STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525348	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Health and Rehabilitation Center	70 Greentree Rd Clintonville, WI 54929

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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and policy review, the facility failed to timely report an allegation of physical abuse for 2 residents (R) (R1 and R2) of 3 sampled residents. On 7/24/25 at approximately 6:30 AM, R1 put R1's arms around R2's neck, pulled R2 toward R1, and pinched R2's ear. Staff stated R2 appeared upset and did not want the interaction to occur. Staff did not report the abuse until another incident occurred that afternoon. Findings include:Review of the facility's Abuse Prevention policy, dated 7/2024, indicated it is the policy of the facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, resident representatives, families, friends, or other individuals. All alleged violations will be reported via phone or in writing within two hours to the State LicensingAgency.Review of R1's Face Sheet indicated R1 was readmitted to the facility on [DATE] with diagnoses including mental disorder, schizophrenia, major depressive disorder, and cognitive communication deficit.Review of R2's Face Sheet indicated R2 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, and chronic kidney disease. Review of a Misconduct Incident Report provided by the facility, dated 7/30/25 at 2:36 AM, indicated that while investigating an incident between R1 and R2 on 7/24/25 at approximately 3:55 PM, the facility discovered another incident that occurred that morning at approximately 6:30 AM. The incident was witnessed by staff but not reported. During an interview on 10/9/25 at 11:28 AM, Licensed Practical Nurse (LPN)1 stated on the morning of 7/24/25 at approximately 6:30 AM, R2 was tearful when another staff informed LPN1 they saw R1 pinch R2's ear. LPN1 said R1 put R1's arms around R2's neck and pulled R2 toward R1. When R2 became upset about the interaction, R1 pinched R2's ear. LPN1 stated LPN1 observed R2 who appeared upset and did not want the interaction to occur. LPN1 stated the residents were separated, however, LPN1 did not report the abuse it until it happened again that afternoon. LPN1 agreed LPN1 should have reported the first occurrence which may have prevented the second occurrence. During an interview on 10/9/25 at 1:13 PM, the Director of Nursing (DON) stated staff should have reported the incident that occurred on the morning of 7/24/25.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525348	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Health and Rehabilitation Center	70 Greentree Rd Clintonville, WI 54929

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and policy review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Level II referral was completed after a significant change in mental status for 1 resident (R) (R1) of 1 resident reviewed. A psychiatric evaluation on 7/23/25 indicated R1 had self-injurious behaviors and hit/pinched others. The evaluation contained recommendations to increase R1's divalproex (anticonvulsant medication) and quetiapine (antipsychotic medication). A PASARR Level II referral was not completed.Findings include:Review of the facility's Resident Assessment - Coordination with PASARR Program policy, dated 7/24, revealed the facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. Any Level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review. Examples include: a. A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms. A resident whose condition or treatment is or will be significantly different from that described in the resident's most recent PASARR Level II evaluation and determination.Review of R1's Face Sheet indicated R1 was readmitted to the facility on [DATE] with diagnoses including mental disorder, schizophrenia, major depressive disorder, and cognitive communication deficit.Review of R1's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 9/2/25, indicated R1 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R1 had severe cognitive impairment. Review of R1's State of Wisconsin Department of Human Services Pre-admission Screening and Resident Review (PASARR) Level I Screen, dated 3/24/24, indicated R1 did not meet the criteria for Level II because R1 did not meet the criteria for sections two and three.Review of R1's Psychiatric Evaluation, dated 7/23/25, indicated R1 was evaluated due to behaviors including self-injurious behavior and hitting and pinching others. The evaluation contained recommendations to increase divalproex (anticonvulsant medication) and quetiapine (antipsychotic medication) and evaluate the appropriateness of R1's current level of care. Review of Progress Notes between May 2025 and October 2025 indicated R1 had 16 documented incidents of self-harm, 11 incidents of aggression toward staff, 4 incidents involving other residents, and 9 incidents of different behaviors. During an interview on 10/9/25 at 2:09 PM, the Social Services Director (SSD) was aware of R1's increase in behaviors, however, it did not occur to her to check if R1 needed a PASARR Level II referral. During an interview on 10/9/25 at 1:13 PM, the Director of Nursing (DON) stated she attended R1's July psych meeting. The DON stated the facility was aware of R1's behaviors, had been trying to address them, and was in the process of finding alternate placement for R1. The DON was unsure of the PASARR process.