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M 000	INITIAL COMMENTS On 12/11/2025, Surveyor conducted a complaint investigation at Forest Glen. Additional information was gathered through 12/16/2025. The complaint was substantiated, and 2 deficient practices were identified. Census: 3	M 000		
M 614	88.11(3) INVESTIGATION OF ABUSE OR NEGLECT As soon as possible after being contacted under sub. (1) the licensing agency shall undertake an investigation of the reported abuse or neglect. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure investigations were completed when allegations of caregiver misconduct were brought to their attention. The provider was aware of at least 7 allegations of caregiver misconduct involving Caregivers C and D. The provider did not recognize all allegations as potential caregiver misconduct that required an investigation and reporting. Throughout the timeline of events, the provider, including Manager G, Regional Director H, and Administrator B, had access to the documentation and reports. The provider did not ensure oversight of employees or review was conducted to recognize the documented allegations and staff conduct required investigation and reporting. A partial investigation	M 614		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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was conducted into two of the allegations of misconduct, and the provider dismissed their own findings.

Findings include:

On 12/01/2025, the Department received a complaint alleging the provider was made aware of multiple incidents of caregiver misconduct and did not conduct investigations in response.

Surveyor reviewed Resident 1's record and noted Resident 1 was admitted on 12/13/2023 and had an appointed guardian for health care (Guardian I.) Resident 1's diagnoses included cognitive delay, disruptive mood dysregulation disorder, autistic disorder, pervasive developmental disorder and reactive attachment disorder from childhood. Resident 1's Individual Service Plan (ISP) (undated) did not include references to any disruptive, attention seeking, or aggressive behavior, and did not include a behavioral support plan. There was no documentation of the resident being a reliable or unreliable reporter/ historian. The ISP did include "Self-concept" which noted the resident at times had difficulty expressing his/her feelings including, "[Resident 1] has a history of changing [his/her] personality when around people [s/he] cares about because [s/he] doesn't want them mad at [him/her.] This tends to hinder [Resident 1's] expression of [his/her] feelings ..." During an interview with Caregiver F on 12/11/2025 and an interview with Caregiver E on 12/12/2025 both caregivers stated Resident 1 could be easily manipulated into going along with others as s/he did not like confrontation. Both caregivers indicated, in their experience, Resident 1 was a reliable historian.

On 12/12/2025 at 3:30 PM, Surveyor interviewed

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Area Director A, Regional Director H and Administrator B. The administrators clarified they were Manager G's supervisors. The provider confirmed all incident reports are available for staff review and all of Manager G's supervisors had access to the incident reports for review.

Surveyor reviewed Resident 1's incident reports and observation notes, e-mails and forwarded text exchanges from Manager G, and conducted interviews with Resident 1 on 12/11/2025 11:00 AM, Caregiver F on 12/11/2025 at 11:30 AM, Caregiver E on 12/12/2025 at 9:19 AM, Manager G on 12/12/2025 at 12:47 PM, and Administrator B, Area Director A and Regional Director H on 12/12/2025 at 3:30 PM and 12/16/2025 at 2:30 PM to determine an approximate timeline of reported events and corresponding action by the provider:

Timeline of Reported Allegations of Misconduct

08/18/2025:
1- Surveyor reviewed an incident report dated 08/18/2025, written by Manager G. The report noted "Behavior- Resident to Staff Altercation." The incident report noted Resident 1 was questioned about hiding Caregiver D's cleaning products. Manager G noted questioning Resident 1 why s/he "only complains about the spray when ... [Caregiver D] uses it and not when any other staff member uses it," and [Resident 1] replied, "because I don't LIKE [him/her] and I don't WANT [him/her] here." Manager G did not document any further questions or inquiry as to why the Resident felt so strongly about Caregiver D.

During the interview on 12/12/2025 at 3:30 PM with Area Director A, Regional Director H and Administrator B, the provider acknowledged

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Resident 1's statement regarding their feelings towards Caregiver D should have initiated further questioning to ensure Resident 1's physical, mental, and emotional safety.

2- Per the incident report dated 08/18/2025, Resident 1 took Caregiver D's cleaning supplies into his/her bedroom and locked his/her door, refusing to come out. Per the incident report, observation notes dated 08/18/2025 written by Caregiver D, and the provider's documented interview with Caregiver D on 09/22/2025, Resident 1's door was unlocked with a key against his/ her explicit verbal wishes to have his/her door remain locked. The provider did not conduct an investigation into Resident 1's federal right being violated.

During the interview on 12/16/2025 at 2:30 PM with Area Director A, Regional Director H and Administrator B, the provider acknowledged it was documented on 08/18/2025 that Resident 1 did not want his/her door to be opened and that staff, against Resident 1's wishes, used a key to open his/her door. The provider acknowledged at the time of the incident they did not recognize the breech of Resident 1's right and an investigation and retraining of staff did not occur.

