

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019884	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREENFIELD HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 334 S GREENFIELD AVE WAUKESHA, WI 53186		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	INITIAL COMMENTS On 07/28/2026, Surveyors conducted a verification visit at Greenfield Home. Fifteen (15) deficiencies were identified; 8 were repeat deficiencies from statement of deficiency (SOD) 0QP111, dated 04/03/2026. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 3	{M 000}		
{M 216}	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure the home, and its operation complied with this chapter and all other laws governing the home and its operations potentially affecting 3 of 3 residents. The provider has been unable to maintain compliance with Chapter 88 of the Department of Health Services-Licensed Adult Family Home regulations. At the time of this verification visit, the provider had 7 repeat violations and 8 new violations. This is a repeat violation from statement of deficiency (SOD) #0QP112, dated 07/28/2026. Findings include: On 08/03/2026, Surveyor reviewed department	{M 216}		

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

TITLE

(X6) DATE

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{M 216}	Continued From page 1 files and identified the following: The provider has been licensed as a non-ambulatory adult family home since 03/04/2023, with a capacity of 4 residents and approved client groups including emotionally disturbed/mental illness, irreversible dementia/Alzheimer's disease, alcohol/drug dependency, traumatic brain injury, terminal illness, physical disability, correctional clients, advanced age, and developmental disability. Example 1: On 05/07/2026, the Department issued Statement of Deficiency (SOD) OPQ111 and Notice of Special Orders letter notifying the provider of the results of a complaint standard survey at Greenfield Home. As a result of the survey, the following 13 deficiencies were identified: M0216 - DHS 88.04(2)(a) Responsibilities M0260 - DHS 88.05(2) Access to Home and Within Home M0328 - DHS 88.05(3)(n)2 Clean Bedding and Linens M0346 - DHS 88.05(4)(d)2.b Fire Evaluation Annual Evaluation M0380 - DHS 88.06(2)(a) Admission - Health Exam M0384 - DHS 88.06(2)(b) Service Agreement Except Respite M0404 - DHS 88.06(3)(a) Individual Service Plan & Assessment M0426 - DHS 88.07(1)(a) Resident Care - General Requirements M0430 - DHS 88.07(1)(c) Activities and Services M0464 - DHS 88.07(3)(d) Medication - Written Order M0472 - DHS 88.07(4)(b) 3 Nutritious Meals and	{M 216}		

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{M 216}	Continued From page 2 Snacks M0474 - DHS 88.07(4)(c) Food Prepared and Stored in a Sanitary Manner Z0005 - DHS 12.05 Background Check Requirements The Notice of Special Orders included the following: "Based on the results of the Department ' s investigation and pursuant to authority provided in Wis. Stat. § 50.02(2)(am)2., and Wis. Admin. Code § DHS 88.03(6)(g)2.f., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Greenfield Home NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency 0QP111 are corrected, compliance is verified by the Department, and this Order is rescinded in writing. SPECIAL ORDERS Based on the results of the Department ' s investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Greenfield Home: 1. Pursuant to Wis. Admin. Code § DHS 88.03(6) (g)2.e., the licensee shall develop and implement corrective measures to ensure that residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. The licensee shall document the corrective actions that will be (or have been) implemented to resolve each deficiency identified in Statement of Deficiency (SOD) 0QP111.	{M 216}		

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{M 216}	Continued From page 3 WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) of each resident with a copy of SOD 0QP111 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with this Order. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request. WITHIN 45 DAYS of receipt of this notice, the licensee will provide training to all service providers on the corrective actions taken to resolve each deficiency identified in SOD 0QP111. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training." On 07/28/2026 at 11:30 a.m., Surveyor asked Program Manager E for documentation that the licensee provided Resident 1, Resident 2, Resident 3 and Resident 4's guardian's and managed care organizations with a copy of SOD 0QP111. Program Manager E stated that Resident 1 is his/her own legal decision maker and that a copy was sent in the mail to Resident 2's guardian, so s/he did not have documentation that it was sent. Program Manager E stated s/he would check to see if the provider has documentation that a copy of the SOD was provided to each resident's case manager. On 07/28/2026 at 11:34 a.m., Licensee A forwarded Surveyor an email from Managed Care Organization (MCO) F, dated 05/08/2026, that	{M 216}			

