STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525726	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Health Center	962 E. Garland St. E West Salem, WI 54669

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 - Minimal harm or potential for actual harm 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 record review, interviews, personnel file review, and facility policy review, the facility failed to ensure residents were free from verbal and physical abuse from staff for two of six sampled Residents (R1 and R4). Facility staff used inappropriate and unprofessional language toward residents and handled residents during care in a manner described as rough and not aligned with individualized care approaches for residents with known behavioral symptoms. Findings include: Review of the facility's undated policy titled, Resident Protection: Abuse, Neglect, Mistreatment and Misappropriation of Resident Property; Injuries of Unknown Source, revealed Its purpose is that each resident/client will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion.residents will be protected from abuse, neglect, and harm while they are resident at the facility. No abuse or harm of any type will be tolerated, and resident and staff will be monitored for protection. Violations involving mistreatment, resident abuse, neglect or misappropriation of resident property will not be tolerated by this facility. All efforts will be aided to prevent these acts by employees, volunteers, contractors, and residents and to take significant and effective action should they occur. Example 1 Review of R1's face sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance and alcohol related dementia. Review of R1's quarterly Minimum Data Set (MDS) at the time of the incident, found under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 09/22/25, revealed the resident exhibited physical behavioral symptoms, and was highly dependent on staff for activities of daily living (ADLs), requiring extensive nursing care and supervision. Review of R1's care plan located under the Care Plan tab of the EMR revealed an area of concern, implemented on 08/08/24, that indicated R1 may make threats, may strike out at you, push or grab requiring staff to use a calm approach to complete care. Review of a facility reported incident (FRI), provided by the facility, and dated 11/04/25, revealed that on the evening of 11/03/25, Certified Nursing Assistants (CNAs) 1 and CNA2 were assisting R1 with a bath. CNA1 reported that during the bath, the resident was combative and resistive to care and CNA2 stated, [R1] if you don't stop, I am going to give you a cold shot. Per the report, CNA1 added that CNA2 then took the shower head and sprayed the resident on his legs. During an interview on 05/19/26 at 1:58 PM, CNA1 confirmed she had been employed at the facility since September 2025 and obtained her certification through the facility's training program. CNA1 reported that on 11/04/25 she notified the Director of Nursing (DON) that she believed CNA2 behaved inappropriately in both speech and actions during resident care. CNA1 stated that on 11/03/25 at approximately 6:30 PM, she was assisting CNA2 with bathing R1 using a tub and motorized shower chair. She reported that during the bath, R1 became agitated, physically aggressive, and may have spit at CNA2. CNA1 stated she heard CNA2 say to the resident, [R1] if you don't stop, I am going to give you a cold shot, or if you don't calm down, I will give you a cold shot. CNA1 stated the comment took her by surprise, and she intervened to take control of the situation. She indicated that the resident did not appear injured or in distress and was calmer when care was completed by her alone. (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 - Minimal harm or potential for actual harm Residents Affected - Few	CNA1 reported she had not previously observed CNA2 act abusively toward other residents but described CNA2 as sometimes being short and using a raised tone of voice. CNA1 acknowledged awareness of the facility's abuse policy. Review of CNA1's facility provided personnel file confirmed completion of abuse training on 10/28/25 and dementia training on 10/29/25. During an interview on 05/20/26 at 8:19 AM, CNA2 confirmed that the incident occurred on a scheduled shower day and described the R1 as always very combative. She reported that she and another staff member were attempting to transfer the resident into the shower chair, which required time to properly secure and position the resident. She added that once the resident was in position, she turned the water on to warm up. CNA2 stated that during the process, R1 was physically aggressive, grabbing her hair and her arm. She indicated that once the resident was positioned, she initiated the bath and reached behind her to obtain the handheld shower head. She reported that the water had been running for approximately 90 seconds and described the temperature as what she considered normal, although she acknowledged that she did not check the water temperature prior to use. CNA2 stated she held the shower head in her right hand over the resident's left shoulder and intended to begin spraying at the resident's feet and gradually move upward. She indicated that when the water contacted the resident's legs, he released her arm, allowing her to proceed. She reported that the bath was completed, with her assigned partner assisting by positioning the resident's feet in the tub. CNA2 stated that following the shower, the resident was dressed and returned to his room. She reported that at the end of the shift, her coworker commented that she had water boarded the resident. CNA2 acknowledged that it was possible water may have contacted the resident's face when she passed the shower head over his shoulder. CNA2 reported that she was contacted by facility administration the following day and participated in an interview, during which she stated she was not attempting to harm the resident. She indicated that upon returning for her next scheduled shift, she was terminated on 11/05/25. CNA2 further reported that law enforcement was not involved but that DON advised her that her actions could be seen as abuse. She stated she no longer held a CNA