3- During the altercation on 08/18/2025, Caregiver D alleged Resident 1 used a racial slur against him/her during a verbal altercation (noted in the provider's 09/22/2025 interview with Caregiver D) and that police intervention was needed at the facility. The provider's incident report dated 08/18/2025, written by Manager G, did not include reference to the verbal altercation or police involvement. No investigation into Caregiver D's conduct was conducted and the required self- report to the Department for police

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M 614	Continued From page 4 involvement was not submitted. 08/23/2025: 4- Surveyor interviewed Resident 1 on 12/11/2025 11:00 AM, Caregiver F on 12/11/2025 at 11:30 AM, Caregiver E on 12/12/2025 at 9:19 AM, and Manager G on 12/12/2025 at 12:47 PM. Each interview noted, on or around 08/23/2025, an incident occurred when Caregiver C was working that resulted in Resident 1's right shoulder going through the facility's dining room wall. (Photo 1) Caregiver C reported via phone on 08/23/2025 to Manager G that the hole was created by the staff and residents "roughhousing," resulting in Resident 1 tripping and falling into the wall. Manager G stated as Caregiver C and the residents were laughing, s/he accepted the explanation without further question and did not investigate or document the incident. On 12/12/2025 at 3:30 PM, Surveyor interviewed Area Director A, Regional Director H and Administrator B. The administrators recognized Resident 1's ISP identified, and employee interviews note, that Resident 1 had difficulty expressing him/herself and could be easily persuaded to "go along" with Caregiver C's version of events once Resident 1 heard Caregiver C laughing and reporting the hole in the wall as an accident to Manager G. In light of this assessed information about the resident, and the fact that Caregiver C engaged in a behavior, weather intentional or not, that caused the resident to go through the wall, a reasonable and prudent caregiver should have recognized the need to investigate the incident. 08/30/2025 (Per interviews with Resident 1 on 12/11/2025 11:00 AM, Caregiver F on 12/11/2025 at 11:30 AM, Caregiver E on 12/12/2025 at 9:19	M 614		

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M 614	Continued From page 5 AM.): 5- Approximately 1 week after the hole in the dining room wall was made, the hole was fixed by maintenance. Resident 1 stated Caregiver C came up to him/her and told him/her that s/he pushed Resident 1 into the wall on purpose in retaliation for using a racial slur against his/her sibling (Caregiver D); referencing the altercation on 08/18/2025. Resident 1 reported the statement to Caregiver's E and F (dates unknown) and both caregivers stated they reported the allegation immediately to Manager G. Per interview with Manager G on 12/12/2025 at 12:47 PM, Manager G stated upon Caregiver E reporting the allegations (approximately 08/30/2025), s/he immediately called the facility and while on speaker phone, stated to Resident 1 and Resident 2, " Why are you making things up and telling [Caregiver E] lies? You know that is not what happened," accusing Resident 1 and Resident 2 of lying. Manager G stated the allegation of caregiver misconduct that was brought to his/her attention (date known) was not investigated and the allegation against Caregiver C was not reported to the Office of Caregiver Quality (OCQ.) During the interview on 12/16/2025 at 2:30 PM with Area Director A, Regional Director H and Administrator B, the provider acknowledged Manager G did not identify the allegations of misconduct or conduct appropriate follow-up. The administrators also acknowledged Caregiver C's alleged comments to Resident 1 were retaliative and threatening in nature which would constitute caregiver misconduct and should have resulted in an investigation, reporting to OCQ. 09/19/2025: 6- An incident report dated 09/19/2025 and written by Manager G noted, "Behavior- Resident	M 614		

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to Staff Altercation." The incident report noted Resident 1 and Caregiver D had a "verbal altercation." The incident report noted the resident believed Caregiver D "broke the law" and when Resident 1 asked Caregiver D about it, Caregiver D responded with aggression and expletives, "That makes me a [racial slur?!]" The resident noted s/he responded in turn out of frustration and Caregiver D then walked into the living room and said to the resident, "At least I'm not musty and I don't have smelly [explicative] feet!" The resident responded, and Caregiver D then said, "I'd rather smell like a French [explicative] than a smelly [explicative!]"

Surveyor interviewed Manager G on 12/12/2025 at 12:47 PM. Manager G stated Caregiver D called police to the house on 09/19/2025 after the verbal altercation happened. The incident was not self-reported to the Department and the provider did not conduct an investigation into the reported misconduct by Caregiver D or report the allegations to OCQ.

During the interview on 12/12/2025 at 3:30 PM with Area Director A, Regional Director H and Administrator B, the provider acknowledged Caregiver D's alleged comments constituted caregiver misconduct and should have resulted in an investigation, reporting to OCQ and a self-report to the Department regarding the police involvement.

7- The provider was aware of an additional allegation on 09/19/2025. During interviews with Resident 1 on 12/11/2025 11:00 AM, Caregiver F on 12/11/2025 at 11:30 AM, Caregiver E on 12/12/2025 at 9:19 AM, and Manager G on 12/12/2025 at 12:47 PM, each stated they were aware Caregiver D posted a video on social

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media where Caregiver D was heard to be escalating a verbal altercation between him/herself and Resident 1. The provider was aware the recording of the conversation was posted multiple times on social media platforms and did not report Caregiver D to OCQ. The provider stated an investigation into the recording was started but was not complete, and no report to the Department was made.

