.R1 fell during an assist of 1 transfer with Certified Nursing Assistant (CNA) C without proper safety measures in place. Facility did not complete a thorough investigation when they did not interview or investigate for potential risk to other residents throughout the facility.This is evidenced by:The facility's policy and procedure for Abuse Prevention, last reviewed 05/2025, includes, in part: .The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The purpose of the policy is to use a systematic approach to the creating of a climate which encourages the protection of the right to be free from abuse. This will be done by:* 6. A thorough investigation of the allegation will be initiated. 7. The investigation may include, but not limited to:c. Interviewing other residents to determine if they have been abused or mistreated .R1 was admitted to the facility on [DATE] with the following diagnoses: palliative care, atrial fibrillation, congestive heart failure, unspecified dementia, chronic kidney disease, and history of falling. The Minimum Data set (MDS) dated [DATE] indicates R1 has a Brief Interview for Mental Status (BIMS) of 8/15 which indicates R1 has moderate cognition impairment. R1 transfers with assist of one, gait belt, and with walker. Surveyor reviewed investigation notes pertaining to R1's fall incident that stated in part: R1 interviewed about fall on 08/24/25. Facility Reported Incident (FRI) indicates CNA C was transferring R1 from the bathroom to R1's wheelchair and R1 fell on [DATE] at 6:44 AM. R1 did not have a gait belt on or non-slip footwear per plan of care when the fall occurred. Staff verbally educated CNA C on 08/24/25 on safe handling of residents. Director of Nursing (DON) B interviewed CNA C on 08/28/25 about R1's fall and provided written education pertaining to Safe Handling of Residents policy and importance of using gait belt and non-slip footwear.Surveyor did not find any documentation that other residents were interviewed or assessed for any past falls or potential neglect concerns regarding CNA C and safe transfers. On 09/18/25 at 8:57 AM, Surveyor interviewed DON B and asked DON B if any other residents were interviewed after R1's fall to inquire about potential other falls during CNA C transferring other residents and cares. DON B reported to Surveyor that DON B did not interview any other residents after identifying CNA C did not follow the care plan during a transfer. Surveyor did not find a thorough investigation completed to assess for other caregiver neglect concerns with other residents and CNA C.

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