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{M 216}	Continued From page 4 documented that the MCO had received a Notice and Order for SOD #0PQ111 from the department. Surveyor asked Licensee A to provide documentation that SOD 0PQ111 was provided for each MCO and guardian; stating the email provided documented that an MCO was made aware of the no new admission order from the department. On 07/29/2026 at 12:55 p.m., Licensee A stated that MCO F was from Community Care. On 07/29/2026 at 1:09 p.m., Licensee A emailed Surveyor and stated s/he trying to reach out to Resident 3's guardian get that confirmation and Resident 2's guardian stated that s/he doesn't have anything to do with Resident 2. On 08/04/2026 at 8:00 a.m., Licensee A emailed Surveyor confirmation that Resident 4's guardian as provided SOD #0PQ111 on 07/28/2026. The provider did not ensure that within 7 days of receiving SOD 0QP111, the licensee provided the legal representative and case manager (if any) of each resident with a copy of SOD 0QP111 and a copy of the Notice and Order letter. Example 2: On 07/28/2026, Surveyors completed a verification visit survey at Greenfield Home. As a result of the survey, 15 deficiencies were identified. Eight (8) of the 15 deficiencies were repeat violations. The following deficiencies were identified: M0216 - DHS 88.04(2)(a) Responsibilities - Repeat M0260 - DHS 88.05(2) Access to Home and	{M 216}		

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{M 216}	Continued From page 5 Within Home - Repeat M0328 - DHS 88.05(3)(n)2 Clean Bedding and Linens - Repeat M0332 - DHS 88.05(4)(a) Fire Safety-Fire Extinguishers M0336 - DHS 88.05(4)(b)2 Smoke Detectors - Testing And Maintenance M0346 - DHS 88.05(4)(d)2.a Fire Safety Evacuation Plan Review M0410 - DHS 88.06(3)(d) Individual Service Plan M0426 - DHS 88.07(1)(a) Resident Care - General Requirements - Repeat M0430 - DHS 88.07(1)(c) Activities and Services - Repeat M0458 - DHS 88.07(3)(a) Prescription Medications M0462 - DHS 88.07(3)(c) Medication Assistance M0464 - DHS 88.07(3)(d) Medication - Written Order - Repeat M0472 - DHS 88.07(4)(b) 3 Nutritious Meals and Snacks - Repeat M0474 - DHS 88.07(4)(c) Food Prepared and Stored in a Sanitary Manner - Repeat M0570 - DHS 88.10(3)(l) Safe Physical Environment	{M 216}		
{M 260}	88.05(2) ACCESS TO HOME AND WITHIN THE HOME RESIDENT ACCESS TO THE HOME AND WITHIN THE HOME. An adult family home shall be physically accessible to all residents of the home. Residents shall be able to easily enter and exit the home, to easily get to their sleeping rooms, a bathroom, the kitchen and all common living areas in the home, and to easily move about in	{M 260}		

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{M 260}	Continued From page 6 the home. Additional accessibility features shall be provided as follows, if needed to accommodate the physical limitations of the resident or if specified in the resident's individual service plan: This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the adult family home was physically accessible to 3 of 3 residents. Residents were not able to easily enter and exit the home or move about within the home. This is a repeat violation from statement of deficiency (SOD) #0QP111, dated 04/03/2026. Findings Include: On 07/28/2026, Surveyors conducted a verification visit. The provider has been licensed as a non-ambulatory adult family home since 03/04/2023, with a capacity of 4 residents and approved client groups including emotionally disturbed/mental illness, irreversible dementia/Alzheimer's disease, alcohol/drug dependency, traumatic brain injury, terminal illness, physical disability, correctional clients, advanced age, and developmental disability. Observation at Entrance: On 07/28/2026 at approximately 9:00 a.m., Surveyor observed Resident 2 seated in a wheelchair in the dining room. Surveyor observed Resident 1 being transferred from his/her bed to his/her electric wheelchair with a mechanical hoist lift.	{M 260}		

