STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016972	A. BUILDING: _____ B. WING _____	R-C 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFDEN COURT NORTH	6801 W LOOMIS RD GREENDALE, WI 53129

(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
{N 000}	Initial Comments On 04/30/2026, Surveyor completed a verification visit and 4 complaint surveys at Clifden Court North. As a result, all previous deficiencies were corrected. Seven new deficiencies were identified. Three of 4 complaints were substantiated. Two of the 7 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) VZE811, dated 08/25/2022. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 42	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify 1 of 1 resident's (Resident 2) legal representative when the resident sustained an injury of an unknown origin. This is a repeat deficiency. See Statement of Deficiency VZE811, dated 08/25/2022.	N 169		

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

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N 169	Continued From page 1 Findings include: On 04/27/2026, the Department received a complaint alleging the provider did not notify a resident's responsible party when a resident sustained an injury. On 04/30/2026 at approximately 12:30 PM, Surveyor reviewed Resident 2's record. Resident was admitted to the home on 09/15/2025. Resident 2's record indicated Resident 2 had an activated Power of Attorney for Healthcare (POA-HC) agent. An incident report, dated 04/17/2026, stated the following: " ...[Caregiver E] was doing my rounds [Caregiver E] came around to see [Resident 2] room pull [sic] the covers off and notice [sic] blood. [She/He] was fine the first check and change around 1am [sic]. There was a skin tear on [her/his] wright [sic] wrist resident didn't say anything about the pain unless touched too hard. [She/He] doesn't know what happened. [She/He] stated [she/he] think [she/he] might have scratched it ..." On 04/30/2026 at approximately 12:30 PM, Surveyor reviewed a "Grievance Form" with a date of 04/20/2026. The form stated, "[Regional Nurse F] assessed residents left arm. Noted an approx. 4cm (centimeter)x3cm skin tear to left forearm. Also assessed healed skin tear to resident right wrist/forearm area ...Reviewd [sic] incident reports for 2 slin [sic] tears/missing follow-up documentations/notifications. Spoke with North RCC (Residential Care Coordinator) and ADOW (Assistant Director of Wellness) re-educated proper incident report/notification/follow-up expectations for incidents. RA (Resident Assistant) that noted the skin tear on 4/17/26, during 2nd rounds, had not	N 169		

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N 169	Continued From page 2 completed the incidet [sic] report and notifications to the AHCPOA, PCP (primary care physician) and did not provide a statement as to what had occurred ...Mandatory in-service on 4/22/26 added Incident Reports, Notification requirements ..." On 04/30/2026 at approximately 2:00 PM, Surveyor interviewed Regional Nurse F. Regional Nurse F reported Caregiver E did not notify the nurse of the skin tear he/she observed on 04/17/2026. It was not until 04/18/2026 when the hospice nurse came in to see Resident 2 that the nurse became aware of the skin tear. Regional Nurse F confirmed Resident 2's activated POAHC agent was not informed when the skin tear was originally noticed on 04/17/2026.	N 169		
N 171	83.12(5)(c) Notification: change of services or charges. The CBRF shall give the resident or the resident ' s legal representative a 30-day written notice of any change in services available or in charges for services that will be in effect for more than 30 days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 (Resident 3) of 1 resident and his/her legal representatives were given a 30-day written notice of a change in charge for services that would be in effect for more than 30 days. Findings include: On 03/24/2026, the Department received a	N 171		

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N 171	Continued From page 3	N 171		

complaint that the level of care fee was increased without notification.

On 04/30/2026 at approximately 12:30 PM, Surveyor reviewed Resident 3's file. The following was identified:
-Resident 3 was admitted to the home on 05/05/2025. Resident 3's record indicated Resident 3 had an activated Power of Attorney for Healthcare (POAHC) agent.

-"Resident Evaluation," dated on 05/06/2025, indicated Resident 3's care level was "Level 1." The fee for "Level 1" was $0.00.

-Resident 3 was assessed on 01/29/2026 using the "Assisted Living (AL) Service Plan 5 Levels" form. Resident 3's care level was assessed to be "Level 3." The form was signed and dated by Assistant Director of Wellness (ADOW) I and Resident Care Coordinator (RCC) J. The form did not contain a signature from Resident 3's activated POAHC agent.

-Resident 3's billing reported Resident 3 was paying $4,675.00 per month between 07/01/2025 to 12/31/2025. Effective 01/01/2026, Resident 3's billing increased to $4,955.00.

