STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015404	A. BUILDING: _____ B. WING _____	C 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVERLEAF TERRACE LLC	401 CENTER ST BIRNAMWOOD, WI 54414

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N 000	Initial Comments On 04/14/2026 and 04/16/2026, Surveyor conducted 2 complaint investigations and a standard survey at Cloverleaf Terrace LLC. Additional information was gathered through 04/23/2026. Complaint # 50854 was substantiated and complaint # 50861 was unsubstantiated. As a result of the investigation and survey, 10 deficient practices were identified, including 2 repeat deficient practices. Census: 12	N 000		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on record review and interview, the administrator did not uphold his/her responsibilities to supervise daily operations including protection of residents' health and safety and ensuring their rights are respected. Administrator A was aware Resident 1 was being targeted by Resident 2 and was sexually assaulted 4 times. The administrator did not ensure his/her supervision of daily operations	N 214		

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

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N 214	Continued From page 1	N 214		

included prompt or adequate interventions to stop the sexual assaults, minimal documentation of the incidents, investigation of each incident, that each incident was reported timely to the Department, that Resident 1's Power of Attorney for healthcare (POA C) was notified after each incident and did not follow the grievance procedure.

Findings Include:

The provider is licensed to serve residents who may have diagnoses including; traumatic brain injury, developmentally disabled, advanced aged, terminally ill, physically disabled, and/or who have irreversible dementia or Alzheimer's disease.

On 04/03/2026, the Department received a complaint alleging the provider was allowing for continued resident to resident behaviors without providing effective intervention, investigation, documentation, required reporting.

On 04/14/2026 Surveyor reviewed Resident 1 and Resident 2's records:

Resident 1 was admitted on 03/25/2024 with diagnoses including Alzheimer's disease. Resident 1 was on hospice services and had an activated Power of Attorney for Healthcare (POA C.) On 03/25/2026 the hospice RN conducted an assessment of Resident 1's ability to provide consent to a sexual relationship and found Resident 1 was not capable of providing consent.

Resident 2 was admitted on 06/22/2020 with diagnoses including a history of left Cerebral Vascular Accident which caused hemiplegia, hemiparesis and decreased capacity. Resident 2's incapacity required him/her to have a legal

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N 214	Continued From page 2 guardian (Guardian D.) Required Reporting On 03/30/2026, the Department received a self-report from the provider signed by Administrator A on 03/30/2026. The self-report was for an incident that occurred greater than 2 months prior on 01/20/2026. Additional documentation attached to the self-report titled "Administrative Notes" was dated 03/30/2026. The attachment indicated apart from the incident being reported from 01/20/2026 there had been 3 additional incidents where sexual assault occurred between Resident 1 and Resident 2. Chapter 83 codes regarding resident-to-resident incidents/misconduct note elder abuse reporting requirements and adult at risk reporting requirements, which note each individual incident required an internal investigation and self-reporting within 5 days to the Office of Caregiver Quality and/or the Department that had not been completed. Additionally, on 04/14/2026 at 11:00 AM, Surveyor interviewed Administrator A while reviewing records. Surveyor discovered in Resident 2's record there was an additional incident of sexual assault that occurred on 03/12/2026 that was not included in the self-report Administrative Notes. Administrator A confirmed the incident occurred and no investigation or self-report regarding the incident on 03/12/2026 was made. Administrator A stated s/he had been in the role of administrator for over 15 years. Administrator A stated s/he was unaware each incident of sexual assault noted in the self-report attachment and the incident discovered on 03/12/2026 required its own internal investigation and reporting within	N 214		

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5 days. Administrator A reviewed the applicable codes and stated s/he was aware of Chapter 83 codes but was unaware of the elder abuse reporting requirements and the adult at risk reporting requirements referred to within Chapter 83 regarding resident-to-resident incidents/ misconduct. Despite stating s/he was aware of Chapter 83 codes, Administrator A stated s/he did not self-report any of the incidents until s/he was told by Adult Protective Services (APS) on 03/27/2026 that a report regarding the incidents had to be submitted to "the state." The provider is responsible for being aware of all applicable codes and regulations and ensuring they are compliant at all times.

