STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525508	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Meadow Park Hcc	709 Meadow Park Dr Clinton, WI 53525

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. (continued on next page)

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, and including injuries of unknown source, are reported immediately for 1 of 3 residents (R) reviewed for abuse (R1).R1 had an injury of unknown source on 11/7/25 and 11/9/25 that the facility was aware of and did not report the injuries of unknown source to the State Agency. This is evidenced by: The facility's policy Abuse Prevention and Reporting Policy, dated 11/25, includes: I. Purpose To ensure all residents are free from abuse, neglect. This policy establishes clear expectations for the prevention, identification, investigation, and reporting of all allegations or reasonable suspicions of mistreatment. IV. Identification and Reporting 3. Nursing staff must report bruising of unknown origin or other abnormalities. 4. The nursing supervisor is responsible for assessing and reporting such occurrences. 8. Reporting to Other Agencies Wisconsin Division of Quality Assurance (DQA): Must receive the initial allegation report immediately and a five-day final investigation report including findings and corrective actions. R1 admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive brain disorder affecting movement), neuralgia (intense nerve pain), dementia (a cognitive decline affecting memory, thinking, language, and daily function), fibromyalgia (a chronic condition causing widespread body pain, fatigue, sleep issues, and cognitive difficulties), and history of falling. R1's 11/7/25 2:47 PM nurse progress note states, Patient was assessed by DR D (DDS) (Dentist) today. No pain or discomfort reported during assessment. [Company Name] x-ray report was faxed, no new orders were given at this time, dentist recommended no further action unless tooth bother patient. POA [Name] was informed and is in agreement with no further dental work at this time. On 12/16/25 at 11:59 AM, Surveyors interviewed BOM G (Business Office Manager). BOM G indicated on 11/7/25, she used a transport wheelchair and wheeled R1 to the dentist for an appointment. BOM G indicated the dental office was only a couple of blocks from the facility. BOM G indicated R1's wheelchair was too wide to fit through the exam room door, so the dentist provided information to R1 and BOM G in the lobby. BOM G indicated she wheeled R1 back to the facility. BOM G indicated there was no incident that occurred during the transportation to, at, or from the dental office. On 12/16/25 at 11:09 AM, Surveyors interviewed DR D (Dentist) regarding R1's 11/7/25 visit. DR D indicated 2 staff members walked R1 to his office and he spoke with them at length about what he would need to be able to see R1, including a smaller wheelchair. DR D indicated R1's wheelchair was too wide to fit through the exam room door. DR D indicated he spoke with R1 in the lobby. DR D measured both the main door and the exam room door. DR D indicated the main door is 5 or 6 inches wider than the exam door so there should have been no difficulties getting the wider wheelchair into the main door. DR D and his staff do not recall an incident or R1 stating she bumped her leg. DR D indicated R1 had no sign of injury while R1 was waiting in his lobby. R1's hospice note, written by HRN M (Hospice Registered Nurse) dated 11/7/25 at 5:30 PM, includes: Patient verbalized pain to RLE (Right Lower Extremity). Writer asked patient what happened, replied I was out for a walk today and twisted my knee on the uneven sidewalk. Patient is non-ambulatory, hoyer lift (Full body mechanical lift) for transfers and broda chair (a specialized wheelchair designed for comfort, support, and safety) for positioning and comfort. Edema noted to BLE (Bilateral Lower Extremity), 3+ to RLE, 2+ to LLE (Left Lower Extremity). no issues reported by staff. R1's hospice triage note, written by HRN N (Hospice Registered Nurse) dated 11/7/25 at 9:52 PM, includes: LPN I (Licensed Practical Nurse), facility, called to pass on that patient was at dentist today and they bumped her leg on the doorway. She is complaining of pain, but has bruising, No deformity. Offered nurse visit, but patient is currently sleeping and staff report that only time she complains of pain is with touching her leg with the bruising and pain medication as needed is helping.On 12/16/25 at 2:24 PM, Surveyors interviewed LPN I (Licensed Practical Nurse) regarding R1 on 11/7/25. LNP I indicated, LPN K stated in report that R1 had bumped her leg at the dentist and when R1 returned she had complained of pain to her leg. LPN I stated when she went to R1's room, R1 was fine. LPN I indicated R1 had pain with movement when the CNAs would change or turn R1. LPN I indicated R1 had redness to her leg like it was starting to bruise and there was some mild swelling. LPN I indicated staff usually complete and incident report for bruising of unknown origin. LPN I indicated she was unsure if an incident report was completed. LPN I indicated if she charted on this, it would be under R1's progress notes. Of note, R1 does not have a nurse progress note from LPN I regarding this on 11/7/25.On 12/16/25 at 3:35 PM, Surveyors interviewed LPN K regarding R1. LPN K indicated later in the shift on 11/7/25, after R1 had returned from the dentist