certification and received notification that she was placed on a barred list. A review of CNA2's facility provided personnel file revealed she had completed orientation Abuse/Neglect/Exploitation training on 10/28/25, and Hand in Hand dementia training on 10/29/25. During an interview on 05/28/26 at 1:15 PM, the DON confirmed that CNA2 was hired under a CNA training program that was being offered at the facility at the time. She added that there were no concerns prior to this that would indicate a concern. The DON also confirmed that the facility conducted interviews of all residents or their representatives who had received care from CNA2 and received no complaints. The DON also provided documentation of an Abuse and Reporting Reminder course that was assigned facility wide 100% completion by 11/25/25. During an interview on 05/18/26 at 3:19 PM, Nurse Manager (NM) 1, reported that he was notified by the DON that an assessment needed to be completed for R1 as an allegation of abuse had been reported. He reported that he found no skin injury or change in the resident from his baseline emotional state and described R1's baseline as tense and aggressive during care, with hitting and elbowing. Review of the Skin Assessments notes from 11/04/25 through 11/07/25 and located under the Nursing Notes tab of the EMR revealed no concerns. Example 2 Review of the admission MDS under the MDS tab of the EMR with ARD of 02/12/26, revealed a Brief Interview for Mental Status (BIMS) of 00 out of 15 which indicated R4 was severely cognitively impaired. Review of R4's Care Plan located under the Care Plan tab of the EMR, revealed the resident had an alteration in thought process and compromised decision making and indicated that R4 can become verbally agitated and physically aggressive when uncertain. Staff are not to argue or engage in power struggles. Use simple and direct language. Do NOT reorient as this increase agitation. Review of a FRI investigation, provided by the facility and dated 03/07/26, revealed that CNA3 was alleged to have been rough and verbally aggressive during care. The investigation indicated that the Administrator was advised by the night supervisor, Registered Nurse (RN) 2. RN2 advised the Administrator that CNA4 and CNA5 alleged that the staff member cursed at R4 and physically prevented her from getting (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of bed. During an interview on 05/20/26 at 10:21 AM, CNA5 confirmed that she was preparing to leave at the end of her shift, with CNA3 scheduled to take over the assignment. CNA5 stated that she and CNA4 had been unable to complete their assignment prior to shift change, which appeared to upset CNA3. CNA5 reported that CNA3 began cursing, stating, I am not dealing with this shit tonight, and then entered R4's room and said to the resident, I am not dealing with your shit tonight. CNA5 reported that R4 was frequently confused and often resisted being put to bed, and that on this occasion, R4 was attempting to get out of bed by placing her feet on the floor. CNA5 stated that CNA3 responded by grabbing the resident by the ankles and throwing her legs back onto the bed multiple times. CNA5 indicated that she believed the force used had the potential to cause injury to R4. CNA5 stated that she and CNA4 suggested getting R4 up using a mechanical lift, and CNA4 went to retrieve the Hoyer lift. While preparing the resident, CNA5 reported that CNA3 roughly rolled the resident onto her side to place the sling underneath her. CNA5 further reported that while the resident was being lifted, CNA3 swatted the resident's hand as the resident reached for the lift straps. CNA5 clarified that the action was between a push and a slap. CNA5 stated that she reported the incident to the manager on duty (RN2), who subsequently removed CNA3 from the floor. (CNA4 and CNA3 were unable to be interviewed) During an interview on 05/20/26 at 9:30 AM, RN2 reported that the allegation was brought to her attention at approximately 10:30 PM on the evening of 03/07/26, which was her first night supervising. RN2 stated she immediately consulted with NM1 and removed CNA3 from the floor. RN2 reported that staff alleged CNA3 was cursing in the presence of R4 and handling the resident in a rough manner, including throwing the resident's legs back onto the bed, rolling the resident roughly, and swatting at the resident's hand during care. RN2 stated she conducted an immediate assessment of R4 and identified no observable signs of injury or indications of pain. She described the resident as having a flat effect and not displaying behaviors indicative of distress. RN2 reported that during the initial interview, CNA3 denied wrongdoing but admitted to using profanity, stating it was not directed at R4. CNA3 also acknowledged repositioning the resident's legs back onto the bed but denied doing so in a rough manner. RN2 stated she had not received any prior complaints regarding CNA3 and noted this was CNA3's first time working with R4. During an interview on 05/19/26 at 9:12 AM, the Social Worker (SW)/Grievance Official reported that the allegation was reported to the DON, who completed an evaluation of the resident with no concerns identified. He confirmed that he assumed responsibility for the investigation, including conducting staff interviews and record reviews. He added that he was not aware of any prior grievances or care-related concerns involving the staff member, and there were no identified concerns related to other residents prior to this incident. During an interview on 05/18/26 at 1:15 PM, the DON reported that CNA3 had no prior complaints or concerns reported by residents or coworkers. When asked about the employee's separation from the facility, the DON stated it was not directly related to care concerns but indicated that CNA3 had a history of frequent callouts and may have been experiencing caregiver burnout. The DON further stated that local law enforcement had been involved but were unable to substantiate a violation, as accounts of the incident were conflicting among staff. Review of CNA3's facility provided personnel file revealed she had completed Abuse/ Neglect/ Exploitation training on 01/01/26, as well as care giver burnout training on 11/21/25.

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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 record review, interviews, and facility policy review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one of six sample residents (R1) reviewed for abuse. a Certified Nursing Assistant (CNA) was aware of an incident involving R1 and another CNA that was not reported within the required timeframes. Findings include: Review of the facility's undated policy titled, Resident Protection: Abuse, Neglect, Mistreatment and Misappropriation of Resident Property; Injuries of Unknown Source revealed Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the administrator (or designee), and that Staff must always report any ?abuse' or suspicion of ?Abuse' immediately to their supervisor or the administrator. Failure to report is considered to be resident abuse. The policy required that abuse allegations be reported immediately, but not later than 2 hours after the allegation is made when the events involve abuse or serious bodily injury. Review of R1's face sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance and alcohol related dementia. Review of R1's care plan located under the Care Plan tab of the EMR revealed an area of concern, implemented on 08/08/24, that indicated R1 may make threats, may strike out at you, push or grab, requiring staff to use a calm approach to complete care. Review of a facilityˆreported incident (FRI), dated 11/04/25, revealed that on the evening of 11/03/25, Certified Nursing Assistants (CNAs) 1 and CNA2 were assisting R1 with a bath. CNA1 reported that during the bath, R1 was combative and resistive to care and CNA2 stated, [R1] if you don't stop, I am going to give you a cold shot. Per the report, CNA1 added that CNA2 then took the shower head and sprayed the resident on his legs. During an interview on 05/19/26 at 1:58 PM, CNA1 confirmed that on 11/04/25 she notified the Director of Nursing (DON) that she believed CNA2 behaved inappropriately in both speech and actions during resident care. CNA1 stated that on 11/03/25 at approximately 6:30 PM, she was assisting CNA2 with bathing R1 using a tub and motorized shower chair. She reported that during the bath, R1 became agitated, physically aggressive, and may have spit at CNA2. CNA1 stated she heard CNA2 say to R1, [R1] if you don't stop, I am going to give you a cold shot, or if you don't calm down, I will give you a cold shot. CNA1 stated the comment took her by surprise, and she intervened to step in and take control of the situation. She indicated that R1 did not appear injured or in distress and was calmer when care was completed by her alone. CNA1 reported that she had not previously observed CNA2 act abusively toward other residents but described CNA2 as sometimes being short and using a raised tone of voice. CNA1 acknowledged that she was aware of the facility's abuse and reporting policy, and that concerns should be reported immediately to the nurse supervisor. When asked why she did not tell anyone about the incident immediately, CNA1 stated that in her experience at other facilities, reports didn't always make it to administration, and she wanted to report it directly to the DON. She reported that she notified the DON the following day, 11/04/25, rather than at the time of the incident. During an interview on 05/18/26 at 1:15 PM, the DON confirmed CNA2 was hired under a CNA training program being offered at the facility and described CNA2 as softˆspoken and friendly with no prior concerns reported and added that the CNA2 has completed the Abuse training as part of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her orientation on 10/29/26. In a subsequent interview on 05/20/26 at 2:30 PM, the DON confirmed CNA1 reported the incident to her on 11/04/25. When asked why the incident was not reported immediately, the DON stated CNA1 said the situation made her uncomfortable, but she was unsure whether it should be reported. The incident between R1 and CNA2 was not reported timely to facility management/administration.