Notification
Per interview with Administrator A on 04/14/2026 at 11:30 AM and the "Administrative Notes" written by Administrator A on 03/30/2026, "Prior to the 02/10/2026 dates there were conversations in the facility with the POA but admin did not record dates or times. These happened in passing by situations or when POA was there to visit ..."

Per interview with POA C on 03/23/2026 at 5:00 PM, during the meeting on 02/10/2026, the provider only notified him/her of the incident that occurred on 01/22/2026. POA C stated on 04/02/2026 s/he was given a copy of the Administrative notes and discovered there had been multiple incidents of assault. POA C stated upon learning there had been multiple incidents, s/he demanded immediate action to protect Resident 1 or would be removing Resident 1 from the facility.

POA C stated s/he was informed on 03/23/2026 by Former Caregiver G another incident of sexual assault occurred on 03/12/2026. POA C stated

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the incident was not noted in the Administrative Notes which "raised concern about the accuracy and completeness of the facilities reporting practices." POA C stated, "When I addressed this with management, I was told the incidents had been communicated "in passing." I clearly stated that I was never informed of these incidents. Had I been properly notified, I would have immediately escalated the situation and removed my (Resident 1) from the facility..."

Documentation
On 04/14/2026 at 12:00 PM, Surveyor requested to review Resident 1 and Resident 2's records including Individual Service Plans (ISP,) incident reports, observation notes, investigations conducted, grievances, notes from meetings with outside agencies including the Managed Care Organization (MCO,) Adult Protective Services (APS,) Ombudsman and local authorities, and all documentation related to incidents that occurred between Resident 1 and Resident 2 from 01/01/2026 through present (04/14/2026.) Administrator A gave Surveyor Resident 1 and 2's ISP, Care Notes, and 2 e-mails showing correspondence from POA C to Administrator A. Administrator A stated there were no incident reports documented, or investigations conducted at the time of each witnessed sexual assault and therefore there were no additional records to review.

On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated the only documentation of the incident of sexual assault occurred in the resident care notes. Surveyor discovered the only incident documented in Resident 1's care notes was the initial incident on 01/20/2026. None of the 4 incidents where Resident 1 was sexually

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assaulted were documented within his/her records. The sexual assault incidents were only documented in Resident 2's care notes and not in Resident 1's. Administrator A acknowledged if Resident 1 began to have behaviors or negative expressions as a result of being assaulted during the time the sexual assaults were occurring, the health care team and POA C would not be able to correlate his/her behaviors to the occurrences as it was never documented in Resident 1's record that s/he was being repetitively targeted and sexual assaulted by Resident 2.

The care notes regarding the instances of sexual assault in Resident 2's record were minimal and not highlighted in a way to call attention to the incidents for intervention and monitoring. During the interview on 04/16/2026 at 10:30 AM, Administrator A stated s/he had incident reports for incidents involving unknown bruising or caregiver misconduct but had no system in place for documenting other types of significant incidents such as sexual assault or resident behaviors. After a review of the observation notes made by staff, Administrator A acknowledged the current system of documentation did not meet the minimum requirements of documentation of the incidents and did not adequately highlight the incidents separate from daily charting to flag them for continued health monitoring. Times and circumstances such as noted behaviors preceding the incident, when or if interventions were reviewed, implemented, or updated in the residents ISP, a complete list of witnesses and who was notified after the incidents by whom and when were not captured.

Resident 1's ISP (dated 04/02/2026) was sent to Surveyor on 04/15/2026. The ISP's noted under "Other" Resident 1 was to have 1 to 1 supervision

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from 2PM to bedtime to intervene for any unwanted/ unsafe contact ..." The ISP was not specific or informative of the sexual assaults that had been occurring that caused the need for the intervention. The ISP had not been updated since the 1 to 1 supervision was removed from Resident 1 on 04/07/2026.