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that in response to injuries of unknown source, that all alleged violations are thoroughly investigated to rule out the potential for abuse for 1 or 3 residents reviewed (R1).R1 had an injury of unknown source on 11/7/25 and 11/9/25 that the facility was aware of and did not complete a thorough investigation of these injuries. This is evidenced by: The facility's policy Abuse Prevention and Reporting Policy, dated 11/25, includes: I. Purpose To ensure all residents are free from abuse, neglect. This policy establishes clear expectations for the prevention, identification, investigation, and reporting of all allegations or reasonable suspicions of mistreatment. IV. Identification and Reporting 3. Nursing staff must report bruising of unknown origin or other abnormalities. 4. The nursing supervisor is responsible for assessing and reporting such occurrences. V. Protection of Residents Pending Investigation The facility will take immediate and effective measures to protect all residents from potential abuse, neglect. while any allegation or investigation is in process. Protection begins the moment an allegation is made or a suspicion is reported and continues until the investigation is fully resolved. All staff must cooperate fully with internal and external investigative authorities. The facility will immediately evaluate the emotional and physical well-being of the alleged victim(s) and provide support through Social Services, counseling, or other appropriate interventions. All protective measure taken shall be documented in detail in the incident report, including the time, date, and name of the staff member implementing the intervention. The Administrator and/or Director of Nursing will reviewed protective actions daily until the investigation is complete to ensure continued safety and compliance. VI. Final Reporting and Follow-Up 1. Investigator shall obtain and review documentation, interview witnesses, and maintain confidentiality until investigation conclusion. R1 admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive brain disorder affecting movement), neuralgia (intense nerve pain), dementia (a cognitive decline affecting memory, thinking, language, and daily function), fibromyalgia (a chronic condition causing widespread body pain, fatigue, sleep issues, and cognitive difficulties), and history of falling. R1's 11/7/25 2:47 PM nurse progress note states, Patient was assessed by DR D DDS (Dentist) today. No pain or discomfort reported during assessment. [Company Name] x-ray report was faxed, no new orders were given at this time, dentist recommended no further action unless tooth bother patient. POA [Name] was informed and is in agreement with no further dental work at this time. On 12/16/25 at 11:59 AM, Surveyors interviewed BOM G (Business Office Manager). BOM G indicated on 11/7/25, she used a transport wheelchair and wheeled R1 to the dentist for an appointment. BOM G indicated the dental office was only a couple of blocks from the facility. BOM G indicated R1's wheelchair was too wide to fit through the exam room door, so the dentist provided information to R1 and BOM G in the lobby. BOM G indicated she wheeled R1 back to the facility. BOM G indicated there was no incident that occurred during the transportation to, at, or from the dental office. On 12/16/25 at 11:09 AM, Surveyors interviewed DR D (Dentist) regarding R1's 11/7/25 visit. DR D indicated 2 staff members walked R1 to his office and he spoke with them at length about what he would need to be able to see R1, including a smaller wheelchair. DR D indicated R1's wheelchair was too wide to fit through the exam room door. DR D indicated he spoke with R1 in the lobby. DR D measured both the main door and the exam room door. DR D indicated the main door is 5 or 6 inches wider than the exam door so there should have been no difficulties getting the wider wheelchair into the main door. DR D and his staff do not recall an incident or R1 stating she bumped her leg. DR D indicated R1 had no sign of injury while R1 was waiting in his lobby. R1's hospice note, written by HRN M (Hospice Registered Nurse) dated 11/7/25 5:30 PM, includes: Patient verbalized pain to RLE (Right Lower Extremity). Writer asked patient what happened, replied I was out for a walk today and twisted my knee on the uneven sidewalk. Patient is non-ambulatory, hoyer lift (Full body mechanical lift) for transfers and broda chair (a specialized wheelchair designed for comfort, support, and safety) for positioning and comfort. Edema noted to BLE (Bilateral Lower Extremity), 3+ to RLE, 2+ to LLE (Left Lower Extremity). no issues reported by staff. R1's hospice triage note, written by HRN N (Hospice Registered Nurse) dated 11/7/25 9:52 PM, includes: LPN I (Licensed Practical Nurse), facility, called to pass on that patient was at dentist today and they bumped her leg on the doorway. She is complaining of pain, but has bruising, No deformity. Offered nurse visit, but patient is currently sleeping and staff report that only time she complains of pain is with touching her leg with the bruising and pain medication as needed is helping On 12/16/25 at 2:24 PM, Surveyors interviewed LPN I (Licensed Practical Nurse)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide care and treatment in accordance with professional standards of practice (Wisconsin Nurse Practice Act, N6) related to assessment and monitoring of a resident's change in condition. This had the potential to affect 1 of 3 sampled residents (R1).R1 reported to staff that an event occurred at her time away from the facility that caused an increase in pain to her leg/foot. The facility did not complete a Registered Nurse (RN) Assessment timely. Staff observed R1 to have swelling and bruising after the change in condition was noted, staff failed to continuously assess, record, and monitor R1's change in condition for new or worsening symptoms. R1's x ray results showed a questionable non-displaced fracture of the tibia metaphsis (neck portion of a long bone). Evidenced by:Facility policy, titled Change of Condition, dated 9/2020, includes: To ensure that the resident's physician/physician on call/Nurse Practitioner and responsible party is kept informed regarding the resident's change of condition. The attending physician or physician on call/Nurse Practitioner and responsible party will be notified with changes in a residence condition. Document time of call, physician or nurse practitioner or other person spoken to, reason for call, and results or orders received.Interact Change In Condition: When to Report, Version 4.0 Tool, copyright 2011 Florida Atlantic University, includes: Immediate Notification - any symptoms, signs, or apparent discomfort that is: acute or sudden in onset and a marked change in relation to usual symptoms and signs or unrelieved by measures already prescribed. Non-immediate Notification- New or worsening symptoms that do not meet above criteria. Discoloration of skin- immediate- any new discoloration accompanied by significant pain. non-immediate-any new discoloration without any other symptoms. Pain-immediate- new severe pain, or marked increase in chronic pain. non-immediate-increase in frequency or severity of pain.According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient .(e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs .R1 admitted to the facility on [DATE] and had the following diagnoses: Type 2 Diabetes Mellitus with diabetic neurological complications, neuralgia (severe nerve pain that occurs due to irritation or damage to the nerves) and neuritis (inflammation of the nerves), chronic kidney disease stage 3, fibromyalgia (disorder that causes widespread pain throughout the body), epilepsy (Seizure disorder), history of falling, morbid obesity, age related osteoporosis (disease that weakens bones or makes them thinner and less dense), and Parkinson's disease (condition that affects movement and mood when nerve cells in the brain fail to produce enough dopamine.).R1's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/5/25 indicates R1's cognition is moderately impaired with a BIMS (Brief Interview for Mental Status) score of 12 out of 15.R1's Comprehensive Care Plan, initiated 11/22/22, includes: Transfer with 2 assist and hoyer lift (full body lift) . Provide broda chair when up out of bed.(It is important to note the facility did not provide hospice nurse progress notes, as they could not locate them during survey. Surveyor requested them from the hospice agency to obtain copies.)R1's Hospice Progress Note, dated 11/4/25 6:45 AM -8:05 AM, includes: dressing completed, shower completed, linen change completed, no skin changes., no pain during visit. (of note: R1 had no skin changes noted on 11/4/25)R1's Hospice Progress Note, dated 11/5/25 2:02