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{M 260}	Continued From page 7 At approximately 9:20 a.m., Resident 1 stated s/he does not often leave his/her bedroom. Resident 1 stated s/he does not fit in the facility's bathroom so s/he has not showered in 10 months. Surveyor reviewed Resident 1's individualized service plan (ISP), dated 03/26/2026, which documented that Resident 1's mobility is with the use of a wheelchair at all times. On 07/28/2026 at 9:27 a.m., Resident 2 stated s/he does not remember the last time s/he had a shower but stated that s/he has to stand up and staff assist him/her into the bathroom, noting there is not enough room for a wheelchair. Bathroom: Surveyor observed the facility's only bathroom. It did not appear to have appropriate space for the turning radius of a wheelchair. On 07/28/2026 at 9:30 a.m., Program Manager E agreed that Resident 1 cannot get in the shower or fit into the bathroom to use the toilet. Interior Accessibility and Emergency Exit: On 07/28/2026 at 9:47 a.m., Surveyor toured the environment with Program Manager E. Surveyor observed two stairs leading from the kitchen area to the rear portion of the home, which included the facility's second emergency exit and Resident 3's bedroom. Program Manager acknowledged that Resident 1 and Resident 2 are unable to access the 2nd emergency exit and stated, "[Resident 1 and Resident 2] only exit through the front, only Resident 3 does both. [Resident 1 and Resident 2] cannot because of the stairs. Surveyor observed Program Manager E unlock	{M 260}		

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{M 260}	Continued From page 8 the deadbolt above the door handle to open the second emergency exit. Outside the exit was a ramp that had an approximate 1-inch drop, creating an uneven transition from the ramp to the ground surface. Follow-Up Interview: On 07/28/2026 at 11:30 a.m., Surveyor reviewed the concerns with Program Manager E and Consultant G. Consultant G stated that the facility needs to have a contractor come out to address the ramp and the back hallway with stairs to make the facility accessible to residents. Cross Reference: M0332 - DHS 88.05(4)(a) Fire Safety-Fire Extinguishers M0336 - DHS 88.05(4)(b)2 Smoke Detectors - Testing And Maintenance M0346 - DHS 88.05(4)(d)2.a Fire Safety Evacuation Plan Review	{M 260}		
{M 328}	88.05(3)(n)2 CLEAN BEDDING AND LINENS Appropriate bedding and linens that are maintained in a clean condition. When a waterproof mattress cover is used, there shall be a washable mattress pad, the same size as the mattress, over the waterproof mattress cover. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that there was a washable mattress pad on Resident 1 and Resident 2's waterproof mattress. This is a repeat violation from statement of	{M 328}		

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{M 328}	Continued From page 9 deficiency (SOD) #0QP111, dated 04/03/2026. Findings include: On 07/28/2026 at 9:47 a.m., Surveyor toured the environment with Program Manager E. Surveyor observed Resident 1 and Resident 2 had a waterproof mattress. Surveyor lifted the corner of his/her comforter to see the bedding. Surveyor observed a fitted sheet with no washable mattress pad. Program Manager E stated that s/he purchased washable mattress pads for the residents and was unsure why they were not on the made beds. Program Manger E asked Caregiver B where the washable mattress pads were. Caregiver B pulled them out of a closet in the hallway and removed them from the original plastic package. On 07/28/2026, at approximately 11:00 a.m., Surveyor reviewed the above concerns with Program Manager E and Consultant G. Program Manager E stated s/he will make sure that the washable mattress pads are taken out of the package and used.	{M 328}			
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire	M 332			

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M 332	Continued From page 10 extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a fire extinguisher was mounted at the head of the stairway leading from the pantry to the basement. Findings include: On 07/28/2026 at 9:47 a.m., Surveyor toured the environment with Program Manager E. Surveyor observed a stairway leading from the facility's pantry to the basement, there was not a fire extinguisher mounted at the head of the stairway. Program Manager E stated that the extinguisher was in the front hallway of the facility. Surveyor observed to get to the fire extinguisher from the top of the stairway you would have to go through the pantry, through the kitchen and into the front hallway; approximately 15 feet away. The fire extinguisher was not visible from the stairway, pantry or kitchen. Cross Reference: M0260 - DHS 88.05(2) Access to Home and Within Home M0336 - DHS 88.05(4)(b)2 Smoke Detectors -	M 332		

