STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018569	A. BUILDING: _____ B. WING _____	R 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVERCREST	503 CLOVERCREST CT WATERTOWN, WI 53094

(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
{N 000}	Initial Comments On 05/26/2026, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Clovercrest, a community-based residential facility (CBRF) located in Watertown, WI. As a result of the survey, 1 deficiency was identified. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 3	{N 000}		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the documented dosage of oxycodone administered to Resident 5 was accurate as to what was administered on 05/15/2026.	N 415		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 415	Continued From page 1 Findings include: On 05/26/2026, at approximately 10:20 a.m., Surveyor approached the home to conduct a verification visit. Two law enforcement officers, Officer X and Officer Y, were standing outside the front door talking with Caregiver F. Upon Surveyor's approach and introduction, Officer X reported that law enforcement was there on a complaint related to missing narcotic medication for Resident 5. Officer X reported that s/he was able to verify that someone at the home signed for at least some of Resident 5's dispensed narcotic medication. At approximately 11:30 a.m., Surveyor interviewed Caregiver F. Caregiver F reported that both officers had also been onsite yesterday related to the same concern and allegation that Resident 5's oxycodone was stolen. Caregiver F reported that Resident 5 was his/her own legal representative. Caregiver F confirmed that the provider's contracted pharmacy delivered all of Resident 5's medications to the home shortly before his/her admission, and that staff signed for them and immediately stored them in the locked medication closet. Caregiver F confirmed that staff administered Resident 5's medications and that s/he was known to request his/her oxycodone tablets frequently. On 05/26/2026, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 05/11/2026 with diagnoses including migraines, rheumatoid arthritis, and intellectual disability. Resident 5's prescriptions included oxycodone 10 mg tablets with instructions to, "Take 1/2 to 1 tablet (5-10 mg) by mouth every 8 hours as needed for leg pain. Do not take mor [sic] than 3 tablets in any 24 hour period."	N 415		

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N 415	Continued From page 2 At approximately 12:52 p.m., Surveyor observed Resident 6's oxycodone card. The card showed that 45 tablets dispensed, packaged in 90 half-tablet bubble packs. Surveyor reviewed the proof-of-use record for Resident 5's oxycodone. Surveyor observed that while the dosage the oxycodone was counted in was not specified on the record, the count started at 90 and for all but one occasion, staff documented administering "2" for each administration - findings which were consistent with how his/her oxycodone was packaged and the administration of up to 2 half-tablets in accordance with his/her order. Surveyor observed one occasion, 05/15/2026 (11:20 a.m.) in which staff documented administering "1." In reviewing Resident 5's medication administration record (MAR) for that day, Surveyor observed an entry made that same date and time (05/15/2026 at 11:20 a.m.) with the annotation, "gave 2 1/2 pills." Surveyor noted that this was inconsistent with the proof-of-use record entry for that day. Surveyor noted that it appeared as if the staff who signed the proof-of-use record counted the 2 half-tablets as 1 full tablet for that sole occasion, which would therefore make the rest of the remaining counts from 05/15/2026 - 05/26/2026 inaccurate. At approximately 1:30 p.m., Surveyor interviewed Caregiver F and Coordinator of Administrative Services (Coordinator) A. Caregiver F reported s/he recalled being informed about that occasion on 05/15/2026 because the staff who gave the medication informed him/her that s/he only administered a single half-tablet of oxycodone to Resident 5 due to a misunderstanding of the prescription instructions. Caregiver F reported	N 415		

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N 415	Continued From page 3 that as a result of that, s/he believed the proof-of-use record was accurate and consistent with how staff audited Resident 5's oxycodone (with the "1" administered indicating a single half-tablet) and that the MAR was inaccurate (with the annotation that 2 half-tablets were administered that time). Caregiver F confirmed s/he recalled only a single half-tablet of oxycodone was administered to Resident 5 on 05/15/2026 at 11:20 a.m. Caregiver F and Coordinator A reported understanding of Surveyor's concern that Resident 5's MAR did not accurately reflect that oxycodone dosage administered to Resident 5.	N 415		