

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Clement Manor Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3939 S 92nd St Greenfield, WI 53228	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interviews, record review, facility policy review, and review of the facility's investigation, the facility failed to ensure two residents (Resident (R)2 and R5) of nine residents reviewed for abuse, were free from physical abuse. R2 physically abused R5 on 09/04/25. R5 physically abused R2 on 10/30/25. This had the potential to cause emotional and/or physical harm to both R2 and R5. Findings include: 1. Review of R2's electronic medical record (EMR) referred to as a dashboard indicated the facility admitted the resident on 08/06/21. Review of a document provided by the facility for R2 titled comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/14/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 which revealed the resident was severely cognitively impaired. The resident had no behaviors directed to self or to others during this assessment period. The resident was dependent on staff for activities of daily living. A review of a document provided by the facility for R2 titled, Interdisciplinary Notes, dated 09/04/25, indicated R2 approached Licensed Practical Nurse (LPN) 1 and asked LPN1 to take R5 outside and kill her. LPN1 directed R2 not to speak that way and was moved away from R5. R2 then wheeled herself to R5 and kicked R5's wheelchair and again was separated. Verbal redirection was provided to R2. LPN1 documented that nursing walked off the unit and R2 then approached R5 and pulled her hair and would not let go. LPN1 documented staff intervened and removed R2 from R5. Review of a document provided by the facility for R2 titled, Interdisciplinary Notes, dated 10/31/25, indicated on 10/30/25, R2 was in the dining room when R5 approached her and began to pinch the back of her hand. R5 then attempted to run R2's feet over with R5's wheelchair. Both residents were immediately separated. R2 was assessed and sustained no injuries. LPN3 wrote this entry. 2. Review of R5's EMR referred to as a dashboard indicated the facility admitted the resident on 07/12/22. Review of a document provided by the facility for R5 titled quarterly, MDS with an ARD of 08/14/25, indicated the resident had a BIMS score of one out of 15 which revealed the resident was severely cognitively impaired. The resident had no behaviors directed to self or to others during this assessment period. Review of a document provided by the facility for R5 titled, Interdisciplinary Notes, dated 09/04/25, written by LPN1 indicated R5 was sitting in the dining room when R2 approached R5 and pulled her hair and would not let go. R5 was assessed and sustained no injuries. Review of a document provided by the facility for R5 titled, Interdisciplinary Notes, dated 10/30/25, LPN3 noted R5 attempted to run over R2's feet with R5's wheelchair. A review was conducted of the facility's undated investigation titled, Summary, (referenced to 09/04/25) indicated R2 approached R5 and pulled her hair. R2 was removed from the dining area. Calls were placed to the administrative staff. The State Survey Agency (SSA) was notified along with the physician and the resident's responsible party. R5 was assessed and had no injuries. Both residents did not recall the incident. Both were assessed psychosocially by the Social Services Director (SSD), and both were referred to psychiatric services. There were no further recommendations made at this time. There was evidence that the</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 525327	If continuation sheet Page 1 of 4

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>facility interviewed other residents and staff as part of their investigation. A review was conducted of the facility's undated investigation titled, Summary (referenced to 10/30/25 resident to resident altercation) indicated that R2 was in the dining room and R5 told her to get out of the way. Certified Nursing Assistant (CNA)5 observed R5 pinching the back of R2's hand and then attempted to run over R2's feet. There was evidence that both residents' physician and representatives were notified of the resident-to-resident altercation. There was evidence that the facility completed interviews with staff and residents. There was evidence that the facility notified the State Survey Agency timely initially and then provided a five-day summary. During an interview on 02/11/26 at 9:19 AM, CNA5 confirmed she had observed the 10/30/25 incident that involved R5 and R2. CNA5 stated R5 intentionally placed her hands on R2's hands and pinched her. CNA5 stated she considered R5's action to R2 was abuse since the act was intentional from R5 to R2. CNA5 stated R2 was crying as a result. During an interview on 02/11/26 at 10:18 AM, CNA10 confirmed she witnessed R2 pulling the hair of R5 on 10/30/25, CNA10 stated R2 would not let go of R5's hair and R5 could not pull away from R2. CNA10 confirmed the resident-to-resident altercation that involved R2 and R5 was abuse. During an interview on 02/11/26 at 11:09 AM, the SSD and the Social Services Assistant (SSA) confirmed that the resident-to-resident altercation that happened on 09/04/25 and 10/30/25 and involved R2 and R5 were both considered abuse. During an interview on 02/11/26 at 10:25 AM, the Administrator stated she was the one who completed the abuse investigation and this included gathering written statements and determined that abuse occurred with both resident-to-resident altercations that involved R2 and R5. Review of a facility's policy titled, Freedom from Abuse, Neglect, Exploitation, Misappropriation of Property dated 03/25, indicated .Residents will not be subjected to abuse by anyone, including staff; other residents; consultants, or volunteers.