During the interview on 04/16/2026 at 10:30 AM, Administrator A stated incident reports would be filled out when an investigation needed to be conducted and as the provider had no system to document sexual assaults in an incident report, no investigations were conducted. Administrator A stated s/he did not document any meetings, interviews, communications, directives for health monitoring, interventions or staff updates, despite being aware of Chapter 83 for minimum documentation and investigation requirements. Administrator A stated s/he had a new binder and a plan to begin documenting incidents and interactions.

Administrator A acknowledged the lack of documentation and notification in the Administrative Notes dated 03/30/2026, "Corrective action plan for missing documentation is that administration has a binder that is specifically for admin to note all communications with residents/ POA's/ guardians/ incidents. Binder for ALL staff to use specifically for incident report logs that will be checked daily by administration to reduce any miscommunication or lack of communication between staff and administration."

On 04/23/2026 at 5:00 PM, Surveyor interviewed POA C. POA C stated s/he expressed his/her concern and grievance to Administrator A on 04/02/2026, 04/07/2026 and through 04/15/2026

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N 214	Continued From page 7 when s/he removed Resident 1 from the facility. POA C stated at no time did Administrator A provide him/her with a written response to his/her grievance summarizing the findings and any actions taken to resolve the issue. Administrator A was aware on 01/20/2026 that an incident of inappropriate touch first occurred between Resident 1 and Resident 2. Administrator A allowed for passive neglect of Resident 1 by abdicating his/her responsibilities as an administrator. Administrator A did not ensure adequate reporting, grievance procedure, documentation, notification, monitoring, investigation and interventions were put into place which allowed for 4 subsequent sexual assaults to occur. Cross Reference N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0220 DHS 83.17(2)(a) Employees Screened for Communicable Disease N0277 DHS 83.25 Continuing Education N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits N0416 DHS 83.37(2)(e) Other Administration Given Or Delegated By RN N0426 DHS 83.38(1)(b) Supervision N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills N0538 DHS 83.48(3)(a) Fire Detection System Inspected Annually	N 214		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after,	N 219		

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N 219	Continued From page 8 the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. Administrator A did not obtain a response from the Department of Justice (DOJ) and a Government Findings Report (GFR) for Assistant Administrator B that included all other names by which s/he has been known and states s/he lived in within 5 years of the date of hire. Findings include: On 04/16/2026, Surveyor reviewed Assistant Administrator B's employee record including his/her background check information. Assistant Administrator B was hired on 12/08/2023 and completed a Background Information Disclosure (BID) that noted s/he had 5 names by which s/he has been known, and s/he lived in Illinois and Michigan within the last 5 years. Surveyor reviewed there was 1 DOJ response dated 07/02/2024 (approximately 7 mnths after hire) that listed only 2 of the 5 names for Assistant	N 219		

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N 219	Continued From page 9 Administrator B. On 04/16/2026 at 12:30 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was responsible for completing all caregiver background checks for employees. Administrator A stated s/he must have missed completing the background check when Assistant Administrator B was hired and submitted later in the year (July 2024.) Administrator A stated s/he was unaware each of the 5 aliases documented on the BID needed to be checked. Administrator A confirmed s/he did not conduct an out of state background check for Assistant Administrator B for Illinois or Michigan. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 219		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.	N 220		

