| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015803 | A. BUILDING: _____ B. WING _____ | C 12/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| IVY MANOR OF WEST BEND BUILDING 3 | 365 S FOREST AVE WEST BEND, WI 53095 |

| (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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| N 000 | Initial Comments<br><br>On 12/03/2025, Surveyor conducted one (1) complaint investigation at Ivy Manor of West Bend Building 3. As a result of the survey, two (2) deficiencies were identified, complaint was substantiated.<br><br>Census: 20 | N 000 | | |
| N 158 | 83.12(2)(a) Caregiver: Investigating abuse & neglect<br><br>Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the provider did not take immediate steps to ensure the safety of all residents, thoroughly investigate, and maintain documentation of the investigation in response to reports received which alleged | N 158 | | |

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

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| N 158 | Continued From page 1<br>potential abuse, neglect and/or mistreatment of residents.<br><br>Findings include:<br><br>On 11/17/2025, the Department received concerns regarding resident being recorded during cares.<br><br>On 12/03/2025 at 9:30 AM, Surveyor requested Resident 1's record, Caregiver C's employee file and the investigation for the incident with Resident 1 being recorded from Administrator (ADM) A.<br><br>On 12/03/2025 at 10:25 AM, Surveyor interviewed Resident 1. Resident 1 was pleasant, but not a good historian.<br><br>On 12/03/2025 at 10:35 AM, Surveyor interviewed Caregiver (CG) B. CG B confirmed s/he was in the room with CG C when CG C recorded Resident 1. CG B stated CG C was upset with how Resident 1 acted and stated s/he was videoing Resident 1 to show his/her spouse. CG B stated s/he reported the incident to management as soon as s/he had left the room. CG B stated the video was audio only and s/he didn't believe you could see Resident 1's face.<br><br>On 12/03/2025 at 10:42 AM, Surveyor interviewed Facilities Manager (FM) D. FM D confirmed s/he was told of the incident with Resident 1. FM D stated s/he investigated and terminated CG C for the recording. FM D stated everything was verbal and that s/he did not have any documentation to provide to the Surveyor. FM D acknowledged CG C admitted to taking a video, but FM D did not request to see video. | N 158 | | |

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| N 158 | Continued From page 2<br><br>On 12/03/2025 at 10:55 AM, Surveyor interviewed ADM A. ADM A stated s/he was out of town when this incident occurred, and that FM D was the staff person in charge. ADM A confirmed s/he did not have any investigation to provide to Surveyor. ADM A confirmed s/he had not self-reported this incident to Bureau of Assisted Living (BAL) or Office of Caregiver Quality (OCQ).<br><br>On 12/03/2025 at 11:00 AM, Surveyor reviewed Resident 1's record. Resident 1 admitted on 06/26/2023. Resident 1 had diagnosis including depression, major depressive disorder, Alzheimer's Disease and anxiety disorder.<br>Resident 1's individual service plan stated:<br>Bathing - Needs to have some level of assistance for bathing needs.<br>Dressing - Resident requires partial assistance from staff to complete dressing tasks.<br>Eating - Resident requires staff to monitor food consumption.<br>Grooming - Resident requires staff monitoring and/or reminders and cues to complete grooming tasks.<br>Toileting - Has incontinence/dribbles and is unable to manage on their own.<br>Aggressive/Combative - Yells out "Nursing Home Administrator" or "Patient abuse."<br>Resident 1's record did not have any documentation of Resident 1 being recorded. There were no incident reports regarding Resident 1 being recorded.<br><br>Surveyor reviewed CG C's employee file. There was documentation in CG C's file dated 06/26/2025 reflecting CG C's position was ended as of 06/25/2025, with last day of physical work 06/25/2025. The reason stated "unprofessionalism" and signed by ADM A. There | N 158 | | |

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| N 158 | Continued From page 3 | N 158 | | |

was an employee checklist dated 06/25/2025 stating terminated - reason "unprofessionalism" signed by FM D, and under notes stated, "Took video when giving [Resident 1] a shower."