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on record review, interview, and facility policy review, the facility failed to have a physician ordered medication available for administration for one of one resident (Resident (R) 5). The facility failed to decrease the order of Eliquis (blood thinner) when the physician ordered Paxlovid (an antiviral). The potential when administering Paxlovid in conjunction with Eliquis increased the risk for severe bleeding. Findings include: Review of R4's electronic medical record (EMR) referred to as the EMR dashboard indicated the facility admitted the resident on 04/07/22. Review of document provided by the facility titled, Physician Orders, dated 12/24/25, indicated the Medical Director ordered Eliquis 5 milligrams (mg) to be administered every 12 hours for a history of deep vein thrombosis (DVT). The order indicated the last dose was to be administered on 02/11/26. Review of a document provided by the facility for R4 titled, Medication Record for 02/2026, indicated the resident was administered Eliquis 5 mg every 12 hours. The AM dose of Eliquis was held on 02/04/26 through 02/08/26. The Medication Record indicated the PM dose of Eliquis 5mg was held on 02/03/26, 02/04/26, 02/05/26, and again on 02/08/26. The resident was administered Eliquis 5mg on 02/06/26, and on 02/07/26. Review of a document provided by the facility for R4 titled, Physician Orders, dated 02/02/26 indicated that the Medical Director ordered Paxlovid 150 mg-100 mg tablets in a dose pack to be administered twice a day for four days. Review of a document provided by the facility for R4 titled, Medication Record for 02/2026 indicated the resident was administered both the AM and PM Paxlovid doses from 02/02/26 until 02/06/26. Review of a document provided by the facility for R4 titled, Physician Orders, dated 02/03/26, indicated that the Medical Director ordered Eliquis 2.5 milligrams to be administered twice a day, times eight days. The document indicated the last dose administered was on 02/08/26. Review of a document provided by the facility for R4 titled, Medication Record for 02/2026, indicated the resident was administered Eliquis 2.5 mg every 12 hours. The AM doses were administered from 02/04/26 to 02/08/26. The PM doses were administered from 02/03/26 until 02/08/26. Review of a document provided by the facility for R4 titled, Medication Incident Report, dated 02/09/26, indicated that the facility discovered that three doses of Eliquis 5mg on the PM shift were administered when it should have been held. The incident report revealed that R4 was to receive Eliquis 2.5mg from 02/01/26 to 02/08/26. Licensed Practical Nurse (LPN)3 was involved in the medication error. Registered Nurse (RN)1 was the staff member who identified the error. In addition, the resident received Eliquis 7.5mg for three days in which the PM dose was not held. The Medical Director was notified of the error and directed the staff to monitor the resident for signs of bleeding and lightheadedness. During an interview on 02/11/26 at 2:22 PM, LPN3 confirmed that she was involved in the medication error with R4. LPN3 stated normally when the Medical Director orders a prescription the pharmacy or the Medical Director will notify the staff of the medication change. LPN3 stated she was unaware of the reduction of the Eliquis from 5mg to 2.5mg. LPN3 stated she received the Eliquis 2.5mg and returned it back to the pharmacy since she was unaware of the new order. LPN3 stated the Medical Director ordered Paxlovid for R4 since the resident had COVID-19. LPN3 stated that there was potential for negative interaction and this was the reason for the decrease in the Eliquis from 5mg to 2.5mg. LPN3 stated once she became aware of the new order, she wrote the order for Eliquis 2.5mg two times a day for eight days. LPN3 stated the new order for Eliquis was administered correctly for five days on the morning shift. LPN3 stated she did not order the Eliquis 5mg to be held on the evening shift. During an interview on 02/11/26 at 3:02 PM, RN1 stated what she heard was that the Medical Director made a dose reduction of the Eliquis 5mg to 2.5mg and the pharmacy did not alert the nursing staff. During an interview on 02/11/25 at 3:23 PM, RN3, a nurse supervisor stated she</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>completed an investigation on the medication error and determined the Medical Director put in for a reduction of the Eliquis 5mg to 2.5mg due to R4 being placed on Paxlovid and there was a communication failure. RN3 stated she was unsure why the Medical Director did not contact the nursing staff for the medication reduction. RN3 stated the facility was still investigating the medication error. During an interview on 02/12/26 at 8:53 AM with the Lead Consultant Pharmacist she stated that on 02/01/25 the pharmacy received an order for the Paxlovid from the Medical Director. The Lead Consultant Pharmacist stated that the medication order for the Paxlovid created a level one flag since it was considered a possible medication interaction since R4 was on Eliquis. The Lead Pharmacy Consultant stated that a pharmacist contacted the Medical Director to alert him of the possible interactions, and that was when the Medical Director ordered the Eliquis to be decreased to 2.5mg for eight days. The Lead Consultant Pharmacist stated her expectation was to have the pharmacist then contact the facility to alert the nursing staff of the new order change. During an interview on 02/12/26 at 9:39 AM, with RN2, Director of Nursing (DON)2, stated that the medication error of R4 being administered Eliquis 7.5mg was made by LPN6, who was new to the facility. RN2 stated that LPN6 had not been contacted yet for the medication error. RN2 stated LPN6 administered Eliquis 7.5 mg on 02/06/26 and again on 02/07/26. Review of a facility policy titled Provider Pharmacy-Requirements undated indicated . Policy Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies. Accurately dispensing prescriptions based on authorized prescriber orders. Screening each new medication order for an appropriate indication or diagnosis, for drug interactions withother medications ordered for the resident; for duplication of therapy with other drugs in the same therapeutic class ordered for the resident; and for appropriate drug dose, dosing interval, and route of administration, based on resident and other pertinent variables. If diagnosis or indication is not available, notifying the nursing staff of the need to obtain the information from the prescriber.</p>		