STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019918	A. BUILDING: _____ B. WING _____	C 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE WINDS	**4219 LAKESHORE ROAD HAVEN, WI 53083**

(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 04/06/2026, with additional information gathered through 04/13/2026, Surveyor investigated 1 complaint and conducted a standard survey at Lakeshore Winds. The complaint was substantiated. As a result of the standard survey, 4 new deficiencies were identified. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department an incident of a resident missing from the home for Resident 1. Findings Include: On 04/06/2026, Surveyor reviewed Resident 1's incident report dated 09/28/2025. The incident report documented the following:	M 134		

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

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M 134	Continued From page 1 " ... [Resident 1] then took a shower and when finished, left the property without stating [his/her] intention to staff. Writer realized [s/he] had left and contacted the On-Call Manager. Writer then contacted law enforcement. A Sheriff deputy was dispatched to a nearby Piggly Wiggly market where [s/he] found [Resident 1]. [Resident 1] was safely returned home. The deputy spoke with Writer ...It was [Resident 1] who contacted dispatch and shared [his/her] location ..." On 04/07/2026, Surveyor reviewed the department's files for submitted self-reports for Lakeshore Winds. There was no self-report regarding the elopement that occurred on 09/28/2026. On 04/09/2026, at 3:00PM, Surveyor interviewed Licensee E. Licensee E reported s/he found the self-report document but had no verification it was sent to the department.	M 134		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written assessment and individual plan (ISP) was developed for each resident within 30 days after placement for	M 404		

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M 404	Continued From page 2 Resident 1. Findings Include: Based on record review and interview, the provider did not ensure a written assessment and individual plan (ISP) was developed for each resident within 30 days after placement for Resident 1. Findings Include On 04/06/2026, Surveyor reviewed Resident 1's record. The record documented Resident 1 was admitted on 09/05/2025. On 04/07/2026, at approximately 9:45AM, Surveyor requested to review Resident 1's ISP. Program Director A (PD-A) provided Surveyor with an assessment dated 08/26/2025 but could not locate the initial ISP at that time. On 04/07/2026, Surveyor reviewed Resident 1's undated ISP for the review timeframe of 10/05/2026 through 04/05/2026. On 04/07/2026, at 11:39AM PM, Surveyor interviewed PD-A. PD-A advised the undated ISP was for the 6-month review that has not been scheduled yet. PD-A confirmed the absence of the initial ISP that should be developed within 30 days after placement.	M 404		
M 408	88.06(3)(c) ASSESSMENT IDENTIFY NEEDS & ABILITIES The assessment shall identify the person's needs and abilities in at least the areas of activities of daily living, medications, health, level of	M 408		

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M 408	Continued From page 3 supervision required in the home and community, vocational, recreational, social and transportation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the assessment included the level of supervision required at home and the community. Findings Include: On 02/02/2026, the department received a complaint regarding supervision. On 04/06/2026, Surveyor reviewed Resident 1's record. The record identified Resident 1 was admitted on 09/05/2025. On 04/06/2026, Surveyor reviewed Resident 1's assessment, dated 08/26/2025. The assessment identified Resident 1 had a diagnosis of autism, bipolar disorder, attention-deficit/hyperactivity disorder (ADHD) and schizophrenia with hallucinations and paranoia. Review of the assessment revealed it did not include information regarding supervision: Level of Supervision " ...has 2-3 staff on at [mental health crisis facility] ..." The assessment noted Resident 1 had one instance of walking off from the mental health crisis facility due to hearing voices. The assessment further noted Resident 1 had a history of suicidal ideations and attempts. The	M 408		

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M 408	Continued From page 4 assessment did not specify Resident 1's supervision needs. Note: Resident 1 was residing at a mental health crisis facility at the time of the assessment. There were no other assessments completed after Resident 1's admission on 09/05/2026. On 04/09/2026, at 3:00PM, Surveyor interviewed Program Director A and Licensee B. Program Director A and Licensee B acknowledged the assessment did not identify the level of supervision needed for Resident 1. Resident 1 had diagnosis autism, bipolar disorder, attention-deficit/hyperactivity disorder (ADHD) and schizophrenia. Resident 1 was assessed by the provider while s/he was residing at a metal health crisis facility. The provider's assessment noted s/he had a history of leaving the facility but did not identify the supervision needs once admitted to the adult family home.	M 408		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it.	M 556		

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M 556	Continued From page 5	M 556		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure residents had the opportunity to make decisions relating to aspects of life in the adult family home for Resident 1 and Resident 2.

The pantry containing dry foods, canned foods and snacks was locked, preventing 4 of 4 residents from accessing food items at their preferred times. Additionally, knives were in a locked lockbox preventing 4 of 4 residents from using them when needed.