On 12/03/2025, Surveyor reviewed the Department's Caregiver Program Manual, a resource for providers, last revised 10/2024. It read in part, "ENTITY INTERNAL INVESTIGATION RESPONSIBILITIES- Protection of Clients- Immediately upon learning of the incident, the entity must take necessary steps to protect clients from possible subsequent incidents of misconduct or injury...All entities regulated by DQA must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: Collecting and preserving any physical and documentary evidence including videos; Interviewing alleged victims and witnesses; Collecting other corroborating/disproving evidence; Involving other regulatory authorities who can assist...e.g., local law enforcement...; and Documenting each step taken during the internal investigation. These steps should be taken as part of the entity's initial attempt to determine what, if anything, happened and to determine the complete factual circumstances surrounding the alleged incident. An entity's internal investigation will assist in determining if an incident must be reported to DQA (Office of Caregiver Quality)..."

On 12/03/2025 at 11:50 AM, Surveyor interviewed ADM A. Surveyor shared the video with ADM A. ADM A confirmed s/he believed CG B and CG C were the 2 staff in the video and confirmed Resident 1 was the person receiving cares in the bathroom. The video was graphic in nature and

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| N 158 | Continued From page 4<br><br>CG B was verbally abusing Resident 1. Resident 1 yelled to get out, yelled, "Help!" and yelled, "Nursing Home Administrator!" several times during the video, however the video continued for 2 minutes 33 seconds.<br><br>The provider did not take immediate steps to ensure the safety of all residents, thoroughly investigate, and maintain documentation of the investigation in response to reports received which alleged potential abuse, neglect and/or mistreatment of residents. | N 158 | | |
| Y3100 | 50.09(1)(f) Resident's Rights In Certain Facilities<br><br>(f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to:<br>1. Privacy for visits by spouse or domestic partner. If both spouses or both domestic partners under ch. 770 are residents of the same facility, the spouses or domestic partners shall be permitted to share a room unless medically contraindicated as documented by the resident ' s physician, physician assistant, or advanced practice nurse prescriber in the resident ' s medical record.<br>2. Privacy concerning health care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. Persons not directly involved in the resident ' s care shall require the resident ' s permission to authorize their presence.<br>3. Confidentiality of health and personal records, and the right to approve or refuse their release to any individual outside the facility, except in the case of the resident ' s transfer to another facility or as required by law or 3rd-party payment contracts and except as provided in s. 146.82 (2) | Y3100 | | |

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| Y3100 | Continued From page 5<br>and (3). | Y3100 | | |

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure residents were free from recording.

Findings include:

On 12/03/2025 at approximately 9:30 AM, Surveyor requested Resident 1's record and asked Administrator (ADM) A if s/he had any knowledge of Resident 1 being recorded. ADM A confirmed s/he had received information from Facilities Manager (FM) D that s/he had terminated Caregiver (CG) C for unprofessionalism.

On 12/03/2025 at 10:35 AM, Surveyor interviewed Caregiver (CG) B. CG B confirmed s/he was in the room with CG C when CG C was recording Resident 1. CG B stated CG C was upset with how Resident 1 acted and stated s/he was videoing Resident 1 to show his/her spouse. CG B stated s/he reported the incident to management as soon as s/he had left the room. CG B stated s/he believed the video was audio only and that you could not see Resident 1's face.

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| Y3100 | Continued From page 6<br><br>On 12/03/2025 at 10:42 AM, Surveyor interviewed Facilities Manager (FM) D. FM D confirmed s/he was told of the incident with Resident 1. FM D stated s/he investigated and terminated CG C for the recording. FM D acknowledged CG C admitted to taking a video, but FM D did not request to see video.<br><br>On 12/03/2025, Surveyor reviewed CG C's employee file. There was documentation in CG C's file dated 06/26/2025 reflecting CG C's position was ended as of 06/25/2025, with last day of physical work 06/25/2025. The reason stated "unprofessionalism" and signed by ADM A. There was an employee checklist dated 06/25/2025 stating terminated - reason "unprofessionalism" signed by FM D, and under notes stated, "Took video when giving [Resident 1] a shower."<br><br>On 12/03/2025 at 11:50 AM, ADM A stated s/he had not seen the video. ADM A confirmed it would be a violation of work rule to use a camera/phone in a resident area. Surveyor shared the video with ADM A showing Resident 1 receiving cares in the bathroom. ADM A was concerned with the video and how CG C was talking to/treating Resident 1.<br><br>The provider did not ensure residents were free from recording. | Y3100 | | |