

Wisconsin Department of Health Services

|                                                             |                                                                                                                                                                                                   |                                                                             |                                                                                                                          |                          |                                                                    |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0017504</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>02/02/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CASTLE MANOR III</b> |                                                                                                                                                                                                   |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2319 W GRANGE AVE</b><br><b>GREENFIELD, WI 53221</b>                         |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                      | ID<br>PREFIX<br>TAG                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| M 000                                                       | <b>INITIAL COMMENTS</b><br><br>On 02/02/2026, Surveyor conducted 4 complaint investigations and an abbreviated survey. Four of 4 complaints were unsubstantiated. No deficiencies were identified | M 000                                                                       |                                                                                                                          |                          |                                                                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE