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	04/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review the facility failed to ensure a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted and following accepted national standards this has the potential to affect the census (58). From Feb-April 2026 there were 33 staff call ins from work without giving their symptoms to the facility (i.e. sick) and/or had a symptom that could have been a respiratory virus symptom (i.e. cough/cold/headache/sore throat) and should have been tested prior to coming back to work. This is evidenced by: The Facilities Policy and Procedure entitled Staff Management and Exclusion dated 9/25, documents in part: The facility will manage situations involving staff with acute respiratory illness (ARI) or exposure in accordance with existing guidance from the CDC (Centers for Disease Control and Prevention), state, and local health departments. Guidance 1. Staff with mild to moderate ARI, regardless of whether testing is performed, and who are not moderately to severely immunocompromised can return to work after the following criteria have been met: a. At least 3 days have passed since symptom onset, and b. At least 24 hours have passed since the last fever without the use of fever-reducing medications, and c. Symptoms (e.g., cough, shortness of breath) have improved, and d. They feel well enough to return to work . Document entitled Employee Illness Log dated 2020 documents the following pertinent column headings and information below table: Report Date, Employee, Vomiting, Fever, Diarrhea .A respiratory cough, sore throat, runny nose, Comments or other symptoms, Date returned to work .Employees with diarrhea or vomiting must be excluded from work for at LEAST 24 hours after symptoms are gone. Food service Workers with diarrhea or vomiting must be excluded from work for at LEAST 48 hours after symptoms are gone. February staff call ins documents the following: -Sore throat x1 -Headache x 5 -Sick x 5 -Stomach issues/Stomach/Food Poisoning x 2 March staff call ins documents the following: -Headache x 2 -Sick x 9 -Stomach Issues/Food Poisoning/Stomachache x 4 -Cough/cold x 1 April staff call ins documents the following: -Headache x 1 -Sick x 2 -Stomach Issues x 1 The staff line list Feb-April 2026 only documents one specific symptom which is fever. There is no consistent time off for staff, it varies from 1-7 days from date of call in to return to work. On 4/23/26 at 11:19 AM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked AODN/IP C when the staff line list documents sick what symptoms does that include, ADON/IP C replied when not respiratory, headache as example, mild symptoms probably. Surveyor asked ADON/IP C how long should staff be off work if they call in sick, ADON/IP C said the one thing we ask is if they have a fever then we follow ARI (Acute Respiratory Illness) protocol. Surveyor asked ADON/IP C if any staff have COVID testing completed prior to returning to work, ADON/IP C indicated that some staff have tested. ADON/IP C further explained she's trying to screen and get better with the line listing and checking for more than one symptom. On 4/23/26 at 11:40 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B would you expect staff to have symptoms listed for call ins so that the IP is able to determine how long they need to be off work, DON B stated yes. Surveyor asked DON B would you expect staff that have COVID symptoms present to have a COVID test completed prior to returning to work, DON B replied yes.

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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review the facility failed to implement written policies and procedures for screening employees to prevent abuse, this affected 3 of 8 background checks reviewed.PT J (Physical Therapist) lived outside of Wisconsin (WI) in Illinois (IL) and did not have an IL or national background check completed.SSD K (Social Service Director) and Receptionist L did not have WI Caregiver Background check completed and as a result they did not have the Government Findings Report resulted.This is evidenced by:The Facilities Policy and Procedure entitled Abuse Prevention and Reporting dated 11/25 documents, in part: .III. Prevention the facility is committed to preventing abuse, neglect, misappropriation, and exploitation by fostering a culture of safety, respect, and accountability. Prevention efforts include careful employee screening .1. Pre-Employment Screening The facility maintains a safe environment by ensuring that all employees and contracted personnel meet strict background and credentialing requirements prior to hire. The facility will not employ or contract with any individual who: Has been convicted of abuse, neglect, or misappropriation of resident property. Is listed on the Wisconsin Caregiver Misconduct Registry of the Office of Inspector General (OIG) Exclusion List. Has any disciplinary action on a professional license related to abuse, neglect, exploitation, or misappropriation. Required Checks Prior to Hire: Before an employee begins work, the following verifications must be completed and documented .Conduct a Wisconsin Department of Justice (DOJ) Background Check in accordance with DHS 13 (Department of Health Services). If the applicant currently resides in Illinois or has lived outside of Wisconsin within the past three (3) years, complete the appropriate State Police Healthcare Worker Background Check (Illinois or other applicable state) .The Facilities Policy and Procedure entitled Criminal Background Investigations Wisconsin Facilities dated 1/25, documents in part: .The facility is committed to ensuring the safety and well-being of all residents by conducting thorough background checks on all employees, contractors, and volunteers in accordance with Wisconsin Department of Health Services (DHS) and Division of Quality Assurance (DQA) requirements. No individual shall be permitted to work in a capacity that provides care or services to residents without appropriate background screening and clearance. This policy applies to: All prospective and current employees and volunteers and students with resident contact .Example 1PT J (Physical Therapist) was hired on 6/7/25 as a contracted therapy employee. PT J indicated on her Background Information Disclosure (BID) that she does or did live outside of WI in the last 3 years. PT J did not have an IL (Illinois) or national background check completed. Example 2SSD K (Social Service Director) was hired on 1/3/26 and did not have the Wisconsin Caregiver Background Check completed, because of that, she does not have the Government Findings Report results. Example 3 Receptionist L was hired on 2/26/26 and did not have the Wisconsin Caregiver Background Check completed, because of that, she does not have the Government Findings Report results.On 4/22/26 at 1:32 PM, Surveyor interviewed BOM M (Business Office Manager). Surveyor asked BOM M how SSD K and Receptionist L did not have the Government Findings Report, BOM M stated they aren't clinical staff. Surveyor asked BOM M if she could help me understand what that means in relation to completion of their pre-employment background check, BOM M explained that she runs the Caregiver Background Check for clinical staff and the general for non-clinical staff. Surveyor asked BOM M if these staff, On 4/22/26 at 3:28 PM, Surveyor interviewed BOM M. Surveyor asked BOM M if PT J's contracted company had an IL or national background check for her, BOM M replied that PT J is not working in an IL facility, so they didn't do one.On 4/23/26 at 9:31 AM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A would you expect all staff to have the caregiver background check completed, NHA A said yes, in IL all staff are fingerprinted, so that is how this was overlooked. Surveyor asked NHA A would you expect any staff that has resided outside of WI to have that state specific or a national background check completed, NHA A replied yes.

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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	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 interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the appropriate agencies for 1 of 1 abuse allegations of Residents (R7). R7 reported an abuse allegation involving CNA D (Certified Nursing Assistant). This incident was reported to NHA A (Nursing Home Administrator), DON B (Director of Nursing), and CNA F (Certified Nursing Assistant), but was not reported to the state agency.Evidenced by: Facility policy titled Abuse Prevention and Reporting Policy, undated, states, in part: . III. Prevention. Orientation and Annual Training Topics include: . Identification, prevention, and reporting of abuse under both federal and Wisconsin law. Mandatory reporting laws, including who must report, how to report, and applicable timeframes . IV. Identification and Reporting: 1. All employees, contractors, and volunteers must immediately report any allegation or reasonable suspicion of abuse, neglect, misappropriation, or exploitation to their supervisor and the Administrator or designee. 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. R7 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/11/26, indicates R7 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating R7 is cognitively intact. Section GG of R7's MDS indicates that she requires partial/moderate assistance for rolling left to right. On 4/20/26 at 2:36 PM, during an interview, R7 indicated that she no longer allows CNA D (Certified Nursing Assistant) to care for her. R7 stated that, approximately two weeks prior, CNA D hurt her while rolling her in bed. R7 stated that normally the aides use the draw sheet under her to assist with rolling her in bed, but that CNA D just used his hands, and it felt like fists were pushing into her hips. R7 stated that it hurt so bad that she almost started crying. R7 indicated that she told CNA I about it, who was also working that night, and asked that CNA D not provide cares for her anymore. Surveyor reviewed the facility grievance forms, which included a grievance dated 4/6/26, stating: Concern: Requests CNA D not to do her cares anymore. This was documented by AD G (Activities Director) who forwarded the concern to NHA A (Nursing Home Administrator). NHA A documented, Follow-up action taken: CNA D no longer doing cares for her talked with R7 and her preference is CNA D not provide cares. CNA D and R7 both aware. On 4/22/26 at 10:34 AM, Surveyor interviewed R7 about the incident between her and CNA D. R7 stated again that when CNA D was putting her on the side, he hurt her. R7 stated it was like he used his fists putting her on the hip, although it was probably just his palms. R7 stated that she has arthritis in both hips, and that when the other aides roll her over, that they use the draw sheet so as not to cause pain. R7 indicated that CNA F was also aware of the