On 04/30/2026 at approximately 1:30 PM, Surveyor interviewed ADOW I. ADOW I reported that when Resident 3 was admitted into the facility, Resident 3 was assessed to be at a Level 1, however, Resident 3 only being charged for room and board and not for the cares being provided. Once the new management company came in, all residents were reassessed to ensure they were receiving the appropriate level of care.

On 04/30/2026 at approximately 2:05 PM,

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N 171	Continued From page 4 Surveyor interviewed Administrator G. Administrator G could not confirm if Resident 3's activated POAHC agent was informed of the rate increase 30 days prior to the new rate going into effect. Administrator G reported that since starting his/her role on 04/23/2026, he/she has received multiple complaints from residents and families about the rate increase. Administrator G has been working on meeting with residents and families regarding the rate increase.	N 171		
N 189	83.13(3)(b) Post house rules, resident rights, grievances The CBRF shall post all of the following: House rules, resident rights and grievance procedures as required under s. DHS 83.32(2) (b). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the grievance procedure was posted. This had the potential to affect 42 of 42 residents residing within the facility. Findings include: On 04/28/2026 at approximately 6:30 AM, Surveyor reviewed the department's facility file. Surveyor identified the department received 4 complaints between 03/12/2026 to 04/27/2026. On 04/28/2026 at approximately 2:00 PM, Surveyor toured the facility with Administrator G. Surveyor and Administrator G were able to locate the grievance procedure. As Surveyor and Administrator G toured the facility, Administrator G asked Receptionist H where the grievance procedure was posted. Receptionist H reported	N 189		

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N 189	Continued From page 5 Administrator C instructed him/her to take the grievance procedure down. On 04/28/2026 at approximately 3:56 PM, Surveyor interviewed Administrator G. Administrator G reported Administrator C no longer works for the company. Administrator G started his/her role as Administrator on 04/23/2026. One thing Administrator G identified was there was no formal grievance process. On 04/28/2026, Administrator G implemented a formal grievance form for residents, and resident's family could complete, should they want to file a formal grievance.	N 189		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner for 2 (Resident 3 and Resident 4) of 3 residents reviewed. Resident 3 did not receive his/her "bedtime" medications on 01/31/2026. Resident 4 did not receive 69 doses of his/her medications between January 2026 to March 2026.	N 352		

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N 352	Continued From page 6 Findings include: On 04/23/2026, the department received a complaint alleging residents were not being provided with prescribed medications. On 04/30/2026 at approximately 12:30 PM, Surveyor reviewed resident's records. The following was identified: Resident 3 was admitted on 05/05/2025. Resident 3 is diagnosed with atrial fibrillation (afib) and flutter, type 2 diabetes mellitus with hyperglycemia, and other cardiomyopathies. Resident 3's individual service plan (ISP), dated 01/29/2026, indicated staff assisted Resident 3 with medication management and administration. Resident 3 had a physician order for the following medications: Eliquis tablet 2.5 milligrams, one table by mouth twice daily to prevent blood clots in chronic afib, PreserVision areds with lutein, one capsule by mouth twice daily (indications for use: eye health) trazadone tablet 50 milligrams, one tablet by mouth at bedtime (indications for use: insomnia) Resident 3's medication administration record (MAR) indicated Resident 3 was not administered with the following "Bedti (bedtime)" medications on 01/31/2026: Eliquis tablet 2.5 milligrams, preservision areds with lutein, and trazadone Resident 4 was admitted on 01/12/2026. Resident 4 was diagnosed with bipolar disorder, spinal stenosis, cystic disease of liver, and disorders of bone density and structure. Resident	N 352		

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N 352	Continued From page 7 4's ISP, dated 01/28/2026, indicated staff assisted Resident 4 with medication management and administration. Resident 4's had a physician order for the following medications: Austedo tablet 9 milligrams, two tablets (18 milligrams) by mouth every morning and at bedtime for tardive dyskinesia (indications for bipolar/tardive) Divalproex sodium delayed release 250 milligram tablets, one tablet by mouth every morning and at bedtime for bipolar disorder (indications for use: bipolar) Vraylar 3 milligram capsule, one capsule by mouth at bedtime for bipolar disorder (indications for use: bipolar) Resident 4's January 2026 MAR indicated Resident 4 was not administered Austedo on 16 occasions, divalproex on 14 occasions, and Vraylar on 7 occasions. Resident 4's February 2026 MAR indicated Resident 4 was not administered Austedo on 1 occasion and Vraylar on 1 occasion. Resident 4's March 2026 MAR indicated Resident 4 was not administered Austedo on 28 occasions, divalproex on 1 occasion, and Vraylar on 1 occasion. On 05/03/2026 at 8:40 PM, Surveyor received an email from Family Member K. Family Member K reported Resident 4 was assessed for placement at Clifden Court on 01/06/2026 to ensure the facility would be able to obtain all prescribed medications prior to Resident 4's arrival on 01/12/2026. Family Member K also provided Clifden Court with all remaining medications Resident 4 had at home after Resident 4 moved into Clifden Court as Family Member K found that Resident 4 was not receiving their prescribed medications due to it "not being in the cart."	N 352		