Surveyor reviewed the investigation documentation which consisted of interviews conducted on 09/22/2025:
The interview with Caregiver D on 09/22/2025 noted details regarding the event on 08/18/2025 and 09/19/2025 when verbal altercations occurred and there was police intervention at the facility. The interview did not contain information regarding the video that was posted.

The investigation was incomplete and did not contain a summary of findings, final determinations, or reporting.

09/25/2025-09/26/2025:
Per interview with Administrator B on 12/16/2025 at 2:30 PM, the provider was aware of an allegation that Resident 1 had inappropriate verbal behavior towards Caregiver D. The provider did not investigate, assess the behavior, determine the cause of the behavior, provide education to residents, provide re-education to staff regarding challenging behaviors, or establish other interventions as an appropriate means of communication. The provider chose to issue involuntary discharges to both Resident 1 (09/25/2025) and Resident 2 (09/26/2025.) The involuntary discharges were later rescinded (unknown date after 09/27/2025.)

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M 614	Continued From page 8 09/27/2025: Caregiver E texted Manager G expressing concern for Resident 1 and 2 due to the involuntary discharge and the allegations they reported to him/her regarding Caregiver C and D 's misconduct and lack of investigation or repercussion. Manager G responded via text that the residents' allegations were false, despite not having conducted an investigation, and stated, " ... You can't take everything these guys say as the truth trust me, they all lie, and they lie a lot ..." Per interview with Manager G on 12/12/2025 at 12:47 PM, when asked if s/he reported the allegations or conducted an investigation Manager G stated, "I didn't do anything. How was I to know what happened that night? I just got a call and they were laughing ... I don't know what happened." Manager G minimized the incident and stated when the maintenance person came to repair the hole in the wall that the wall had been worked on before so it "wouldn't take much" to break through and stated, "It's not like there was solid wood behind it or anything." During the interview on 12/16/2025 at 2:30 PM with Area Director A, Regional Director H and Administrator B, the provider acknowledged Manager G did not identify the allegations of misconduct or conduct appropriate follow-up. 12/11/2025: Surveyor began the Department complaint investigation including review of documentation, observations, and interviews with Resident 1 on 12/11/2025 11:00 AM, with Caregiver F joining at 11:30 AM. Caregiver F stated a few weeks after the hole was made on 08/23/2025, s/he spoke with Resident 1 about what happened. Caregiver F stated at this time, Resident 1 was comfortable	M 614		

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enough to confide that s/he did not actually trip into the wall but that Caregiver C shoved him/her into the wall. Resident 1 nodded "yes" in corroboration as Caregiver F stated this. Resident 1 stated his/her shoulder and back hurt for days after, but s/he was too afraid to say anything because s/he didn't want to worry Manager G and s/he was embarrassed about the incident because s/he was confused about why it happened and why Caregiver C was laughing when s/he was hurt. Resident 1 expressed s/he went along with Caregiver C's story about tripping because s/he was embarrassed and confused about what happened emotionally. Once Resident 1 was around trusted caregivers, such as Caregiver F and Caregiver E, s/he was comfortable enough to say what really happened but was still scared because s/he said s/he "doesn't like conflict." Caregiver F stated s/he was "livid" about what happened to Resident 1 and immediately told Manager G. Caregiver F stated, "playing or not playing, you don't ever put your hands on someone with enough force to put them through the wall ... Some people are not meant to be caregivers." Caregiver F stated s/he believed Manager G would report and conduct an investigation but has not been interviewed by any management about the incident after reporting it to Manager G. Resident 1 walked up to the wall where the hole had been patched over and demonstrated how s/he was shoved into the wall and Surveyor observed the patchwork aligned with the resident's general standing height and shape of impacting his/her right shoulder as Resident 1 demonstrated.

12/12/2025:
Surveyor conducted interviews with Caregiver E at 9:19 AM, and Manager G at 12:47 PM, and Area Director A, Administrator B, and Regional

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M 614	Continued From page 10 Director H at 3:30 PM. The timeline of allegations of misconduct and reporting was reviewed with the provider. As a result of the complaint investigation conducted by the Department, the provider stated they would begin an internal investigation into the event on 08/23/2025 and the associated allegations of misconduct within the timeline that followed. On 12/12/2025 at 9:19 AM, Surveyor interviewed Caregiver E. Caregiver E stated, "When I saw the hole, I was taken aback by it. I have been in some houses where somebody punched through a wall, even cheap walls, you don't just make a giant hole like that. It was like half the size of (Resident 1's) body and as tall as (him/her) ... there's no way (s/he) just fell into it at that height. I can't imagine the force it would have taken to shove someone through that wall. I don't care if you are rough housing or not, you never put your hands on a resident and especially never with so much force that they would go through a wall ... (S/he) told me (his/her) back hurt for days. No one took (him/her) in to be seen. Even if you have an incident where it's two residents wrestling around, if someone goes through the wall you have them get seen. I couldn't believe it. No one took (him/her) to the ER..." 12/16/2025: Surveyor conducted an exit interview with Area Director A, Administrator B, and Regional Director H. The provider stated they believed the allegations against Caregiver D were reported to OCQ but no report of allegations of misconduct by Caregiver C was submitted. Surveyor requested to review the documentation for the investigations into the allegations of misconduct. The investigation documentation received was staff and resident interviews pertaining to the	M 614		

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incident on 08/23/2025. The resident interviews (dated 12/12/2025, unnamed interviewer) consisted of 5 questions and did not include investigation of the other identified allegations of caregiver misconduct.

