| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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<br><br>On 03/04/2024, with information gathered through 03/11/2024, Surveyor conducted a standard licensure survey and a complaint investigation at Whispering Willows. Nineteen deficiencies were identified.<br><br>Three of the 19 deficiencies were repeat violations (see Statement of Deficiency (SOD) 6KJH11 and SOD OS9011).<br><br>Census: 7 | N 000 | | |
| N 220 | 83.17(2)(a) Employees screened for communicable disease.<br><br>The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 3 of 3 employee records (Licensed Practical Nurse C, Caregiver D, and Caregiver E) reviewed had been screened for clinically apparent communicable disease, including tuberculosis (TB), by a physician, physician assistant, clinical nurse practitioner or a | N 220 | | |

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 |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 220 | Continued From page 1<br>licensed registered nurse within 90 days before the start of employment.<br><br>Findings include:<br><br>On 03/06/2024, Surveyor reviewed Licensed Practical Nurse (LPN) C's, Caregiver D's, and Caregiver E's record.<br><br>LPN C was a previous employee that was hired back in 02/2023. LPN C's record contained a plain piece of paper that stated, "As best of my knowledge and understanding I am free of communicable diseases. I have been tested negative for Tuberculosis. Dated 04/04/2022. Signed by LPN C.<br>The record did not contain the test results of the TB test and did not contain a signature of a medical professional.<br><br>Caregiver D started employment in 06/2023 and his/her record contained a plain piece of paper that stated, "As best of my knowledge and understanding I am free of communicable diseases. I have been tested negative for Tuberculosis. Dated 06/11/2023. Signed by Caregiver D.<br>The record did not contain the test results of the TB test and did not contain a signature of a medical professional.<br><br>Caregiver E started employment in 2021 and his/her record did not contain a communicable disease screen or TB test results.<br><br>On 03/07/2024 at 5:37 PM, Surveyor emailed Licensee A and stated that the communicable disease screen statements were not signed by a medical professional and there were no TB tests submitted. | N 220 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 220 | Continued From page 2<br><br>As of 03/11/2024 at 4:30 PM, Surveyor did not receive any additional documentation. | N 220 | | |
| N 230 | 83.19 Orientation<br><br>Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following:<br>(1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 1 staff record reviewed received all required orientation training prior to performing job duties.<br><br>Caregiver D did not have training to include emergency and disaster plan and evacuation procedures.<br><br>Findings include:<br><br>On 03/06/2024, Surveyor reviewed Caregiver D's training record.<br><br>Caregiver D was hired in 06/2023. Surveyor could not locate orientation training pertaining to | N 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 230 | Continued From page 3<br>emergency and disaster plan and evacuation procedures.<br><br>On 03/07/2024 at 5:37 PM, Surveyor emailed Licensee A and stated Caregiver D's record did not include training in emergency and disaster plan and evacuation procedures.<br><br>As of 03/11/2024 at 4:30 PM, no additional documentation has been received. | N 230 | | |
| N 239 | 83.20(2)(a)-(d) Department-approved training courses.<br><br>Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material.<br>Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety.<br>First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking.<br>Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. | N 239 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 239 | Continued From page 4 | N 239 | | |

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure 1 of 3 staff records reviewed obtained all department approved training as required.

Caregiver D did not have training in fire safety and first aid and choking within 90 days after starting employment.

Caregiver D did not contain evidence of training or evidence of meeting an exemption for medication administration.

Findings include:

On 03/06/2024, Surveyor reviewed Caregiver D's record.

Caregiver D, hired in 06/2023, contained the Nurse Aide certification, issued 08/25/2021 and expired in 08/31/2025. Caregiver D's record did not contain documentation that s/he had completed a medication aide training program with this certification.

Caregiver D's record did not contain department approved training or an exemption in medications, first aid and choking, and fire safety.

On 03/06/2024, Surveyor reviewed Resident 1's February 2024 and March 2024 medication administration records which documented Caregiver D administered his/her medications on 02/01, 02/02, 02/04, 02/12, 02/18, 02/23, 03/01, 03/02, and 03/03.