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N 352	Continued From page 8 On 04/28/2026 at approximately 1:30 PM, Surveyor interviewed Assistant Director of Wellness (ADOW) I. ADOW I stated reports are generated daily, which includes medication that was documented as not administered. On 01/19/2026, pharmacy was called as it was noticed Resident 4 had not received their medications. A stat order was placed until the new cycle started, which was scheduled for 01/21/2026. ADOW I was not sure why Resident 4's medications were not within the building prior to their admission. During Resident 4's admission, there were discrepancies of Resident 4's co-pays, which is why Resident 4's Austedo was "not in the cart." ADOW I reported the facility has since implemented a new procedure to ensure medications are within the facility prior to a resident admitting into the facility.	N 352		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure each resident's Individual Service Plan (ISP) was implemented for 1 (Resident 2) of 3 residents reviewed. Resident 2 had a history of skin tears. The intervention identified was staff were to report any skin alterations to a nurse and observe/document/report location, size, and treatment of skin injury and/or new or worsened alterations in skin integrity as outlined in their ISP.	N 388		

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N 388	Continued From page 9 Findings include: On 04/27/2026, the Department received a complaint alleging lack of notification of injuries being reported to a nurse. On 04/28/2026 at approximately 12:30 PM, Surveyor reviewed Resident 2's record. Resident 2's record indicated the following: -Resident 2 was admitted on 09/05/2025. -Resident 2's ISP, with a review date of 02/15/2026 stated the following: " ...Focus: The resident has actual impairment to skin integrity ...Interventions/Tasks: ... Observe skin. Keep skin clean and dry. Hydrate skin with lotion, as needed. Report any skin alterations to nurse. Observe/document/report location, size, and treatment of skin injury and/or new or worsened alterations in skin integrity ..." -Incident report dated, 03/29/2026 stated the following: " Nurse was notified by house manager the evening of 03/29/2026 that family reported a skin tear. Nurse found out who had known about the incident and finally got a call back with what happened ...Staff is going to write up a statement and nurse educated staff on who to report incidents to and when to report them ..." -Written statement from Assistant Director of Wellness (ADOW) I, dated and signed on 03-30-2026 stated, "Writer was notified by [Nurse L] that resident had a skin tear to left lower arm. Writer was not notified by staff of incident ..." On 04/30/2026 at approximately 2:00 PM, Surveyor interviewed Regional Nurse F. Regional Nurse F confirmed Caregiver E did not follow Resident 2's ISP when Caregiver E identified Resident 2 had a skin tear. Regional	N 388		

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N 388	Continued From page 10 Nurse F reported all staff was reeducated on the importance of notifying nurses of injuries and completing incident reports.	N 388		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the prescribing practitioner, supervising nurse or pharmacist, as soon as possible, after 1 of 1 resident (Resident 4) missed medications for more than 2 consecutive days. Findings include: On 04/23/2026, the department received a complaint alleging residents were not being provided with prescribed medications. On 04/30/2026 at approximately 12:30 PM,	N 410		

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N 410	Continued From page 11	N 410		

Surveyor reviewed Resident 4's record. The following was identified:

Resident 4 was admitted on 01/12/2026. Resident 4 was diagnosed with bipolar disorder, spinal stenosis, cystic disease of liver, and disorders of bone density and structure. Resident 4's individual service plan (ISP), dated 01/28/2026 indicated staff assisted Resident 4 with medication management and administration. Resident 4's record did not identify correspondence from the provider with Resident 4's prescribing physician about missed medications. Resident 4 had a physician order for the following medications:

Austedo tablet 9 milligrams, two tablets (18 milligrams) by mouth every morning and at bedtime for tardive dykinesia (indications for bipolar/tardive)
Divalproex sodium delayed release 250 milligram tablets, one tablet by mouth every morning and at bedtime for bipolar disorder (indications for use: bipolar)
Vraylar 3 milligram capsule, one capsule by mouth at bedtime for bipolar disorder (indications for use: bipolar)