Review of Provider Investigation Interviews

Resident 1:
Question 2- "Is there any caregiver that doesn't treat you well? If so, who and what do they do?"
Resident 1 responded, "[Caregiver C] and [Caregiver D] are not nice at all. [Caregiver D] nags and pushes buttons [Caregiver C] threw me at a wall once ..."

Question 3- "Is there any caregiver that doesn't treat your roommates well? If so, which caregiver what did they do that makes them feel this way?"
Resident 1 responded, "[Caregiver D] sprayed bleach on [Resident 2's] dog. [Caregiver C] has hit and roughhoused with [Resident 2.]"

Question 4a- "Do you recall a few months ago how the hole in the wall happened? ..."
Resident 1 responded, "Yes I was pushed by staff into the wall."

Question 4b, contingency directives- "If they don't remember the hole or need a reminder, ask if it was because people were wrestling or rough housing? If so, who was involved?"
Resident 1 responded, "[Caregiver C] and I got into an argument. I thought we were goofing around until [s/he] told me after [sic] ..."

Question 4c- "Was this a funny thing or was somebody upset?"
Resident 1 responded, "I thought it was funny until [s/he] made it serious with [his/her]

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comment."

Question 4d- "Did anybody get hurt? Who and where were they hurt?"
Resident 1 responded, "My shoulder hurt."

Question 4e- "Who caused the hole in the wall?"
Resident 1 responded, "I did. I went I went through it."

Question 4f- "What did you do when you saw the hole in the wall?"
Resident 1 responded, "Shocked. I didn't retaliate since I was so shocked."

Question 4g- "Did you tell anybody about this? If so, who and what did you tell them about what happened?"
Resident 1 responded, "Yes. I told [Caregiver F] and [Caregiver E] I thought it was just goofing around but then [Caregiver C's] comment didn't sit right."

Resident 2:
Question 4a - "Do you recall a few months ago how the hole in the wall happened? ..."
Resident 2 responded, "[Caregiver C] pushed [Resident 1] through the wall."

Question 4b contingency directives- "If they don't remember the hole or need a reminder, ask if it was because people were wrestling or rough housing? If so, who was involved?"
Resident 2 responded, "Seemed like roughhousing that turned into something else."

Question 4c - "Was this a funny thing or was somebody upset?"
Resident 2 responded, "Someone upset. [Caregiver C.]"

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M 614	Continued From page 13 Question 4e - "Who caused the hole in the wall?" Resident 2 responded, "[Caregiver C] by pushing [Resident 1.]" Question 4g- "Did you tell anybody about this? If so, who and what did you tell them about what happened?" Resident 2 responded, "[Manager G.] We called [him/her] and told [him/her] that we put a hole in the wall." Question 5- "Is there anything more you want to tell me?' Resident 2 responded, "[Resident 1] should have said something sooner." Both resident interviews stated Resident 1 was pushed into the wall by Caregiver C in a manner that made both residents identify the misconduct was intentional and aggressive. Per interview on 12/16/2025 at 2:30 PM with Area Director A, Regional Director H and Administrator B, the provider dismissed their own findings and subsequently did not report a summary of findings to the Department or report Caregiver C to OCQ. Caregiver C was allowed to continue employment and working with Residents 1 and 2 despite the evidence collected by the provider during both resident interviews. The provider did not ensure investigations were completed when at least 7 allegations of caregiver misconduct were reported involving Caregivers C and D. The provider did not recognize all allegations as potential caregiver misconduct that required an investigation and reporting. As a result of the Department's complaint investigation, the provider began an investigation on 12/12/2025 that did not include	M 614		

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M 614	Continued From page 14 all identified allegations of caregiver misconduct spanning from 08/18/2025 through 12/12/2025. The documentation of the investigation submitted for Surveyor review on 12/16/2025 did not address each allegation of misconduct and did not include a summary of findings or written responses to the individual grievances brought to their attention. The documentation was limited to interview notes where both Residents 1 and 2 indicated caregiver misconduct occurred. The provider conducted no further investigation or reporting and subsequently dismissed their own findings. Cross Reference: Y3234 DHS 50.09(1)(e) Treatment	M 614		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact.	Y3234		

