

Wisconsin Department of Health Services

|                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                                                                          |                                                                    |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0017143</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/16/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINDY RIDGE CARE INC HOLLISTER HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>325 HOLLISTER AVE</b><br><b>TOMAH, WI 54660</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| N 000                                                                           | <p>Initial Comments</p> <p>On 07/12/2024, Surveyor conducted a self-report review and a standard licensure survey at Windy Ridge Care INC Hollister House.</p> <p>Data for this survey was received and reviewed through 07/16/2024.</p> <p>The self-report needed no further action from the provider.</p> <p>Three deficiencies related to the standard licensure survey were identified. One of the 3 was a repeat deficiency. See Statement of Deficiency (SOD) MZB311, dated 10/08/2019.</p> <p>Census: 6</p>                                                                                                                                                                                                                                                                                                  | N 000                                                                                       |                                                                                                                          |                                                                    |
| N 358                                                                           | <p>83.32(3)(n) Rights of Residents: Safe environment</p> <p>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe environment for residents that cannot safeguard themselves from environmental hazards.</p> <p>This is a repeat deficiency. See Statement of Deficiency (SOD) MZB311, dated 10/08/2019.</p> | N 358                                                                                       |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

|                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                                                                                          |                                                                    |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0017143</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/16/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINDY RIDGE CARE INC HOLLISTER HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>325 HOLLISTER AVE</b><br><b>TOMAH, WI 54660</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| N 358                                                                           | Continued From page 1<br><br>Findings include:<br><br>The provider is licensed to care for up to 6 residents in the client groups of developmental disabilities, terminally ill, emotionally disturbed/mental illness, traumatic brain injury, alcohol/drug dependent, correctional clients, and physically disabled.<br><br>On 07/12/2024 at approximately 10:00 AM, Surveyor entered the facility to conduct a licensure survey. Surveyor stepped on the first step leading to the front door. Surveyor noticed the board on the front step was loose and the step moved when weight was placed on it. Surveyor then noted two of the rail spindles on the left side of the steps were loose and there were screws exposed, facing upward.<br><br>Surveyor interviewed Administrator A on 07/12/2024 at approximately 1:30 PM. During interview with Administrator A, Surveyor shared the concern with the step and spindles on the steps. Surveyor asked him/her how long the step and spindles had been in need of replacement. Administrator A stated they've needed replacement for approximately two weeks and repairs had been on the schedule for about two weeks. These steps are at the main entrance to the facility. Surveyor stated to Administrator A that due to the sharp screws facing skyward, the steps are a risk to anyone entering the facility. Administrator A stated the steps would be repaired immediately. | N 358                                                                                       |                                                                                                                          |                                                                    |
| N 488                                                                           | 83.44(1)(c) Clothes dryers enclosed and vented<br><br>Clothes dryers. The CBRF shall enclose any                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | N 488                                                                                       |                                                                                                                          |                                                                    |

Wisconsin Department of Health Services

|                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                             |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0017143</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/16/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINDY RIDGE CARE INC HOLLISTER HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>325 HOLLISTER AVE</b><br><b>TOMAH, WI 54660</b>                              |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| N 488                                                                           | <p>Continued From page 2</p> <p>clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation and interview, the provider did not ensure the clothes dryer vents were rigid metal material.</p> <p>Findings include:</p> <p>The provider is licensed to care for up to 6 residents in the client groups of developmental disability, terminally ill, emotionally disturbed/mental illness, traumatic brain injury, alcohol/drug dependent, correctional clients and physically disabled.</p> <p>On 07/12/2024 at approximately 10:40 A.M., Surveyor observed the laundry room located on the second floor. Surveyor noted the dryer vent was a flexible tube and not rigid metal material.</p> <p>On 07/12/2024 at approximately 1:30 PM, during interview with Administrator A, Surveyor shared these concerns with Administrator A. Administrator A acknowledged the concern and stated the venting would be replaced.</p> | N 488                                                                       |                                                                                                                          |  |                                                                    |
| N 617                                                                           | <p>83.55(6)(b) Bath and toilet areas: water temperature</p> <p>The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | N 617                                                                       |                                                                                                                          |  |                                                                    |

Wisconsin Department of Health Services

|                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                                                                                          |                                                                    |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0017143</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/16/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINDY RIDGE CARE INC HOLLISTER HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>325 HOLLISTER AVE</b><br><b>TOMAH, WI 54660</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| N 617                                                                           | <p>Continued From page 3</p> <p>140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation and interview, the provider did not ensure the hot water temperatures in both facility bathroom sinks and kitchen sink did not exceed 115 degrees Fahrenheit (F).</p> <p>Findings include:</p> <p>The provider is licensed to care for up to 6 residents in the client groups of developmental disability, terminally ill, emotionally disturbed/mental illness, traumatic brain injury, alcohol/drug dependent, correctional clients, and physically disabled.</p> <p>The Bureau of Quality Assurance (BQA) and the Bureau of Assisted Living (BAL) issued, respectively, BQA Memo-98-021 (1998) and DQA publication P-01942 (2017) regarding hot water temperatures. These documents listed hot water temperature thresholds and the harm hot water temperatures can inflict on consumers with physical or psychological conditions that prevent instant recoil from dangerously hot water. This document reaffirms the temperature thresholds listed in BQA Memo-98-021 and DQA P-01942.</p> <p>Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these</p> | N 617                                                                                       |                                                                                                                          |                                                                    |

Wisconsin Department of Health Services

|                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                                                                                          |                                                                    |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0017143</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/16/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINDY RIDGE CARE INC HOLLISTER HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>325 HOLLISTER AVE</b><br><b>TOMAH, WI 54660</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| N 617                                                                           | <p>Continued From page 4</p> <p>individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause 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 P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017).</p> <p>Sustained contact with dangerously hot water can result in second and third degree burns according to the following thresholds:</p> <p>110 degrees F is 13 minutes.<br/>120 degrees F is 10 minutes.<br/>127 degrees F is 1 minute.<br/>130 degrees F is 30 seconds.</p> <p>On 07/12/2024 at approximately 10:30 AM, Surveyor tested the temperature of the water at the sink in the kitchen. The water temperature was 130 degrees F. Surveyor then checked the downstairs resident bathroom and the upstairs resident bathroom. The downstairs bathroom hot water was 131 degrees F. The temperature of the hot water in the upstairs bathroom was 131 degrees F.</p> <p>Surveyor discussed this concern with Administrator A on 07/12/2024 at approximately 1:30, and asked that the temperature of the water be reduced to 115 degrees F. Administrator A acknowledged the hot water temperatures and adjusted the temperatures the same day.</p> | N 617                                                                                       |                                                                                                                          |                                                                    |