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N 220	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees reviewed (Assistant Administrator B, Caregiver D, and Caregiver E) were screened for tuberculosis and communicable disease by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse. Findings include: On 04/14/2026 and 04/16/2026, Surveyor conducted a standard survey. Surveyor reviewed Assistant Administrator B's employee record and noted s/he was hired on 12/08/2023. There was no evidence in Assistant Administrator B's record s/he was screened for communicable disease or tuberculosis. Surveyor reviewed Caregiver D's employee record and noted s/he was hired on 12/05/2024. There was no evidence in Caregiver D's record s/he was screened for tuberculosis. Caregiver D had a filled out communicable disease screening sheet that was undated and unsigned. Surveyor reviewed Caregiver E's employee record and noted s/he was hired on 01/22/2024. Of the required 2 step tuberculosis screening, Caregiver E had only 1 step completed. Caregiver D had a filled out communicable disease screening sheet that was undated and unsigned. On 04/16/2026 at 12:30 PM, Surveyor interviewed Administrator A who acknowledged all 3 caregivers reviewed were missing completed tuberculosis and communicable disease screenings.	N 220		

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N 220	Continued From page 11 Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 220		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Assistant Administrator B received at least 15 hours of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and include, at a minimum, standard precautions, client group related training, medications, resident rights, prevention and reporting of abuse, neglect and misappropriation, fire safety and emergency procedures including first aid. Findings include: On 04/16/2026, Surveyor reviewed Assistant Director B's employee record and noted s/he was	N 277		

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N 277	Continued From page 12 hired on 12/08/2023 as an Assistant Director who would also provide direct resident care. Assistant Administrator B's record did not include evidence of any continuing education in 2025. On 04/16/2026 at 11:00 AM, Surveyor interviewed Administrator A who said s/he supervised the training of all the staff. Administrator A stated s/he tried to do various training topics at team meetings. Surveyor inquired whether s/he had any documentation of the training/meetings, and s/he said no. Surveyor inquired whether Assistant Director B received any continuing education in 2025 and s/he said no. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 277		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 out of 2 residents reviewed (Resident 1 and Resident 2) had annual evacuation evaluations completed. The facility is licensed as a Class C non-ambulatory (CNA). A class C non-ambulatory CBRF serves residents who are ambulatory, semi-ambulatory or non-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting	N 394		

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N 394	Continued From page 13 the CBRF without help or verbal or physical prompting. The provider is licensed to serve residents who may have diagnoses including; traumatic brain injury, developmentally disabled, advanced aged, terminally ill, physically disabled, and/or who have irreversible dementia or Alzheimer's disease. Findings include: On 04/16/2026 at 1:00 PM, Surveyor reviewed resident records while interviewing Administrator A. Surveyor requested to review the evacuation evaluation documentation for Residents 1 and 2. Administrator A stated s/he was unaware the resident evacuation evaluations had to be reviewed annually. Administrator A showed Surveyor the most recent records the provider had for the residents. Surveyor reviewed Resident 1's most recent evacuation evaluation was dated 03/27/2024. Administrator A confirmed an evacuation evaluation for 2025 was not completed. Surveyor reviewed Resident 2's most recent evacuation evaluation was dated June of 2021. Administrator A confirmed the evacuation evaluations for 2022, 2023, 2024, and 2025 were not completed. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills	N 394		
N 416	83.37(2)(e) Other administration given or delegated by RN	N 416		

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N 416	Continued From page 14 Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure unlicensed caregivers were delegated by a Registered Nurse (RN) prior to administering injectable medications for Residents 3 and 4. Findings Include: The provider is licensed to serve residents who may have diagnoses including, traumatic brain injury, developmentally disabled, advanced aged, terminally ill, physically disabled, and/or who have irreversible dementia or Alzheimer's disease. On 04/16/2026 at 12:00 PM, Surveyor interviewed Administrator A while reviewing the provider's records, including employee files and training. Administrator A provided Surveyor with a list of employees with their dates of hire and noted 9 of 15 of the employees were responsible for passing medication, including injections. Administrator A confirmed the provider serves residents that require insulin injections while identifying Resident 3 and Resident 4 as both requiring daily insulin injections to be administered by the any of the 9 medication passing staff. Administrator A stated the previous RN left	N 416		