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Y3234	Continued From page 15 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employees. Resident 1 expressed mistreatment by Caregiver C and Caregiver D. Resident 1's expression of his/her likes, dislikes, concerns and reporting regarding Caregiver C and Caregiver D were not handled with respect by the provider and resulted in further mistreatment of the resident. Findings include: On 12/01/2025, the Department received a complaint alleging the provider was made aware of multiple incidents of caregiver misconduct. Surveyor reviewed Resident 1's record and noted Resident 1 was admitted on 12/13/2023 and had an appointed guardian for health care (Guardian I.) Resident 1's diagnoses included cognitive delay, disruptive mood dysregulation disorder, autistic disorder, pervasive developmental disorder and reactive attachment disorder for childhood. Resident 1's Individual Service Plan (ISP) did not include references to any disruptive, attention seeking, or aggressive behavior, and did not include a behavioral support plan. There was no documentation of the resident being a reliable or unreliable reporter/ historian. The ISP did include "Self-concept" which noted the resident at times had difficulty expressing his/her feelings including, "[Resident 1] has a history of changing [his/her] personality when around people [s/he] cares about because [s/he] doesn't want them mad at [him/her.] This tends to hinder [Resident 1's] expression of [his/her] feelings ..." During an interview with Caregiver F on 12/11/2025 and an	Y3234		

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interview with Caregiver E on 12/12/2025 both caregivers stated Resident 1 could be easily manipulated into going along with others as s/he did not like confrontation. Both caregivers indicated, in their experience, Resident 1 was a reliable historian.

Timeline
Surveyor reviewed Resident 1's incident reports and observation notes, e-mails, text exchanges provided by Manager G, and conducted interviews with Resident 1 on 12/11/2025 11:00 AM, Caregiver F on 12/11/2025 at 11:30 AM, Caregiver E on 12/12/2025 at 9:19 AM, Manager G on 12/12/2025 at 12:47 PM, and Administrator B, Area Director A and Regional Director B on 12/13/2025 at 3:30 PM and 12/16/2025 at 2:30 PM.

08/18/2025- The provider had a staff to resident "altercation," made emotionally threatening statements to Resident 1, and dismissed Resident 1's emotional expression:

Surveyor reviewed an incident report dated 08/18/2025, written by Manager G. The report noted "Behavior- Resident to Staff Altercation." The incident report noted Resident 1 was questioned about hiding Caregiver D's cleaning products. Manager G noted telling the resident that hiding Caregiver D's cleaning products was theft. During an interview with Resident 1 on 12/11/2025 at 11:00 AM Resident 1 stated s/he was upset with Caregiver D and didn't know what else s/he could do as a means of expressing their emotions, and decided to hide Caregiver D's cleaning products in their room. Resident 1 expressed fear when he/s was told by Manager G that s/he was stealing. Telling the resident that their actions constituted theft was intentionally

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alarmist, paternalizing, and manipulated the resident by taking advantage of their cognitive disability to frighten them into changing their expressive behavior.
The incident report further noted Manager G questioning Resident 1 on why s/he "only complains about the spray when ... [Caregiver D] uses it and not when any other staff member uses it, and [Resident 1] replied "because I don't LIKE [him/her] and I don't WANT [him/her] here." The nature of the question was not respectful, and Manager G did not document any further questions or inquiry as to why the resident felt so strongly about Caregiver D. Resident 1's expression of his/her feelings was documented as being limited when faced with authority figures and his/her expression was not treated with respect by following up with questions as to why s/he disliked the caregiver.

During the interview on 12/12/2025 at 3:30 PM with Area Director A, Regional Director H and Administrator B, the provider acknowledged Resident 1's statement regarding their feelings towards Caregiver D should have initiated further questioning to ensure Resident 1's physical, mental, and emotional safety and that telling the resident hiding the cleaning products was theft was inappropriate coercion/ intimidation.

Per the incident report dated 08/18/2025, Resident 1 took Caregiver D's cleaning supplies into his/her bedroom and locked his/her door refusing to come out. Per the incident report, observation notes dated 08/18/2025 written by Caregiver D, and the provider's interview with Caregiver D on 09/22/2025, Resident 1's door was unlocked with a key against his/ her explicit verbal wishes to have his/her door remain locked. The provider did not acknowledge Resident 1's

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federal right being violated or the treatment of the resident that caused him/her to lock him/herself in his/her bedroom.

08/23/2025- Caregiver C physically interacted with Resident 1 which resulted in Resident 1's right shoulder going through the dining room wall. The provider was aware Resident 1 could be easily persuaded and did not further question the treatment of the resident:

Surveyor interviewed Resident 1 on 12/11/2025 11:00 AM, Caregiver F on 12/11/2025 at 11:30 AM, Caregiver E on 12/12/2025 at 9:19 AM, and Manager G on 12/12/2025 at 12:47 PM. Each interview noted, on or around 08/23/2025, an incident occurred when Caregiver C was working that resulted in Resident 1's right shoulder going through the wall. Caregiver C reported via phone on 08/23/2025 to Manager G that the hole was created by the staff and residents "roughhousing," resulting in Resident 1 tripping and falling into the wall. Manager G stated as Caregiver C and the residents were laughing, s/he accepted the explanation without further question and did not investigate or document the incident, or recognize the potential mistreatment and /or manipulation of the resident.