Resident 4's January 2026 medication administration record (MAR) indicated Resident 4's Austedo tablet 9 milligrams was not available on the following dates: 01/12-2026-01/19/2026. Resident 4 missed 14 consecutive doses. Resident 4's divalproex sodium delayed release 250 milligram tablets was not available on the following dates: 01/12/2026-01/19/2026. Resident 4 missed 13 consecutive doses. Resident 4's Vraylar 3 milligram capsule was not available on the following dates: 01/13/2026-01/19/2026. Resident 4 missed 7

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N 410	Continued From page 12 consecutive doses. Resident 4's March 2026 MAR indicated Resident 4's Austedo tablet 9 milligrams was not available on the following dates: 03/10/2026-03/31/2026. Resident 4 missed 28 consecutive doses. On 04/28/2026 at approximately 1:30 PM, Surveyor interviewed Assistant Director of Wellness (ADOW) I. ADOW I reported Resident 4 saw their primary care physician and psychiatrist multiple times since admission, but could not confirm if the above missed doses were reported to Resident 4's medical providers. ADOW I stated he/she reviewed all documents from the scheduled medical visits and nothing was documented about the consecutive missed doses. ADOW I was aware prescribing physicians are to be notified after 2 consecutive missed doses, but could not state why Resident 4's prescribing physician was not notified. ADOW I reported reaching out to the pharmacist, however, it was not until 03/19/2026.	N 410		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.	N 415		

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N 415	Continued From page 13	N 415		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not have documentation of the time of medication administration, the person administering the medication or treatment and the name, dosage, date and time of medication taken or treatments performed and initialed in the medication administration record (MAR) for 1 (Resident 4) of 3 residents reviewed.

The provider did not accurately document when Resident 4 was and was not administered medications.

This is a repeat deficiency. See Statement of Deficiency VZE811, dated 08/25/2022.

Findings include:

On 04/23/2026, the department received a complaint alleging residents were not receiving medication.

On 04/30/2026 at approximately 12:30 PM, Surveyor reviewed Resident 4's record. The following was identified:

Resident 4 was admitted on 01/12/2026. Resident 4 was diagnosed with bipolar disorder, spinal stenosis, cystic disease of liver, and disorders of bone density and structure. Resident 4's individual service plan (ISP), dated 01/28/2026, indicated staff assisted Resident 4 with medication management and administration. Resident 4 had a physician order for the following medications:

Austedo tablet 9 milligrams, two tablets (18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016972	A. BUILDING: _____ B. WING _____	R-C 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFDEN COURT NORTH	6801 W LOOMIS RD GREENDALE, WI 53129

(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
N 415	Continued From page 14	N 415		

milligrams) by mouth every morning and t bedtime for tardive dyskinesia (indications for bipolar/tardive)
Divalproex sodium delayed release 250 milligram tablets, one tablet by mouth every morning and at bedtime for bipolar disorder (indications for use: bipolar)
Vraylar 3 milligram capsule, one capsule by mouth at bedtime for bipolar disorder (indications for use: bipolar)

Resident 4's January 2026 medication administration record (MAR) indicated Resident 4's Austedo tablet 9 milligrams was not available due to "Med not available from pharmacy" on the following dates: 01/12-2026-01/19/2026, however, on the morning of 01/16/2026, Resident 4's MAR indicated Resident 4 was administered Austedo.

Resident 4's divalproex sodium delayed release 250 milligram tablets was not available due to "Med not available from pharmacy" on the following dates: 01/12/2026-01/19/2026, however, Resident 4's MAR indicated Resident 4 was administered divalproex on the morning of 01/16/2026 and 01/17/2026.

Resident 4's March 2026 MAR indicated Resident 4's Austedo tablet 9 milligrams was not available due to "Med not available from pharmacy" on the following dates: 03/10/2026-03/31/2026, however, Resident 4's MAR indicated Resident 4 was administered Austedo in the morning on 03/11/2026, 03/18/2026, 03/20/2026, 03/22/2026, 03/25/2026, and 03/31/2026 and on the night of 03/14/2026, 03/18/2026, 03/19/2026, 03/20/2026, 03/22/2026, 03/24/2026, 03/26/2026, 03/28/2026, 03/29/2026, and 03/30/2026.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 415	Continued From page 15 On 04/28/2026 at approximately 1:30 PM, Surveyor interviewed Assistant Director of Wellness (ADOW) I. ADOW I acknowledged the inconsistencies within Resident 4's MARs. ADOW I could not confirm if Resident 4 did in fact receive the medications when the medications were administered as given. ADOW I did not believe Resident 4 received Austedo in March 2026 as Resident 4's co pay was over $11,000.	N 415		