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M 332	Continued From page 11 Testing And Maintenance M0346 - DHS 88.05(4)(d)2.a Fire Safety Evacuation Plan Review	M 332			
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and staff interview, the facility did not ensure each smoke detector was tested monthly to make sure it was operating. Findings include: The provider has been licensed as a non-ambulatory adult family home since 03/04/2023, with a capacity of 4 residents and approved client groups including emotionally disturbed/mental illness, irreversible dementia/Alzheimer's disease, alcohol/drug dependency, traumatic brain injury, terminal illness, physical disability, correctional clients, advanced age, and developmental disability. At the time of the survey, 3 residents lived in the home; 2 required a wheelchair for mobility. On 07/28/2026 at 10:46 a.m., Surveyors requested documentation of the monthly smoke	M 336			

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M 336	Continued From page 12 detector tests from Program Manager E. Program Manager E stated s/he does not have documentation of testing the facility's smoke detectors, s/he stated s/he did not know s/he had to document it. The smoke detectors were not checked monthly as required in 2025 or the first half of 2026. Cross Reference: M0260 - DHS 88.05(2) Access to Home and Within Home M0332 - DHS 88.05(4)(a) Fire Safety-Fire Extinguishers M0346 - DHS 88.05(4)(d)2.a Fire Safety Evacuation Plan Review	M 336		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure each resident was evaluated to determine whether the resident was able to evacuate the home without any help within 2 minutes. Resident 1 was unable to exit the home within 2	M 344		

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M 344	Continued From page 13 minutes without any help. Findings include: On 07/28/2026 at approximately 9:00 a.m., Surveyor observed Resident 2 seated in a wheelchair in the dining room. Surveyor observed Resident 1 being transferred from his/her bed to his/her electric wheelchair with a mechanical hoist lift. Surveyor reviewed the record of Resident 1. Resident 1 was admitted to the provider on 11/03/2025. Resident 1's evacuation assessment, dated 11/03/2025 documented that Resident 1 needs full assistance with 2 staff members that the the evacuation time was 2 minutes 30 seconds. Surveyor reviewed Resident 1's individualized service plan (ISP), dated 03/26/2026, which documented that Resident 1's mobility is with the use of a wheelchair at all times. On 07/28/2026 at 10:46 a.m., Surveyor interviewed Program Manager E regarding Resident 1's evacuation time. Program Manager E stated that the evacuation time of 2 minutes 30 seconds was when Resident 1 was already up in his/her wheelchair. Program Manager E stated that the facility has not completed an evacuation drill while Resident 1 was been in bed or sleeping, only when s/he is awake. Program Manager E acknowledged that Resident 1's evacuation time was over two minutes with the assist of 2 staff with Resident 1 already in his/her wheelchair. Surveyor asked if Program Manager E had submitted a waiver to the department for Resident 1's evacuation time being over 2 minutes or had identified Resident 1 as a point of	M 344		

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M 344	Continued From page 14 rescue. Program Manager E stated no, but that s/he understands what the concern is with evacuation times stating, "Now that you mention it, it makes sense." Cross Reference: M0260 - DHS 88.05(2) Access to Home and Within Home M0332 - DHS 88.05(4)(a) Fire Safety-Fire Extinguishers M0336 - DHS 88.05(4)(b)2 Smoke Detectors - Testing And Maintenance	M 344		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following: This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure 2 of 2 individual service plans (ISPs) included all required information. Resident 1 and Resident 2's ISP did not include a description of services provided by the licensee to meet assessed needs. Findings include: On 07/28/2026, Surveyors reviewed Resident 1's and Resident 2's record and identified the following: Example 1-Resident 1	M 410		

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M 410	Continued From page 15 On 07/28/2026 at 9:15 AM, Surveyor toured Resident 1's room and observed a hospital bed with bed rails, a Hoyer lift in the hallway and Resident 1 was in a motorized wheelchair. On 07/28/2026 at 9:20 a.m., Surveyor interviewed Resident 1. Resident 1 stated that the caregivers only got him/her up for the day because of the Surveyors. Resident 1's nails were also long and had debris under them. Resident 1 stated that they need to cut and clean his/her nails today. Resident 1 stated that s/he cannot get into the bathroom, so s/he has not had a bath or shower in 10 months, that the provider cleans him/her up in bed. Resident 1 reported that s/he has not had breakfast yet. On 07/28/2026 at 9:30 a.m., Program Manager E confirmed that Resident 1 cannot get in the shower or fit into the bathroom to toilet, so they provide a bed bath and change his/her incontinence garments. Program Manager E stated that breakfast is served usually at 8 o'clock am and acknowledged that none of the residents had eaten yet. On 07/28/2026 at 9:35 AM, Surveyors interviewed Caregiver D. Caregiver D stated that Resident 1 used the Hoyer lift and did not ambulate on his/her own. Resident 1 was admitted on 11/03/2025 with diagnosis including multiple sclerosis, hypertension, cirrhosis, and history of strokes. Resident 1's ISP dated 03/26/2026 did not include a description of services provided by the licensee to meet Resident 1's use of the hospital bed with side rails, the Hoyer lift, or required personal cares. The ISP stated that Resident 1	M 410		