situation, as she told her that she doesn't allow CNA D to care for her anymore because he hurt her. On 4/22/26 3:04 PM, Surveyor interviewed CNA F about the incident between R7 and CNA D. CNA F stated that when she works the night shift, she has to provide cares for R7, even if she is not working that hall, because R7 does not want CNA D working with her anymore. CNA F stated that R7 told her it was because CNA D was rough with her one night about two to three weeks ago. Surveyor asked CNA F if she had reported this to anyone. CNA F indicated that all the staff knew about it, and that there had been other female residents that thought CNA D was aggressive while doing cares. CNA F stated that she would consider being rough or aggressive as abuse. On 4/22/26 at 3:32 PM, Surveyor interviewed AD G (Activities Director) who stated that she documented what R7 said on the grievance form but did not have any additional information about it. AD G stated that she turned the form over to NHA A on the same day she received the concern from R7. 4/22/26 at 3:40 PM, Surveyor interviewed CNA D about the incident with R7. CNA D confirmed that he works primarily the night shift and that he often (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	works the hall that R7 resides on. CNA D stated that R7 refuses his service and that she said he hurt her when turning her. CNA D stated that he told his colleagues that he would not be able to take care of her. CNA D stated he told NHA A and SC E (Scheduling Coordinator), to ensure that there was always another CNA working that could assist R7. On 4/22/26 at 3:46 PM, Surveyor interviewed SC E (Scheduling Coordinator) about the incident between R7 and CNA D. SC E stated that CNA D reported to her that R7 no longer wanted him to care for her. SC E stated it was reported to her that R7 just did not want any male caregivers, so she makes sure to always schedule two people on that hallway so that someone else can go in and take care of R7. Surveyor pointed out to SC E multiple observations of other male caregivers providing cares for R7. SC E stated that she thought R7 might not want CNA D caring for her because they were close in age. SC E indicated that she had never heard that CNA D was rough or aggressive in providing cares for R7, and if she had she would report it right away to DON B and NHA A. SC E stated that DON B might have more information on CNA D being rough with R7. On 4/23/26 at 9:21 AM, Surveyor interviewed NHA A (Nursing Home Administrator) about the incident between R7 and CNA D. NHA A stated that R7 is very particular and told her that she didn't want CNA D to provide cares for her anymore. NHA A indicated that when she asked R7 for more details, that she didn't really give a specific reason. NHA A stated that no one had reported to her that CNA D was rough with or hurt R7, and if they did, she would have reported it right away. NHA A stated that it was her expectation that staff would report any and all allegations of abuse to her promptly so that she could report it to the state agency. On 4/23/26 at 9:37 AM, Surveyor interviewed DON B (Director of Nursing) about the incident between R7 and CNA D. DON B stated that R7 told her that CNA D was a little rough with her when he put her on her side. DON B indicated that she asked R7 to provide further explanation, and that R7 stated that CNA D goes too quickly and kind of tosses her this way and that way. DON B stated that she didn't feel like R7's concern rose to the level of anything major, and that if they thought CNA D's conduct was abuse in any way, of course they would have reported it. Of note: The facility provided Surveyor with documentation of staff education that occurred on 4/8/26 and included a Knowledge Check form stating, A Resident tells the nurse that the night shift CNA was. rough with her while providing. care. Answer: Report this to the DNS (Director of Nursing Services. This education was presented at an Inservice/Meeting which was attended by 31 staff members. The facility staff list provided to the survey team documented 84 active staff members, which indicates approximately 36% of the staff were educated on abuse. On 4/23/26 at 9:47 AM, Surveyor called and left a message with CNA I for information about the incident between R7 and CNA D but did not receive a call back. The Facility considered this a grievance instead of an abuse allegation, despite multiple staff members knowing that R7 considered CNA D to be rough with her; therefore, they did not follow their policy and did not report this accusation of abuse to the state reporting agencies. Cross Reference F610.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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 allegations of abuse, neglect, exploitation, or mistreatment, all alleged violations were thoroughly investigated for 1 of 1 resident (R7) reviewed for abuse. On 4/6/26, the facility became aware of an allegation of abuse by a Certified Nursing Assistant (CNA) to a resident and did not conduct a thorough investigation. Evidenced by: Facility policy titled Abuse Prevention and Reporting Policy, undated, states, in part: . III. Prevention: The facility is committed to preventing abuse, neglect, misappropriation, and exploitation by fostering a culture of safety, respect, and accountability. 3. Resident and family engagement: All residents and families are informed of the facility's grievance and concern procedures. Resident and family concerns are documented, investigated, and reviewed. 