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N 416	Continued From page 15 employment with the provider around the beginning of June of 2024. Administrator A stated 5 medication passers out of 9 would have RN delegation training from the previous RN but there had not been another RN to delegate under their license since June of 2024. Administrator A confirmed all medication passers hired after June 2024 did not have RN delegation for passing injectable medications to Resident 3 and 4. Administrator A was unable to provide a record for RN delegation training for Caregiver H (hired 06/17/2024,) Caregiver D (hired 12/05/2024,) Caregiver I (hired 04/13/2026,) or Caregiver J (hired 10/10/2025.) Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0277 DHS 83.25 Continuing Education	N 416		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review, interview, and	N 426		

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N 426	Continued From page 16 observation, the provider did not ensure supervision and behavior management adequate to meet the resident's needs. The provider was aware Resident 2 sexually assaulted Resident 1 and did not effectively intervene to prevent at least 3 additional assaults (4 witnessed in total.) Findings include: The provider is licensed to serve residents who may have diagnoses including; traumatic brain injury, developmentally disabled, advanced aged, terminally ill, physically disabled, and/or who have irreversible dementia or Alzheimer's disease. On 04/03/2026, the Department received a complaint alleging the provider was allowing for continued resident to resident behaviors without providing effective intervention or reporting. On 04/14/2026 at 12:00 PM, Surveyor requested to review Resident 1 and Resident 2's records including Individual Service Plans (ISP,) incident reports, observation notes, investigations conducted, grievances, notes from meetings with outside agencies including the Managed Care Organization (MCO,) Adult Protective Services (APS,) Ombudsman and local authorities, and all documentation related to incidents that occurred between Resident 1 and Resident 2 from 01/01/2026 through present (04/14/2026.) Administrator A gave Surveyor Resident 1 and 2's ISP, Care Notes, 2 e-mails showing correspondence from Resident 1's Power of Attorney for Healthcare (POA C) to Administrator A, and a copy of a self-report including "Administrative Notes" that were written on 03/25/2026. Administrator A stated there were no incident reports or investigations conducted and therefore no additional records to review.	N 426		

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N 426	Continued From page 17 Surveyor reviewed the records received and noted: Resident 1 was admitted on 03/25/2024 with diagnoses including Alzheimer's disease. Resident 1 was on hospice services and had an activated Power of Attorney for Healthcare (POA C.) On 03/25/2026 the hospice RN conducted an assessment of Resident 1's ability to provide consent to a sexual relationship and found Resident 1 was not capable of providing consent. Resident 2 was admitted on 06/22/2020 with diagnoses including a history of left Cerebral Vascular Accident which caused hemiplegia, hemiparesis and decreased capacity. Resident 2's incapacity required him/her to have a legal guardian (Guardian D.) Timeline: On 04/14/2026 at 11:30 AM and 04/16/2026 at 10:30 AM, Surveyor Interviewed Administrator A. On 04/23/2026 At 5:00 PM, Surveyor interviewed POA C. Administrator A stated the provider relied on daily "care notes" in the resident's individual records and shift-to-shift discussions to communicate between caregivers. Administrator A gave Surveyor "Administrative Notes" written by Administrator A on 03/30/2026. Surveyor conducted interviews and reviewed the records to establish a timeline of events: 1/20/2026 In Resident 1's care notes dated 01/20/2026, Caregiver D noted Resident 1 was observed placing Resident 2's hand on his/her chest. Caregiver D noted Resident 2 was told to remove his/her hand and that Administrator A was updated about the incident. No interventions or	N 426		

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additional information was documented.

On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated at the time on 01/20/2026, the provider did not believe the incident was indicative of possible sexual behavior and believed it was a one-time occurrence that was documented for other staff members to be aware of. Administrator A stated s/he did not inform POA C of the incident as at the time s/he did not believe it merited a notification.