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M 410	Continued From page 16 required a bed alarm for high risk of nighttime falls. Surveyor did not observe the bed alarm. Resident 1's ISP stated "Personal Care Setup assistance for showering; cueing for oral hygiene. Daily" On 07/28/2026 at 10:00 AM, Surveyor interviewed Resident 1. Resident 1 stated that s/he never needed a bed alarm. Resident 1 stated that staff assisted him/her with the Hoyer lift every day. On 07/28/2026 at 11:10 AM, Surveyor interviewed Program Manager E and Program Manager E stated that Resident 1 had used the hospital bed with rails since his/her move in date. Program Manager E confirmed that Resident 1 took bed baths daily and could not fit into the facility bathroom. Program Manager E stated that Resident 1 did not need a bed alarm. Program Manager E acknowledged that there were several typing mistakes in the ISP for Resident 1. Example 2-Resident 2 On 07/28/2026 at 9:20 AM, Surveyors toured Resident 2's room and observed commode and soiled bedding. Resident 2 was observed in the dining area in his/her wheelchair. Surveyor observed Resident 2 did not appear to have clean hair. On 07/28/2026 at 9:27 a.m., Resident 2 remarked that s/he does not remember the last time s/he's had a shower and stated s/he has to clean him/her self up in the morning. Resident 2 was admitted on 02/20/2025 with diagnosis including anxiety, major depression, mild cognitive impairment, and epilepsy. Resident	M 410		

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M 410	Continued From page 17 2's ISP dated 03/26/2026 did not identify the use of commode or any toileting needs. The ISP identified the following: "fall risk high. Bed alarm to be used at night." Resident 2's ISP indicated that Resident 2 "enjoys the Two Rivers garden area." Resident 2's ISP stated "Personal Care Setup assistance for showering; cueing for oral hygiene. Daily" On 07/28/2026 at 9:45 AM, Surveyors interviewed Resident 2. Resident 2 stated that s/he did not use a bed alarm. Resident 2 stated that s/he yells for help when it is needed. Resident 2 stated that s/he did not know about a garden. On 07/28/2026 at 11:10 AM, Surveyors interviewed Program Manager E. Program Manager E stated that Resident 2 did not need a bed alarm. Program Manager E stated that there was not a Two Rivers garden area at the facility. Program Manager E acknowledged that there were several typing mistakes in the ISP for Resident 2.	M 410		
{M 426}	88.07(1)(a) RESIDENT CARE-GENERAL REQUIREMENTS The licensee shall provide a safe, emotionally stable, homelike and humane environment for residents. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not provide a safe, emotionally stable, homelike and humane environment for 3 of 3 residents. This is a repeat violation from statement of	{M 426}		

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{M 426}	Continued From page 18 deficiency (SOD) #0QP111, dated 04/03/2026. Findings include: On 07/28/2026 at approximately 9:00 a.m., Surveyors walked into the facility and observed Resident 2 at the kitchen table, sitting in his/her wheelchair. Resident 2 stated things are still not good and s/he had a fall that no one helped him/her with. Resident stated s/he has not had breakfast yet and is sitting at the table hoping s/he might get some. Surveyor observed Resident 2's hair was greasy and unkempt, his/her finger nails were long with dark debris under them and the facility had a strong scent of body odor. On 07/28/2026 at 9:09 a.m., Surveyor reviewed the facility's menu that was posted on the refrigerator which documented that eggs, toast, and applesauce was for breakfast. At 9:11 a.m., Surveyor observed 3 soiled chux pads laying on the bedroom floor of Resident 2's room. Surveyor observed a commode alongside Resident 2's bed that a dried bowel movement in the bowl and brown smears along with handle. Resident 2's bed was made; when Surveyor pulled the comforter back the sheets were visibly soiled along with a soiled, washable chux pad. Surveyor alerted staff to the odor and cleanliness of Resident 2's room. Caregiver D picked up the soiled disposable chux pads on Resident 2's bedroom floor and the washable chux pad from Resident 2's bed and moved them to the floor in a corner of the kitchen. On 07/28/2026 at 9:20 a.m., Surveyor interviewed Resident 1. Resident 1 stated that the caregivers only got him/her up for the day because of the	{M 426}			