4. Documentation and Oversight: . The Administrator and/or Director of Nursing will review 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. R7 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/11/26, indicates R7 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating R7 is cognitively intact. Section GG of R7's MDS indicates that she requires partial/moderate assistance for rolling left to right. On 4/6/26, the facility became aware of an allegation of abuse between CNA D (Certified Nursing Assistant) and R7. A grievance/concern form completed by AD G (Activities Director) documented: Concern: Requests CNA D not to do her cares anymore. This was documented by AD G (Activities Director) who forwarded the concern to NHA A (Nursing Home Administrator). NHA A documented, Follow-up action taken: CNA D no longer doing cares for her talked with R7 and her preference is CNA D not provide cares. CNA D and R7 both aware. On 4/22/26 at 10:34 AM, Surveyor interviewed R7 about the incident between her and CNA D. R7 stated again that when CNA D was putting her on the side he hurt her. R7 stated it was like he used his fists putting her on the hip, although it was probably just his palms. R7 stated that she has arthritis in both hips, and that when the other aides roll her over, that they use the draw sheet so as not to cause pain. R7 indicated that CNA F was also aware of the situation, as she told her that she doesn't allow CNA D to care for her anymore because he hurt her. On 4/22/26 3:04 PM, Surveyor interviewed CNA F about the incident between R7 and CNA D. CNA F stated that when she works the night shift she has to provide cares for R7, even if she is not working that hall, because R7 does not want CNA D working with her anymore. CNA F stated that R7 told her it was because CNA D was rough with her one night about two to three weeks ago. Surveyor asked CNA F if she had reported this to anyone. CNA F indicated that all the staff knew about it, and that there had been other female residents that thought CNA D was aggressive while doing cares. CNA F stated that she would consider being rough or aggressive as abuse. On 4/22/26 at 3:32 PM, Surveyor interviewed AD G (Activities Director) who stated that she documented what R7 said on the grievance form, but did not have any additional information about it. AD G stated that she turned the form over to NHA A on the same day she received the concern from R7. 4/22/26 at 3:40 PM, Surveyor interviewed CNA D about the incident with R7. CNA D confirmed that he works primarily the night shift and that he often works the hall that R7 resides on. CNA D stated that R7 refuses his service and that she said he hurt her when turning her. CNA D stated that he told his colleagues that he would not be able to take care of her. CNA D stated he told NHA A and SC E (Scheduling Coordinator), to ensure that there was always another CNA working that could assist R7. On 4/22/26 at 3:46 PM, Surveyor interviewed SC E (Scheduling Coordinator) about the incident between R7 and CNA D. SC E stated that CNA D reported to her that R7 no longer wanted him to care for her. SC E stated it was reported to her that R7 just did not want any male caregivers, so she makes sure to always schedule two people on that hallway so that someone else can go in and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take care of R7. Surveyor pointed out to SC E multiple observations of other male caregivers providing cares for R7. SC E stated that she thought R7 might not want CNA D caring for her because they were close in age. SC E indicated that she had never heard that CNA D was rough or aggressive in providing cares for R7, and if she had she would report it right away to DON B and NHA A. SC E stated that DON B might have more information on CNA D being rough with R7. On 4/23/26 at 9:21 AM, Surveyor interviewed NHA A (Nursing Home Administrator) about the incident between R7 and CNA D. NHA A stated that R7 is very particular and told her that she didn't want CNA D to provide cares for her anymore. NHA A indicated that when she asked R7 for more details, that she didn't really give a specific reason. Surveyor asked NHA A if she had any documentation of this interviewed with R7. NHA A stated that she talks to residents all day so it's not possible to document every conversation she has with them. NHA A stated that no one had reported to her that CNA D was rough with or hurt R7, and if they did, she would have reported it right away. NHA A stated that it was her expectation that staff would report any and all allegations of abuse, and that she would do a full investigation, but that she could only go off what was reported to her. On 4/23/26 at 9:37 AM, Surveyor interviewed DON B (Director of Nursing) about the incident between R7 and CNA D. DON B stated that R7 told her that CNA D was a little rough with her when he put her on her side. DON B indicated that she asked R7 to provide further explanation, and that R7 stated that CNA D goes too quickly and kind of tosses her this way and that way. DON B stated that she didn't feel like R7's concern rose to the level of anything major, and that if they thought CNA D's conduct was abuse in any way, of course they would have reported it. The facility did not follow their policy to complete a thorough investigation, as no other residents or staff were interviewed to identify if any further abuse by CNA D had occurred. Cross Reference F609.