01/22/2026
In Resident 1's care notes dated 01/22/2026, Caregiver E noted Resident 2 was discovered with his/her hand up Resident 1's shirt. Caregiver E noted approximately 20 minutes later Resident 2 was found to have sought out Resident 1 and had his/her hand on Resident 1's wheelchair arm. Caregiver E noted Resident 2 was asked to leave Resident 1 alone and when s/he did not, Caregiver E supervised the residents. No notes indicated Administrator A or POA C were notified. Notes from the next shift (Caregiver D) noted Resident 2 continued to seek out Resident 1's company.

On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated when s/he was made aware of the incident (on 01/23/2026) by reviewing the 01/22/2026 care notes and discussions with staff members s/he did not recall updating Resident POA C about the witnessed incident and did not implement interventions to safeguard the residents.

01/27/2026
In Resident 1's care notes dated 01/27/2026, Caregiver D noted Resident 2 continued to seek

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out Resident 1's company, coming physically close to Resident 1 at the dining room table. Caregiver D noted when s/he walked away and came back around the corner Resident 2 had his/her hand down Resident 1's pants. Caregiver D noted Administrator A was notified.

On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated on 01/27/2026, s/he believed s/he notified POA C regarding the incidents "in passing" by alluding to POA C that there was an issue but stated s/he did not discuss the incidents in detail with POA C at the time. Administrator A stated when s/he found out about the witnessed incident on 01/27/2026 was when s/he believed the matter was "serious" enough to merit a discussion with POA C. Administrator A stated no meeting or formal discussion was had until 02/10/2026.

01/28/2026
In Resident 1's care notes dated 01/28/2026, Caregiver F noted Resident 2, "cont. [sic] touching another resident inappropriately after being told not to." During an interview with Caregiver F on 04/16/2026 at 1:00 PM, Caregiver F stated although no formal interventions had been put into place, s/he felt s/he needed to "watch" Resident 2 more closely because s/he "caught" him/her attempting to touch Resident 1, requiring Caregiver F's intervention.

On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated on 01/28/2026 s/he did not implement interventions or notify POA C of the continued potential for behaviors targeting Resident 1. The continued targeting was not included in Administrator A's Administrative Notes.

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N 426	Continued From page 20 02/08/2026 In Resident 1's care notes dated 02/08/2026, Caregiver D noted Administrator A was notified after Caregiver F discovered Resident 2 had his/her hand up Resident 1's shirt. On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated on 02/08/2026, the POA was not immediately notified and no interventions were put into place at the time. 02/09/2026 On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated on 02/09/2026 s/he called POA C to ask to set up a meeting. 02/10/2026 (Discrepancy: Per interview with Administrator A on 04/16/2026 at 10:30 AM, and the "Administrative Notes" written By Administrator A on 03/30/2026, "Prior to the 02/10/2026 dates there were conversations in the facility with the POA but admin did not record dates or times. These happened in passing by situations or when POA was there to visit ..." Per interview with POA C on 03/23/2026 at 5:00 PM, during the meeting on 02/10/2026, the provider only notified him/her of the incident that occurred on 01/22/2026. POA C stated on 04/02/2026 s/he was given a copy of the Administrative notes and discovered there had been multiple incidents of assault. POA C stated upon learning there had been multiple incidents, s/he demanded immediate action to protect Resident 1 or would be removing Resident 1 from the facility.) On 04/16/2026 at 10:30 AM, Surveyor	N 426		

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interviewed Administrator A. Administrator A stated on 02/10/2026 s/he and Assistant Administrator B met with POA C and notified him/her of the incident that occurred on 01/22/2026. At this time on 02/10/2026, a plan was put into place to increase monitoring of Resident 1, including not leaving Resident 1 alone in the common area of the facility and/or placing him/her in his/her room when not able to be in the caregiver's visual control.

The intervention did not address Resident 2's behaviors or supervision needs, or ensure all residents were safe.

02/20/2026
On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated on 02/20/2026 the provider discussed the situation with the local ombudsman who gave the provider a form to conduct an assessment to see if Resident 1 was competent to give consent. Administrator A stated as no one on the staff was an RN they did not conduct the assessment tool and instead waited until the Hospice RN conducted the assessment on 03/25/2026.