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{M 426}	Continued From page 19 Surveyors. Resident 1's nails were also long and had debris under them. Resident 1 stated that they need to cut and clean his/her nails today. Resident 1 stated that s/he cannot get into the bathroom, so s/he has not had a bath or shower in 10 months, that the provider cleans him/her up in bed. Resident 1 reported that s/he has not had breakfast yet. On 07/28/2026 at 9:24 a.m., Surveyor observed that the facility bathroom did not have any means for staff or residents to dry their hands after washing. On 07/28/2026 at 9:27 a.m., Resident 2 remarked that s/he does not remember the last time s/he's had a shower and stated s/he has to clean him/her self up in the morning. On 07/28/2026 at 9:30 a.m., Program Manager E confirmed that Resident 1 cannot get in the shower or fit into the bathroom to toilet, so they provide a bed bath and change his/her incontinence garments. Program Manager E stated that breakfast is served usually at 8 o'clock am and acknowledged that none of the residents had eaten yet. On 07/28/2026 at 9:54 a.m., Surveyor observed a caregiver provide Resident 2 with a bowl of cereal. On 07/28/2026 from approximately 11:30 a.m., Surveyor reviewed the above concerns with Program Manager E. Program Manager E stated s/he understands the concern.	{M 426}		
{M 430}	88.07(1)(c) ACTIVITIES AND SERVICES	{M 430}		

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{M 430}	Continued From page 20 The licensee shall plan activities and services with the residents to accommodate individual resident needs and preferences and shall provide opportunities for each resident to participate in cultural, religious, political, social and intellectual activities within the home and community. A resident may not be compelled to participate in these activities. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not plan activities and services with the residents to accommodate individual resident needs and preferences. This is a repeat violation from statement of deficiency (SOD) #0QP111, dated 04/03/2026. Findings include: On 07/28/2026, at approximately 9:00 a.m., Surveyor entered the facility and observed Resident 2 sitting at the kitchen table in his/her wheelchair. Surveyor asked if Resident 2 if s/he had just had breakfast and what his/her plans were for the day. Resident 2 responded no to breakfast, and that s/he had nothing planned, that there was never anything to do but sit there. On 07/28/2026 at 9:20 a.m., Resident 1 stated there is still nothing to do in the facility besides watch TV in his/her room. Surveyor reviewed Resident 2's record. Resident 2 was admitted on 02/20/2025 with diagnosis including anxiety, major depression, mild cognitive impairment, and epilepsy. Resident 2's	{M 430}		

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{M 430}	Continued From page 21 individualized service plan, dated 03/26/2026, documented that Resident 2 is to have 1:1 staffing. On 07/28/2026 at approximately 9:35 a.m., Surveyor observed a caregiver bring Resident 1 out into the living room. On 07/28/2026 at 9:54 a.m., Surveyor observed Resident 2 was provided with cereal for breakfast. From approximately 9:00 a.m. to 11:30 a.m., Surveyors observed Resident 2 sitting at the kitchen table with no active engagement or conversation from staff. Surveyors observed the same for Resident 1 from approximately 9:35 a.m. to 11:30 a.m. There was no TV or radio on in the common area or bedrooms. On 07/28/2026, at approximately 11:30 a.m., Surveyor reviewed the above concerns with Program Manager E. Program Manager E stated that the caregivers are not providing activities due to the survey process and stated that sometimes they'll take residents to go out for a walk. Program Manager E stated that a neighbor was concerned when staff let Resident 1 go out for a walk the other day due to the heat and stated that was his/her right.	{M 430}			
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.	M 458			

