STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018713	A. BUILDING: _____ B. WING _____	R 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS IV	**2630 N 118TH ST MILWAUKEE, WI 53224**

(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 09/30/2025, Surveyors completed a verification visit at Washington Heights IV. As a result, 6 previous deficiencies were corrected, and 1 deficiency was recited. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 7	{N 000}		
{N 346}	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure the confidentiality of residents' personal information for 1 of 1 resident (Resident 9). Resident 9's dietary restrictions/needs, and bowel movement instructions were posted on a wall in the common dining room and visible to other residents and visitors.	{N 346}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018713	A. BUILDING: _____ B. WING _____	R 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS IV	2630 N 118TH ST MILWAUKEE, WI 53224

(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 346}	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) 9N0K13, dated 11/05/2024. Findings include: On 09/30/2025, at approximately 9:15 AM, Surveyors toured the facility and observed a piece of paper taped to the dining room wall. The paper stated the following: "...[Resident 9] Not to Have Coffee - Do Not Give Creamer - Do Not Give Chocolate - Do Not Give Ice Cream - Do Not Give Lactose Intolerance Food - Cut bite size pieces when needed choking risk and vomited [Individualized Service Plan] (ISP) - Plan Assist [Resident 9] after having a [bowel movement] (BM), making sure the bathroom is cleaned afterwards..." This information was visible to other residents and visitors of the facility. On 09/30/2025, at 10:30 AM, Surveyor interviewed Licensee J and Operations Manager B. Licensee J reported s/he was unaware Resident 9's ISP information was posted on the wall. Administrator B reported s/he posted the information on the wall to update new staff on Resident 9's needs. Operations Manager B reported the information was posted for approximately one week after new staff would start and then would be removed. Licensee J confirmed resident personal information should	{N 346}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018713	A. BUILDING: _____ B. WING _____	R 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEIGHTS IV	**2630 N 118TH ST MILWAUKEE, WI 53224**

(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 346}	Continued From page 2 not have been taped to the wall.	{N 346}		