03/12/2026
Resident 2's care notes dated 03/12/2026 Caregiver H detailed a subsequent event that occurred on 03/12/2026 that was not included in the Administrative Notes. Caregiver H noted s/he came out of the medication room to witness Resident 2 inappropriately touching Resident 1.

On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated s/he accidentally missed documenting the incident that occurred on 03/12/2026 in his/her Administrative Notes. Administrator A was aware

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of the incident and stated on 03/12/2026, Former Caregiver G was assigned to monitor the resident's and when s/he had his/her backed turned in the kitchen Caregiver C came out of the medication room to find Resident 2 touching Resident 1. Administrator A stated POA C was not notified about the incident.

03/23/2026
On 04/23/2026 at 5:00 PM, Surveyor interviewed POA C. POA C stated on 03/23/2026 s/he was present at the facility and was informed by Former Caregiver G about the incident that occurred on 03/12/2026. POA C stated on 03/23/2026, after being informed about the incident that occurred on 03/12/2026, s/he called Administrator A and had an in-person meeting with Assistant Administrator B and asked if there had been any other incidents since the incident that occurred on 01/22/2026 (that s/he was notified about on 02/10/2026.) POA C stated both Administrator A and Assistant Administrator B denied any incident other than the incident that had been reported from 01/22/2026.

03/25/2026
On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A and on 04/23/2026 at 5:00 PM, Surveyor interviewed POA C. Per interviews with Administrator A and POA C, the local police were called on 03/25/2026 to conduct an investigation into alleged resident-to-resident sexual assault. POA C and Hospice services were present at the facility when the Hospice RN conducted the assessment to determine if Resident 1 was capable of consent. The determination was made that Resident 1 was unable to consent. The provider placed 1 to 1 supervision on Resident 1 from 2nd shift from "2 PM to bedtime."

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N 426	Continued From page 23 The intervention was placed on Resident 1 instead of Resident 2 who had the behavior. It did not take into account the other times of the day that 1 to 1 supervision was not provided or the protection of other residents who were also vulnerable and may be at risk. Administrator A stated no investigation was conducted and s/he did not recognize placing the 1 to 1 on Resident 2 would be more effective or that Resident 1 may be offending at other times or with other residents. 03/27/2026 On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated on 03/27/2026 s/he called APS to discuss the incidents and ask if a report needed to be made. 03/30/2026 The Department received a self-report from the provider that included the Administrative Notes indicating the provider was aware the first inappropriate resident-to-resident contact was made on 01/20/2026 with subsequent incidents occurring on 01/22/2026, 01/27/2026, and 02/08/2026 (no record of the incident that occurred on 03/12/2026 was noted on the self-report.) 04/01/2026 On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated on 04/01/2026 the local ombudsman came to the facility to provide the staff with resident rights and HIPAA training. 04/02/2026 On 04/23/2026 at 5:00 PM, Surveyor interviewed	N 426		

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N 426	Continued From page 24 POA C. POA C stated on 04/02/2026 Assistant Manager B gave POA C the administrative notes which indicated there had been incidents in addition to 01/22/2026 including the initial contact on 01/20/2026, and subsequent incidents on 01/27/2026 and 02/08/2026 (omitting the incident on 03/12/2026.) 04/07/2026 On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated on 04/07/2026 APS came to the facility and determined 1 to 1 supervision of Resident 2 was appropriate to ensure all resident's safety at all times. The part-time 1 to 1 supervision on Resident 1 was discontinued and 1 to 1 supervision for 24 hours a day of Resident 2 began. 04/11/2026 On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated A notification was created on 04/11/2026 for the employees to sign as an attestation of acknowledgment. The notification was tilted "Change In Plan Of Action" "After recently meeting with ... APS the recommendation has changed and it is the recommendation that a one-on-one be placed with [Resident 2] ... Doing this ensures safety of ALL residents rather than just one or the other ... during your one-on-one sessions you must not leave being able to see [Resident 2] ... Please sign acknowledgement for right now and we as administration will meet with you guys going into next week with more thorough information related to the job description of the one-on-one." The notice was created 4 days after the 1:1 supervision was directed to begin on 04/07/2026.	N 426		