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M 458	Continued From page 22 This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure medications were securely stored or disposed of according to standards of practice. Resident 2 had expired medications and medication that was not labeled. Resident 4 had medication at the facility after being discharged. Resident 5 had medication at the facility after being discharged months prior. Findings include: On 07/28/2026 at 10:20 a.m., Surveyor audited the facility's medication storage with Program Manager E. Surveyor reviewed Resident 2's medication. Surveyor observed the following medications for Resident 2: -30 tablets of Melatonin 5mg with an expiration date of 02/23/2026. -30 tablets of Loratadine 10mg with an expiration date of 02/23/2026. -46 capsules of APAP 500mg with an expiration date of 02/23/2026. -Trimcinolone 0.1% oint 30g, with an expiration date of 07/07/2026. -60 tablets of Senna-S 8.6-50mg with an	M 458		

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M 458	Continued From page 23 expiration date of 07/07/2026. -30 tablets of Melatonin 5mg with an expiration date of 07/07/2026. -30 tablets of Loratadine 10mg with an expiration date of 07/07/2026. -Poly Glycol 3350 powder 238mg with an expiration date of 07/07/2026. Other concerns included: -A tube of Cadexomer Iodine Gel that was not labeled that Program Manager E identified as Resident 2's. -Antifungal powder treatment that was not labeled that Program Manager E identified as Resident 2's. -Fluticasone Propionate/Salmeterol DISKUS Inhalation Powder 500mcg/50mcg that was not labeled. -Resident 4, unknown date of discharge, Betameth dip 0.05% oint 45g. -Resident 5's nystatin 100,000U/GM pow 60 mg. Program Manager E identified that Resident 5 has not lived at the facility for 6-8 months. Program Manager E identified that s/he is responsible for medication checks and that the staff should be auditing the medications too.	M 458			
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician.	M 462			

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M 462	Continued From page 24 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the provider stored prescription medications and assisted 1 of 2 residents with their prescription medications. Findings include: On 07/28/2026 at approximately 9:10 AM., Surveyors observed Resident 2 sitting at the dining room table. Surveyor asked Resident 2 how s/he was doing. Resident 2 stated that s/he had a bad headache and proceeded to pull up his/her pant leg. Surveyor observed several open and deep red cuts on Resident 2's right leg. Resident 2 stated that s/he had just gotten back from the hospital. On 07/28/2026 at 9:35 AM, Surveyors interviewed Caregiver B. Caregiver B stated that Resident 2 went to the hospital for head and leg pain. Caregiver B stated that Resident 2 was at the hospital for half of the day and then returned to the facility. Caregiver B stated that Resident 2 had imaging done and did not know the official diagnosis for Resident 2. On 07/28/2026 at 10:30 AM, Surveyor reviewed medical documentation from the hospital visit, dated 07/26/2026. Medical documentation indicated that Resident 2 had a skin infection and was prescribed 2 medications, cephalexin and doxycycline hyclate. The medical documentation stated to pick up medications from any pharmacy with the printed prescription on 07/26/2026.	M 462		

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M 462	Continued From page 25 Surveyor reviewed Resident 2's medications with Program Manager E and did not observe the prescribed medications. Surveyor noted Resident 2's Medication Administration Record (MAR), dated 07/15/2026 through 07/28/2026, did not have the cephalexin and doxycycline hyclate listed on the MAR. On 07/28/2026 at 11:15 AM, Surveyor interviewed Program Manager E. Program Manager E stated that Resident 2 "went to the hospital over the weekend so the medications should be coming in sometime today." Program Manager E acknowledged that Resident 2 had an infection and had not had the prescribed medications for 2 days. Program Manager E said that in the future s/he will go to a pharmacy that was open on the weekends.	M 462		
{M 464}	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 resident's reviewed	{M 464}		