On 12/12/2025 at 3:30 PM, Surveyor interviewed Area Director A, Regional Director H and Administrator B. The administrators recognized Resident 1's ISP identified, and employee interviews noted, that Resident 1 had difficulty expressing him/herself and could be easily persuaded to "go along" with Caregiver C's version of events once Resident 1 heard Caregiver C laughing and reporting the hole in the wall as an accident to Manager G. In light of this assessed information about the resident, and the

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fact that Caregiver C engaged in a behavior, weather intentional or not, that caused the resident to go through the wall, a reasonable and prudent caregiver should have recognized the need to investigate the incident and the treatment of the resident that led up to the incident and the persuaded reporting.

08/30/2025- (Per interviews with Resident 1 on 12/11/2025 11:00 AM, Caregiver F on 12/11/2025 at 11:30 AM, Caregiver E on 12/12/2025 at 9:19 AM.) Mistreatment of Resident 1 via staff insisting Resident 1 listen and participate in explicit language via music, staff making threatening statements, presumption of the resident being untruthful, and using a position of authority to coerce the resident to recant his/her statements:

Approximately 1 week after the hole was made the hole was fixed by maintenance. Resident 1 stated Caregiver G came up to him/her and told him/her that s/he pushed Resident 1 into the wall on purpose in retaliation for using a racial slur against his/her sibling (Caregiver D); referencing the altercation on 08/18/2025. Resident 1 reported the statement to Caregiver's E and F (dates unknown) and both caregivers stated they reported the allegation immediately to Manager G.

Interviews:
On 12/11/2025 at 11:00 AM, Surveyor interviewed Resident 1 in his/her private bedroom while Caregiver F remained in the living room. Resident 1 initially stated the hole in the wall (08/23/2025) was made while the staff was "roughhousing" around with the residents. When asked if it was all in fun/ playful, Resident 1 began to rock back and forth and wring his/her hands. Resident 1 shook his/her head to indicate "no" and stated "I

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don't think so. I don't know. I was confused about it at the time ... I thought (Caregiver C) was just joking but then (s/he) pushed me really hard into the wall. My whole shoulder went through and it really hurt ... and then (Caregiver C) started laughing like it was a joke. I was confused. (Caregiver C) called (Manager G) and told (him/her) that I tripped. (S/he) pushed me. I was confused and embarrassed, so I laughed too. I think (Caregiver C) likes me, I don't know. I know (s/he) was mad at me, but I think (s/he) likes me now." Resident 1 began increased movements rocking back and forth, wringing his/her hands, looking down and not making eye contact. Resident 1 stated after the hole was repaired (approximately 08/30/2025) Caregiver C " ...came up to me and told me that (s/he) shoved me into the wall because of what I said to (his/her sibling Caregiver D) like to get back at me for saying it." Surveyor observed Resident 1 have a physical reaction when his/her voice began to crack, and s/he stated his/her "throat dried up" to the point of not being able to talk. Resident 1 needed to get a glass of water and take a moment. While getting water, Surveyor stepped out into the living room where Caregiver F was present to ensure Resident 1 was ok. Caregiver F indicated s/he aware of the concerns and was supportive of Resident 1. When Resident 1 returned it was evident Resident 1 may be more comfortable speaking with Caregiver F present. Resident 1 confirmed this, and the interview continued with Caregiver F.

Caregiver F could not recall exact dated and times but stated Caregiver C's sibling (Caregiver D) worked at the facility in August of 2025. Caregiver F stated Caregiver D would play rap music that included racial slurs and would encourage Resident 1 to sing along, including the

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racial slur lyrics. Resident 1 stated that s/he was uncomfortable rapping all the lyrics, but that Caregiver D kept telling him/her that s/he should. Caregiver F stated there was a voice recording posted multiple times on social media where Caregiver D recorded him/herself and Resident 1 without showing faces and Caregiver F stated it was clear that Caregiver D was goading Resident 1 and intentionally trying to upset the resident into saying something in retaliation. Caregiver F stated eventually the recording noted Resident 1 using a racial slur against Caregiver D. Caregiver F stated in his/her opinion it was contrived as Caregiver D then quit his/her position at the company and began to threaten to sue. Caregiver F stated, "Resident 1 is not a racist. [S/he] loves me. [Resident 1] would not have even known to say that word had it not been [Caregiver D] making [him/her] say it during the music and then goading [him/her] into saying something on camera."

Caregiver F stated a few weeks later s/he spoke with Resident 1 about what happened. Caregiver F stated at this time, Resident 1 was comfortable enough to confide that s/he did not actually trip into the wall but that Caregiver C shoved him/her into the wall. Resident 1 nodded "yes" in corroboration as Caregiver F stated this. Resident 1 stated his/her shoulder and back hurt for days after, but s/he was too afraid to say anything because s/he didn't want to worry Manager G and s/he was embarrassed about the incident because s/he was confused about why it happened and why Caregiver C was laughing when s/he was hurt. Resident 1 expressed s/he went along with Caregiver C's story about tripping because s/he was embarrassed and confused about what happened emotionally. Once Resident 1 was around trusted caregivers, such as

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Caregiver F and Caregiver E, s/he was comfortable enough to say what really happened but was still scared because Resident 1 stated s/he "doesn't like conflict" and didn't want to worry Manager G. Caregiver F stated s/he was "livid" about what happened to Resident 1 and immediately told Manager G. Caregiver F stated, "playing or not playing, you don't ever put your hands on someone with enough force to put them through the wall ... Some people are not meant to be caregivers." Resident 1 walked up to the wall where the hole had been patched over and demonstrated how s/he was shoved into the wall and Surveyor observed the patchwork aligned with the resident's general standing height and shape of impacting his/her right shoulder as Resident 1 demonstrated. Resident 1 stated Caregiver C still worked at the facility and though time has passed s/he continues to have tension when Caregiver C is working because of the threatening statement Caregiver C made about the shove into the wall being intentional and retaliatory.