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N 426	Continued From page 25 04/15/2026 On 04/16/2026 at 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated on 04/15/2026 POA C removed Resident 1 from the provider's services and left the facility. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 426		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted quarterly including at least one drill simulating the conditions during usual sleeping hours in 2025.	N 525		

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N 525	Continued From page 26 This is a repeat deficient practice. See Statement of Deficiency JZXY11 dated 07/19/2024. Findings include: The facility is licensed as a Class C non-ambulatory (CNA). A class C non-ambulatory CBRF serves residents who are ambulatory, semi-ambulatory or non-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. The provider is licensed to serve residents who may have diagnoses including, traumatic brain injury, developmentally disabled, advanced aged, terminally ill, physically disabled, and/or who have irreversible dementia or Alzheimer's disease. At the time of the survey the census was 12. On 04/16/2026, Surveyor reviewed the provider's records for fire drills at the facility. There was evidence 3 out of 4 required fire drills were completed in 2025 (dated 01/27/2025, 06/09/2025, and 08/28/2025.) There were no drills that indicated nighttime simulation. On 04/16/2026 at 11:30 AM, Surveyor interviewed Administrator A. Administrator A confirmed there was no evidence of a drill conducted in Quarter 4 of 2025 or a nighttime simulated drill. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0394 DHS 83.35(5)(b) Annual Evaluation Of Evacuation Limits N0526 DHS 83.47(2)(e) Other Evacuation Drills	N 525		

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N 526	Continued From page 27	N 526		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure emergency or disaster evacuation drills were conducted semi-annually in 2025. This is a repeat deficient practice. See Statement of Deficiency JZXY11 dated 07/19/2024. Findings include: The facility is licensed as a Class C non-ambulatory (CNA). A class C non-ambulatory CBRF serves residents who are ambulatory, semi-ambulatory or non-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. The provider is licensed to serve residents who may have diagnoses including, traumatic brain injury, developmentally disabled, advanced aged, terminally ill, physically disabled, and/or who have irreversible dementia or Alzheimer's disease. At the time of the survey the census was 12. On 04/16/2026, Surveyor reviewed the provider's records for emergency drills at the facility. There was no evidence of emergency or disaster drills being completed in 2025. On 04/16/2026 at 11:30 AM, Surveyor interviewed Administrator A. Administrator A confirmed there	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015404	A. BUILDING: _____ B. WING _____	C 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVERLEAF TERRACE LLC	401 CENTER ST BIRNAMWOOD, WI 54414

(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 526	Continued From page 28 were no emergency or disaster drills completed in 2025. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0525 DHS 83.47(2)(d) Fire Drills	N 526		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire detection systems were inspected and tested annually by certified personnel. Findings include: The facility is licensed as a Class C non-ambulatory (CNA). A class C non-ambulatory CBRF serves residents who are ambulatory, semi-ambulatory or non-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. The provider is licensed to serve residents who may have diagnoses including, traumatic brain injury, developmentally disabled, advanced aged, terminally ill, physically disabled, and/or who have irreversible dementia or	N 538		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015404	A. BUILDING: _____ B. WING _____	C 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVERLEAF TERRACE LLC	401 CENTER ST BIRNAMWOOD, WI 54414

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N 538	Continued From page 29 Alzheimer's disease. On 04/16/2026, Surveyor reviewed the provider's records for fire safety maintenance. There was no evidence of an annual inspection of the fire detection system for 2024 or 2025. On 04/16/2026 at 12:00 PM, Surveyor interviewed Administrator A. Administrator A confirmed no inspection of the fire detection system occurred in 2024 or 2025. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 538		