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{M 464}	Continued From page 26 had a written order from the physician who prescribed the medication specifying who is able to administer the medications. Resident 1 and Resident 2 did not have a physician order for the provider to administer medication. This is a repeat violation from statement of deficiency (SOD) #0QP111, dated 04/03/2026. Findings include: On 07/28/2026, Surveyor reviewed the records of Resident 1 and Resident 2. Program Manager E provided Surveyor with a binder labeled Resident 1 and a binder Labeled Resident 2. Surveyor stated that Resident 1 and Resident 2's records did not include a physician order for the provider to administer medications. On 07/28/2026 at approximately 10:00 a.m., Program Manager E provider Surveyor with physician orders for Resident 1's medications. Surveyor clarified that this was the physician order to prescribe the medication, not for the facility to administer the medications. Program Manager E was unable to provide documentation that Resident 1 and Resident 2's physicians had a written order identifying that the facility was able to administer their medications.	{M 464}			
{M 472}	88.07(4)(b) 3 NUTRITIOUS MEALS AND SNACKS The licensee shall provide to each resident or ensure that each resident receives 3 nutritious meals each day and snacks that are typical in a family setting.	{M 472}			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019884	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/28/2026
NAME OF PROVIDER OR SUPPLIER GREENFIELD HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 334 S GREENFIELD AVE WAUKESHA, WI 53186		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 472}	Continued From page 27 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure each resident received 3 nutritious meals each day and snacks that are typically in a family setting. This is a repeat violation from statement of deficiency (SOD) #0QP111, dated 04/03/2026. Findings include: On 07/28/2026 at approximately 9:00 a.m., Surveyors walked into the facility and observed Resident 2 at the kitchen table, sitting in his/her wheelchair. Resident 2 stated s/he has not had breakfast yet and has no idea if or what they'll serve. On 07/28/2026 at 9:09 a.m., Surveyor reviewed the facility's menu that was posted on the refrigerator which documented that eggs, toast, and applesauce was for breakfast. The menu documented, "Meal Times: Breakfast 8:30am; Lunch 12:00pm; Dinner 5:00pm; Snack 8:00pm". On 07/28/2026 at 9:20 a.m., Resident 1 stated s/he has not been offered breakfast. Program Manager E stated that breakfast is usually at 8 and confirmed that none of the residents had eaten yet. On 07/28/2026 at 9:54 a.m., Surveyor observed Resident 2 was served cereal for breakfast. Surveyor asked Resident 1, who was sitting in his/her wheelchair in the living room, if s/he had breakfast. Resident 1 stated no, s/he was not interested in cereal every day. On 07/28/2026 at 10:28 a.m., Surveyor reviewed	{M 472}		

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{M 472}	Continued From page 28 the menu with Program Manager E as well as the food on hand. Surveyor noted there was no eggs or applesauce. Program Manager E stated that s/he understood the concern and that they need to go grocery shopping. Cross Reference: M0474 - DHS 88.07(4)(c) Food Prepared and Stored in a Sanitary Manner	{M 472}			
{M 474}	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was prepared and stored in a sanitary manner. This is a repeat violation from statement of deficiency (SOD) #0QP111, dated 04/03/2026. Findings include: On 07/28/2026 at 9:05 a.m., Surveyor toured the provider's home. Surveyor observed the following concerns: Refrigerator: -A container of bologna that was open to air, was not dated, and a fly on it. The package stated to use within 7 days of opening. -2 containers of left over food that did not have a label or date.	{M 474}			

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{M 474}	Continued From page 29 Freezer: -A bag of chicken breasts that was open to air. "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) "If you do not seal your food it can get "freezer-burn". This means that water escapes from the food and moves to the coldest part of the freezer - leaving your food dehydrated." (Source: Safefood website, Storing food in the freezer, 2024, https://www.safefood.net/food-storage/freezing (retrieval date - January 2, 2025).) On 07/28/2026 at approximately 9:45 a.m., Surveyor reviewed food safety and storage concerns with Program Manager E who stated s/he will remind staff to label and date food as well as put opened packages in a ziplock bag.	{M 474}		
M 570	88.10(3)(I) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be	M 570		

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M 570	Continued From page 30 hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure hot water was kept at a safe temperature. The water at the kitchen faucet was measured at 131.7° Fahrenheit (F). Three of 3 residents have independent access to the facility's faucets. Findings include: The provider has been licensed as a non-ambulatory adult family home since 03/04/2023, with a capacity of 4 residents and approved client groups including emotionally disturbed/mental illness, irreversible dementia/Alzheimer's disease, alcohol/drug dependency, traumatic brain injury, terminal illness, physical disability, correctional clients, advanced age, and developmental disability. On 07/28/2026 at 10:41 a.m., Surveyor tested the water temperature at kitchen faucet; the water was measured at 131.7°F. Program Manager E stated s/he was aware that the water temperature should be between 110-120° F. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause	M 570			

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M 570	Continued From page 31 scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017.)	M 570			