Findings Include:

On 04/06/2026, at 8:23AM, Surveyor toured the home with Care Team Manager B (CTM-B). Surveyor observed the pantry door had a padlock. Surveyor observed CTM-B open the pantry lock with a key. The pantry contained dry foods, canned foods, condiments and snacks. Surveyor also observed a large lockbox on the counter. Surveyor observed CTM-B use a key to open the lockbox. Surveyor observed the kitchen knives were stored in the lockbox.

On 04/06/2026, at 8:23AM, CTM-B explained the pantry was locked due to Resident 2's behavior. CTM-B described Resident 2 would sneak pantry items and snacks and take them to his/her room. This resulted in Resident 2 having old food and wrappers in his/her room. CTM-B explained residents can have access to the pantry by asking for it to be unlocked. CTM-B was not sure why the knives were locked.

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M 556	Continued From page 6 On 04/06/2026, 8:35AM, Surveyor interviewed Resident 1. Resident 1 reported s/he must ask a caregiver to unlock it the pantry if s/he wants access. Surveyor inquired how long the pantry has been locked. Resident 1 stated, "They just did that." Resident 1 informed Surveyor, "I think the knives are locked because of me, but maybe others too." Resident 1 explained s/he could use the knives when s/he cooks in the kitchen with supervision, so s/he does not hurt him/herself. On 04/06/2026, at approximately 9:15AM, Surveyor interviewed Program Director A (PD-A). PD-A explained the pantry doors were locked because Resident 2 steals other residents' personal food and snacks. PD-A reported the residents asked for the pantry to be locked to prevent Resident 2 from stealing their food. PD-A added locking the pantry is to keep Resident 2 safe as rotten food and wrappers have been found throughout Resident 2's room. RESIDENT 1 On 04/07/2026, Surveyor reviewed Resident 1's Behavior Support Plan (BSP), dated 10/15/2025 by the Managed Care Organization. The BSP did not identify locking knives as an intervention. On 04/07/2026, Surveyor reviewed Resident 1's Safety Plan, dated 12/16/2025. The Safety Plan did not identify the need to lock knives. On 04/07/2026, Surveyor reviewed Resident 1's Individual Support Plan (ISP) for the effective date range of 10/05/2025 through 04/05/2025. The ISP identified the following: Self-Injurious Behavior: "[Resident 1] has a history prior to moving into Lakeshore Winds of	M 556		

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M 556	Continued From page 7	M 556		

hurting [his/herself]. Knives are put up and locked so [s/he] does not have access to them to harm [his/herself] or others.

The ISP noted Resident 1 has a BSP, "Please see attached BSP and Safety Plan."

Surveyor Note: The BSP and Safety Plan did not specify anything regarding behaviors requiring locking knives; however it was identified in the ISP.

RESIDENT 2

On 04/07/2026, Surveyor reviewed Resident 2's Individual Service Plan for the effective date range of 07/30/2025 through 01/31/2026. The ISP noted the following:

Eating: " ...Staff should be in the kitchen with [Resident 2] at all times when she is eating one for in case [s/he] is to choke, two because [Resident 2] will add dressings and other stuff to [his/her] meal and make it to the point that even [s/he] wont [sic]eat it. Staff need to be aware of what [Resident 2] is doing in the kitchen."

Behavior Support Interventions: "... [Resident 2] also steals candy and sodas from [his/her] peers which they have requested to be locked up ..."

Surveyor Note: The ISP did not specify how other residents' food would be secured or that common pantry would be locked.

On 04/07/2026, at 11:11AM, Surveyor interviewed Case Manager C (CC-C). CC-C identified his/herself as Resident 1's managed care organization (MCO) case manager. CC-C stated s/he was not aware of any restrictions in the

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M 556	Continued From page 8 home. CC-C explained restrictions should not be implemented without an assessment and documentation in the managed care organization's member-centered plan (MCP). On 04/08/2026, at 12:22PM, Surveyor interviewed Case Manager D (CC-D) CC-D identified his/herself as Resident 2's managed care organization case manager. CC-D verified s/he was not aware of the restrictions in place in the home and the provider has not completed any rights limitation documents. On 04/09/2026, at 3:00PM, Surveyor interviewed PD-A and Licensee E. PD-A advised s/he has contacted Resident 1 and Resident 2's MCO case managers regarding the need for restrictions. Licensee E confirmed the provider would ensure collaboration with the MCO for client rights limitations moving forward. PD-A added s/he would explore other options for storing other resident's personal snacks. Resident 1's BSP and safety plan did not identify the need for locking knives, but was noted in the ISP. Resident 1's MCO case manager was not aware of the restriction implemented by the provider. Resident 2's ISP identified s/he required supervision anytime s/he was in the kitchen. The ISP identified other residents would like their personal snacks locked, but it did not specify how this would be done. Resident 2's MCO case manager was not aware of the restrictions implemented by the provider.	M 556		