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for 1 of 3 sampled residents (R1) for change of condition.During interviews staff indicated R1 had experienced an increase in pain, a bruise, and swelling to her lower left extremity on 11/7/25. Hospice Nurse Notes reflect R1 was experiencing pain 9 out of 10, 10 out of 10, and 7 out of 10. R1's medical record does not accurately reflect her pain.R1 reported an event happened while she was off premises at an appointment with one or two staff members. R1 reported the event with inconsistent details to facility staff and to hospice staff. Staff failed to capture R1's allegation/details of the event in her medical record.R1 had a dental appointment on 11/7/25 and R1's medical record contained no documentation from this provider.R1's medical record did not contain hospice nurse progress notes.Evidenced by:The facility did not provide a policy related to charting, documentation, or medical record filing.R1 admitted to the facility on [DATE] and had the following diagnoses: Type 2 Diabetes Mellitus with diabetic neurological complications, neuralgia and neuritis, chronic kidney disease stage 3, fibromyalgia, epilepsy, history of falling, morbid obesity, age related osteoporosis, and Parkinson's disease. R1 passed away on 11/16/25 at 12:45 AM.R1's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/5/25 indicates R1's cognition is moderately impaired with a BIMS (Brief Interview for Mental Status) score of 12 out of 15.R1's Hospice Progress Note, dated 11/7/25 9:52 PM, includes: on call triage note: 9:51 PM central time, LPN I, from facility called to pass on that patient was at dentist today and they bumped her leg on the doorway. She is complaining of pain, . has bruising. No deformity. Offered nurse visit, but patient is currently sleeping and staff report that only time she complains of pain is with touching her leg with the bruising and pain medication as needed is helping. LPN I will return call if they would prefer a visit or with any changes.(It is important to note R1's medical record did not have documentation about this event, did not contain a description of R1's bruise, did not have accurate pain assessments, did not have an indication for use of R1's as needed pain medications, did not have a Registered Nurse Assessment, did not contain continued monitoring after change in condition was identified, and did not contain Hospice Nurse Notes or Hospice Nurse Assessments at the time of survey.)R1's Hospice Progress Note, dated 11/9/25 9:30 AM - 11:00 AM, includes:. as needed visit for left lower leg pain. Assessment of left lower leg demonstrates localized edema and bruising to the lateral aspect. Patient does not tolerate movement and cries out with even the slightest movement. Patient, facility, and POA requesting an x ray. pain: yes. pain score: 7 out of 10. goal pain: 4 out of 10. worst pain in the last 24 hours: 10 out of 10. frequency of pain: all of the time. Abnormal musculoskeletal findings: pain/stiffness in left lower extremity. Indicate reason for pain: Patient bumped her leg and has edema and bruising. What discipline did you communicate with: Registered Nurse/Supervisor. On call visit due to unexpected status change involving an adverse event. Indicate other unexpected status change: Patient's left lower extremity was bumped during transport on 11/7/25 resulting in increased pain with movement, bruising, and edema.(It is important to note R1's medical record does not reflect R1's pain.)R1's Nurse Note, dated 11/9/25 at 2:34 PM, includes: Hospice called to be informed that patient continues to have increased pain and requesting to be sent out. Patient was evaluated and X ray was ordered by hospice. Patient and POA informed.(It is important to note R1's medical record does not reflect the increase in pain.)R1's MAR/TAR, for 11/9/25, includes:Pain Evaluation Every Shift- Day- 0 out of 10, Evening- 0 out of 10, Evening- blank, Night-0 out of 10. (It is important to note R1's medical record does not accurately reflect her pain ratings as the facility's pain ratings are 0 out of 10, while the hospice ratings are 10 out of 10, 4 out of 10, and 7 out of 10.)Morphine Sulfate Solution 20 mg/ml. Give 0.5ml by mouth every 4 hours as needed for moderate pain/shortness of breath. Administered at 11:15 AM. (It is important to note the facility recorded R1's pain as 0 out of 10 and then administered her as needed pain medication.)R1's Hospice Progress Note, dated 11/10/25 11:04 AM - 11:44 AM Writer collaborated with hospice staff and facility staff including DON B (Director of Nursing) for today's visit. Writer entered patient's room. Patient sleeping. Writer introduced self and reason for visit. Patient agreeable to visit. Lethargic for remainder of visit. Patient denied shortness of breath. Per patient decreased appetite due to pain. Pain rated 7 out of 10 to left lower extremity. Left lower extremity noted with bruising, light yellow/green in color. Edema noted to lateral aspect of shin/bruised area. +1 to left foot/ankle region, elevated on pillow. Writer asked patient what happened and she replied, I caught my toe on the cement. Per