On 03/07/2024 at 5:37 PM, Surveyor emailed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 239 | Continued From page 5<br><br>Licensee A and stated Caregiver D's record did not include department approved training in medications, first aid and choking, and fire safety.<br><br>On 03/07/2024, Surveyor verified through the CBRF training registry that Caregiver D had not received required Department approved training in medications, first aid and choking, and fire safety.<br><br>As of 03/11/2024 at 4:30 PM, no additional documentation has been received. | N 239 | | |
| N 277 | 83.25 Continuing education<br><br>The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following:<br>(1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 1 staff (Caregiver E) records reviewed received all required continuing education in 2022 and 2023.<br><br>Findings include: | N 277 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 277 | Continued From page 6<br>On 03/06/2024, Surveyor reviewed Caregiver E's record.<br><br>Caregiver E was hired in 06/2021.<br>Caregiver E's record did not contain any continuing education for 2022 and 2023.<br><br>On 03/07/2024 at 5:37 PM, Surveyor emailed Licensee A and stated Caregiver E's record did not contain any documentation regarding his/her continuing education for 2022 and 2023.<br><br>As of 03/11/2024 at 4:30 PM, no additional documentation has been received. | N 277 | | |
| N 352 | 83.32(3)(h) Rights of Residents: Receive medication<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 1 out of 1 resident reviewed.<br><br>Resident 1's Honey Calcium Alginate (wound dressing), Sarna (anti-itch lotion), Vitamin B-12 and Vitamin D3 were not administered at the prescribed times.<br><br>Findings Include: | N 352 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 352 | Continued From page 7<br>On 02/07/2024, the Department received a concern that alleged residents were not receiving their prescribed medications.<br><br>On 03/04/2024, at approximately 1:30 PM, Surveyor discussed the alleged concern with Licensed Practical Nurse (LPN) C and Caregiver D. LPN C and Caregiver D were unsure which resident supposedly did not receive their prescribed medications. Surveyor asked to review the residents progress notes which documented:<br>"01/10/2024 6-2PM - [Resident 1's] leg is not getting done but people are signing for it in the MAR? It needs to be done 2x/day if you don't know how to do it please ask me [Caregiver D]."<br>"01/11/2024 1-4PM - [Resident 1] leg not done again?" Signed by [Caregiver D].<br>"01/15/2024 6AM - [Resident 1's] leg not done all weekend??? Write ups will start when job isn't being done. Per [Licensee A]!<br>Surveyor asked Caregiver D how s/he knew Resident 1's Honey Calcium wound dressing was not being changed. Caregiver D stated, "I dated the pads, so I knew they weren't changed."<br><br>On 03/04/2024, Surveyor reviewed Resident 1's record.<br><br>Resident 1's January, February, and March 2024 Medication Administration Record (MAR), dated 01/12/2024 to 03/04/2024, documented:<br>"Vitamin B-12 - Take 2 tablets (1000 MG) by mouth in the morning for supplement. Start Date: 05/24/2023."<br>"Vitamin D3 - Take one tablet by mouth once a day. Start Date: 05/24/2023."<br>The MAR documented that the medication was not available, and that family would supply it.<br>"Sarna - Apply 1 application topically three times | N 352 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 352 | Continued From page 8<br>daily to affected area of skin. Scheduled at 8AM, 4PM and 8PM. Start Date: 05/26/2022"<br>The MAR documented that the lotion was not applied 11 out of the 84 opportunities. A handwritten note stated, "Needs To Be Done!"<br>The MAR did not have notation regarding rationale as to why the medication was not being administered.<br>"Honey Calcium Alginate - Apply 1 patch topically twice daily. Start Date: 11/30/2023."<br>The MAR had a handwritten note that stated, "Needs To Be Done! Step by Step notes hung up to do this by med cart, in [his/her] room, in cabinet by [his/her] supplies & in here!"<br><br>On 03/04/2024, at approximately 1:30 PM, interviewed LPN C. LPN C stated Resident 1 is now receiving wound care , so staff is no longer responsible for the wound patch. LPN C explained that the family wanted to provide Resident 1's Vitamin B-12 and Vitamin B-3, because it would be cheaper. LPN C stated, "The family keeps telling us they are bringing the vitamins in and then they do not. I have asked if they want the medications discontinued, which they do not." Surveyor asked why notations were made on the MAR stating "Needs To Be Done!" next to Sarna and Honey Calcium Alginate. LPN C stated, "Based on what Caregiver D had noticed and how the resident's skin would appear." | N 352 | | |
| N 387 | 83.35(3)(b) Service plan development: parties involved<br><br>Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s | N 387 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 387 | Continued From page 9 | N 387 | | |

legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the resident's Individual Service Plan (ISP) were signed by the resident or resident's legal representative and/or managed care organization (MCO) representative acknowledging their involvement in, understanding of, and agreement with the plan for 2 of 2 residents reviewed (Resident 1 and Resident 2).

Findings include:

On 03/04/2024, Surveyor reviewed Resident 1's and Resident 2's record.

Example 1: Resident 1
Resident 1 was admitted to the facility on 01/08/2021 and had representative Power of Attorney (POA) G and MCO Care Manager H. Resident 1's ISPs, dated 01/10/2024, 01/03/2023, 07/01/2022, and 09/04/2021 did not contain signatures from the provider, POA G, or CM H.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 387 | Continued From page 10<br><br>Example 2: Resident 2<br>Resident 2 was admitted to the facility on 05/09/2021 and had representative Guardian F and MCO CM I.<br>Resident 2's ISPs, dated 01/10/2024, 07/13/2023, 01/12/2023, 06/01/2022 and 12/04/2021 did not contain signatures from the provider, Guardian F, or CM I.<br><br>On 03/04/2024, at approximately 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he would review the resident ISPs and ensure proper signatures were obtained. | N 387 | | |
| N 389 | 83.35(3)(d) Service plans updated annually or on changes<br><br>Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the | N 389 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 389 | Continued From page 11<br>Individual Service Plan (ISP) for 1 of 1 resident was not updated when there was a change in resident needs and abilities.<br><br>Resident 1's ISP was not updated to include interventions/guidelines regarding his/her fall risks.<br><br>Findings include:<br><br>On 03/04/2024, Surveyor reviewed Resident 1's record and identified the following:<br><br>Resident 1 admitted to the provider on 01/08/2021 with diagnoses including dementia with depression, chronic obstructive pulmonary disease (COPD), anxiety, and history of falling.<br><br>Resident 1's ISP, dated 01/10/2024, documented:<br>"Behaviors - None"<br>"Mobility - Independent"<br>Surveyor noted the ISP did not provide care/guidelines for most categories identified.<br><br>Resident 1's "Accident/Incident Reports" documented:<br>02/11/2024 - Went to get off the chair and slide off the chair and went to the floor. Prevention: Ask him/her if s/he needs help getting up and assist with him/her with help. Stand close to him/her in case something happens.<br>02/01/2024 - I was at the kitchen sink and heard a faint help two times. I went to check and [Resident 1] was on the floor. Prevention: Offer help more often.<br>08/15/2023 - Resident fell backwards getting dressed. Landed on buttocks. Prevention: Resident to ask for assistance.<br>06/02/2023 - Heard resident fall in his/her room. Prevention: Resident reminded to move slowly | N 389 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 389 | Continued From page 12<br>and ask for help if needed.<br><br>Resident 1's managed care organization "Semi Annual/Annual" report, dated 11/12/2020, documented:<br>"History of falling - Some required ER (emergency room) visits, with no sig (significant) injury. Member reports having cane and walker, but does not use them. Encouraged to use them."<br>"Musculoskeletal - Member has musculoskeletal symptoms and weakness, poor balance/coordination ... sometimes feels unsteady when walking, is steady by holding onto furniture when walking, is worried about falling, needs to push with hands to stand up from a chair, and has some trouble stepping up onto a curb."<br>"Functional Exam - Assistance needed with mobility in home. Assistance needed with transfers."<br><br>On 03/04/2024, at approximately 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) C. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he would review the resident ISPs and ensure they were individualized. | N 389 | | |
| N 392 | 83.35(4) Resident satisfaction evaluation.<br><br>Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a | N 392 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 392 | Continued From page 13<br>department form or a form developed by the CBRF and approved by the department.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure that a Resident Satisfaction Survey was completed for all residents in 2022 and 2023.<br><br>Findings include:<br><br>On 03/04/2024, at approximately 2:00 PM, Surveyor asked Licensed Practical Nurse (LPN) C if the provider had sent out the resident satisfaction survey to all residents and their representatives for 2022 and 2023.<br><br>On 03/04/2024, at approximately 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he was unaware if the surveys had been sent out.<br><br>As of 03/11/2024 at 4:30 PM, Surveyor did not receive any additional documentation. | N 392 | | |
| N 394 | 83.35(5)(b) Annual evaluation of evacuation limits<br><br>Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the | N 394 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 394 | Continued From page 14<br>provider did not ensure 2 of 2 resident records reviewed (Resident 1 and Resident 2) were evaluated annually to determine their mental or physical capability to respond to a fire alarm.<br><br>Findings include:<br><br>The provider is licensed to care for a maximum of 11 residents within the client group advanced aged.<br><br>On 03/04/2024, Surveyor reviewed Resident 1's and Resident 2's record.<br><br>Resident 1 was admitted 01/08/2021. Resident 1's record did not contain an evacuation assessment until 03/16/2021, completed by Administrator B.<br><br>Resident 2 was admitted 05/09/2021. Resident 2's record contained an evacuation assessment dated 05/09/2021 and was completed by his/her guardian, Guardian F.<br><br>On 03/04/2024, at approximately 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he was unaware that the evacuation assessments needed to be completed annually by the provider. LPN C stated s/he would review all resident evacuation assessments. | N 394 | | |