On 12/12/2025 at 9:20 AM, Surveyor interviewed Caregiver E. Caregiver E stated, "When I saw the hole, I was taken aback by it. I have been in some houses where somebody punched through a wall, even cheap walls, you don't just make a giant hole like that. It was like half the size of [Resident 1's] body and as tall as [him/her] ... there's no way [s/he] just fell into it at that height. I can't imagine the force it would have taken to shove someone through that wall. I don't care if you are rough housing or not, you never put your hands on a resident and especially never with so much force that they would go through a wall ... [S/he] told me [his/her] back hurt for days. No one took [him/her] in to be seen. Even if you have an incident where it's two residents wrestling around,

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if someone goes through the wall you have them get seen. I couldn't believe it. No one took [him/her] to the ER. [S/he] was embarrassed and I could tell that [s/he] was being made to downplay it. Like peaches and cream, smoothed over like jelly ... The [guys/girls] who live there are smart, don't get me wrong, but they can be taken advantage of. You can put an idea in their head and they're going to be confused about it and go along with it ... [Resident 1] thought [s/he] was having a good time and then got shoved hard into the wall and didn't understand it when [Caregiver C] started laughing and told [Manager G] that [s/he] fell into the wall. I can see [Resident 1] being confused by that and just going with what [Caregiver C] said to get along. [Caregivers C] convinced [him/her] it was an accident then a week later [s/he] told [Resident 1] [s/he] did it on purpose ... I have fun with the [guys/ girls] when I work there. They are all afraid of [Caregiver C] and now I can understand why. I would be afraid too if somebody told me 'I shoved you through the wall for what you've said' ... that's a threat ... like they're going to do it again if you don't behave."

Per interview with Manager G on 12/12/2025 at 12:47 PM, Manager G stated Caregiver E reporting the allegations (approximately 08/30/2025) and asked, "How is it ok for the staff to throw a resident through the wall?" Manager G stated s/he immediately called the facility and spoke with Resident 1 and Resident 2. Manager G stated, "While I was on my phone with [Caregiver C] I called [Forest Glen] from my house phone to ask them why they were making up lies. I said, "Why are you guys lying to (Caregiver E?) That's not what happened and you know it!." Manager G stated s/he was upset and stated to Resident 1, regarding the report that Caregiver C stated the shove was retaliatory, "I

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said to (Resident 1) "Why didn't you tell me about this?" [s/he] knew I was upset. [S/he] said "I didn't want to worry you" and then (s/he) admitted it was all in fun."

Manager G was aware Resident 1 had been assessed as having difficulty expressing his/her feelings when s/he feels someone in authority may be upset and openly coerced Resident 1 into recanting his/her statement by being aware of his/her diagnosis, expressing his/her own "upset" emotions towards Resident 1, and accusing him/her of lying until s/he recanted. In an e-mail dated 12/12/2025 at 11:58 AM, Manager G noted on 09/29/2025 s/he spoke with Resident 1 regarding his/her statement to Caregiver F, telling Caregiver F about Caregiver C telling him/her that the shove was intentional, "[Resident 1] told me [s/he] didn't tell me because [s/he] didn't want to worry or upset me ... I then reminded them that the incident with [Caregiver D] hadn't happened yet at that point and how important it is to be honest." Manager G did not take into account the incident of verbal altercation that occurred on 08/18/2025 happen prior to the hole in the wall on 08/23/2025. Manager G's presumptions lead him/her to chastise Residents 1 and 2 and ignore Resident 1's attempt to explain that s/he had been afraid to tell because s/he didn't want to upset Manager G with the information. The provider did not treat the resident with respect or dignity.

09/19/2025- Staff engaged in a "verbal altercation" with the resident X2 and recorded the resident via phone without their knowledge or consent. The recorded video was subsequently posted on social media:

An incident report dated 09/19/2025 and written

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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by Manager G noted, "Behavior- Resident to Staff Altercation." The incident report noted Resident 1 and Caregiver D had a verbal altercation. The incident report noted the resident believed Caregiver D "broke the law" and when s/he asked Caregiver D about it Caregiver D responded with aggression and expletives, "that makes me a [racial slur?]" The resident noted s/he responded in turn out of frustration and Caregiver D then walked into the living room and said to the resident, "At least I'm not musty and I don't have smelly [explicative] feet!" The resident responded, and Caregiver D then said, "I'd rather smell like a French [explicative] than a smelly [explicative!]"