| N 406 | 83.37(1)(g) Disposition of medications.<br><br>Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be | N 406 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 406 | Continued From page 15<br>sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure the policy for disposing of outdated medications was implemented to maintain compliance with federal, state, and local standards, laws, or regulations. Outdated over-the-counter (OTC) and prescribed medications were observed in the medication closet.<br><br>Findings include:<br><br>On 02/07/2024, the Department received a concern that alleged expired medications were stored in the med cart. | N 406 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 406 | Continued From page 16<br><br>On 03/04/2024, at approximately 2:00 PM, Surveyor reviewed the provider's 2023 annual medication review which documented that expired medications had been found in the med cart. Surveyor asked Licensed Practical Nurse (LPN) C to review the med cart with Surveyor. Surveyor and LPN C found the following expired medications:<br><br>Resident 3<br>Blister cards of 'as needed' (PRN) docusate, expired 01/09/2023, and PRN docusate, expired 09/26/2023<br>Blister card of scheduled 4 MG (milligram) Warfarin, expired 12/17/2023<br>Blister card of scheduled 3 MG Warfarin, expired 12/17/2023<br>Blister card of Meclizine 25 MG, expired 07/07/2023<br><br>Resident 4<br>Blister card of PRN acetamin 500 MG, expired 12/17/2022<br><br>Resident 5<br>Blister card of PRN famotidine, expired 08/18/2023<br><br>On 03/04/2024, at approximately 2:15 PM, Surveyor interviewed LPN C. LPN C stated the medications should have been destroyed. LPN C stated s/he would implement a process to check the med cart for expired medications. | N 406 | | |
| N 408 | 83.37(1)(i) PRN psychotropic medication.<br><br>As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF | N 408 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 408 | Continued From page 17<br>shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure that 1 of 1 (Resident 2's) prescribed PRN (as needed) psychotropic medication (Lorazepam) was monitored at least monthly for the inappropriate use of the PRN psychotropic medication.<br><br>Findings include:<br><br>On 03/04/2024, Surveyor reviewed Resident 2's record.<br><br>Resident 2's December 2023, January 2024, and February 2024 MAR (Medication Administration Record) documented the following medication:<br><br>"Lorazepam 0.5 MG (milligram) tablet, Take 1 tablet by mouth once daily as needed for anxiety. Start Date of 08/21/2023." | N 408 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 408 | Continued From page 18<br><br>Resident 2's December 2023 MAR documented the PRN Lorazepam was administered:<br>12/03 with no documented rationale or outcome<br>12/10 with no documented rationale or outcome<br>12/15 with no documented rationale or outcome<br>12/19 with documented rationale of "Christmas party," outcome of "Good"<br><br>Resident 2's January 2024 MAR documented the PRN Lorazepam was administered:<br>01/17 with documented rationale of "anxiety," outcome of "Better"<br>01/29 with no documented rationale or outcome<br><br>Resident 2's February 2024 MAR documented the PRN Lorazepam was administered:<br>02/07 with no documented rationale or outcome<br>02/14 with documented rationale of "anxiety," outcome of "Better"<br><br>Resident 2's "Individual Service Plan," dated 01/10/2024, documented:<br>"Resident may get 'voice thoughts.' To help calm them down it is good for [him/her] to sit/relax alone or have a PRN Lorazepam."<br><br>Resident 2's January and February 2024 progress notes that correlated with dates PRN Lorazepam was administered, documented:<br>01/17/2024 - "[Resident 2] asked for PRN Lorazepam @ noon - Given."<br>01/29/2024 - No concerns noted.<br>02/07/2024 - No concerns noted.<br>02/14/2024 - "[Resident 2] had PRN when [s/he] came home had the 'squigglies' during [day program], given at 11:30 AM."<br><br>Resident 2's record did not contain any monthly PRN psychotropic medication reviews. | N 408 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 408 | Continued From page 19<br><br>On 03/04/2024, at approximately 2:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he was not aware that PRN psychotropic medications needed to be reviewed monthly and s/he would start to do that. Surveyor stated the rationale for Resident 2's PRN Lorazepam did not match the rationale that staff recorded, compared to what was in his/her ISP. LPN C stated s/he would review and update Resident 2's ISP and discuss with staff documentation requirements. | N 408 | | |
| N 415 | 83.37(2)(d) Documentation of medication administration.<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure proper documentation of the Medication Administration Record (MAR) for 1 of 1 resident record reviewed. | N 415 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 415 | Continued From page 20 | N 415 | | |