The provider was aware of an additional allegation on 09/19/2025 during interviews with Resident 1 on 12/11/2025 11:00 AM, Caregiver F on 12/11/2025 at 11:30 AM, Caregiver E on 12/12/2025 at 9:19 AM, and Manager G on 12/12/2025 at 12:47 PM, each stated they were aware Caregiver D posted a video on social media where Caregiver D was heard to be escalating a verbal altercation between him/herself and Resident 1. The provider was aware the recording of the conversation was posted multiple times of on social media platforms.

09/25/2025-09/27/2025- Despite the mistreatment of Resident 1, Resident 1 was given a 30-day discharge. The notice caused further emotional stress to Resident 1 and Manager G dismissed the reported treatment of the residents and tried to coerce Caregiver E into believing the residents were liars. Resident 1's reporting of mistreatment was presumed as false and was not treated with respect:

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	0015660	A. BUILDING: _____ B. WING _____	C 12/16/2025

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Y3234	Continued From page 26 On 09/27/2025 Caregiver E texted to Manager G about the 30-day notice and the reported treatment of the residents: Caregiver E, "I've been trying to comfort the [boys /girls] as much as I can." Manager G, "I know they are very upset. So am I. [sic] and you. I don't think [Caregiver C] will care one way or another." Caregiver E, "[S/he's] definitely not going to care. [S/he's] definitely going to be ecstatic. [S/he's] definitely going to be happy about both of them too [sic] in particularly being gone, I can almost guarantee that. I'm highly upset. They don't deserve this." Manager G, "I have to agree with you." Caregiver E, "My thing is why [Caregiver C] get [sic] away with throwing a resident into a wall whether it was play or series [sic.] That should have had serious consequences. I don't understand how that was just brushed and swept under the rug." Manager G, "They called me in the middle of the night laughing about it and let me know that it had happened. They were both by the wall and [Resident 1] fell into the wall from what I was told. I don't know if they were wrestling around or what but that's what's happened. [sic] but I do understand what you're saying." Caregiver E, " ... [sic] but the staff should never even be playing with a resident in any type of [sic] form or nature relating to any of that [sic] cause happening. I had discussion with [Resident 1] about that and [s/he] told me exactly how it	Y3234		

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happened and about how the day after how [Caregiver C] said to [him/her] that was for calling my [brother/sister] [racial slur] and I'm pretty sure [Caregiver C] meant it. Anywhere else [Caregiver C] would have lost [his/her] job and now they have to leave but [s/he] gets to stay when [s/he's] done a lot of sneaky underhanded [explicative] to them but it's not my [sic] to judge ... everything is in God's hands."

Manager G, "No that is not the way it happened, I promise you, and I don't recall [Caregiver D] being called [explicative] either prior to that. You can't take everything these [guys/ girls] say as the truth. Trust me, they all lie and they lie a lot ... I came in the morning and caregiver see was still there and it was a big laugh for everyone ..." (Manager G assures Caregiver E of how the event transpired without having conducted an investigation.)

Caregiver E, "OK, you know them better than I do. They just sound so truthful when they're telling the story though I guess I can still be conned by them lol."

Manager G, "I know I'm lied to all the time and it sucks having to figure out what is the truth and what isn't."

Caregiver E, "They may lie but all in all they are pretty good [guys/ girls] for the most part and I hate to see them get uprooted like this ... when I leave I'm always gonna [sic] think about what's going on with [him/her] and how they are being treated. They may lie, but I'm telling you right now [Caregiver C] and [his/her sibling, Caregiver D] are big liars also imagine having to deal with two ..."

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Y3234	Continued From page 28 Per interview with Administrator B on 12/16/2025 at 2:30 PM, the involuntary discharges were rescinded (date after 09/27/2025, unknown.) Administrator B stated the involuntary discharges to Resident 1 and Resident 2 were due to the Resident 1 using a racial slur against Caregiver D. Administrator A stated Caregiver D had subsequently threatened to file legal charges against the provider and that a 30-day discharge to Resident 1 and 2 was then issued. Upon review of the 30- day discharge, there was no provision in the admission agreement signifying a resident could be discharged for their language towards the staff. The 30-day discharge caused undue stress to Resident 1 who thought s/he was going to have to leave his/her home per the text messages from Caregiver E on 09/27/2025 and interview with Resident 1 on 12/11/2025. Resident 1 was not treated with respect or dignity by Caregivers C and D or by Manager G. Resident 1 had staff verbally accost him/her, physically cause harm, and emotionally abuse the resident with their behavior, coercion, and threats. Resident 1 attempted to express his/her feelings only to have Manager G presume s/he was lying and attempt to convince other caregivers that Resident 1 was lying despite not having conducted an investigation into the incidents reported. Manager G was aware Resident 1 was assessed as having difficulty expressing his/her feelings when it may cause confrontation and instead of supporting the resident, caused further mistreatment, distrust, and emotional harm. Cross Reference: M0614 DHS 88.11(3) Investigation Of Abuse Or Neglect	Y3234		

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