Resident 2's prescribed PRN (as needed) Lorazepam (antipsychotic medication) narcotic count did not correlate with his/her MARs. Resident 2's MARs did not document outcome after administering the PRN Lorazepam.

Findings include:

On 03/04/2024, at approximately 11:15 AM, Surveyor observed Resident 2 request a PRN from Licensed Practical Nurse (LPN) C as s/he was having anxiety with the Surveyor in the building.

On 03/04/2024, at approximately 11:30 AM, Surveyor reviewed Resident 2's Lorazepam count with LPN C.

Resident 2's Lorazepam narcotic count sheet documented the medication had been administered 5 times in December 2023, 7 times in January 2024, and 7 times in February 2024.

Resident 2's December 2023 MAR documented the PRN Lorazepam was administered:
12/03 with no documented outcome
12/10 with no documented outcome
12/15 with no documented outcome
12/19 with documented outcome of "Good"
The MAR documented the Lorazepam had been given 4 times, where the narcotic count documented it had been administered 5 times.

Resident 2's January 2024 MAR documented the PRN Lorazepam was administered:
01/17 with documented outcome of "Better"
01/29 with no documented outcome
The MAR documented the Lorazepam had been given 2 times, where the narcotic count

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 415 | Continued From page 21<br>documented it had been administered 7 times.<br><br>Resident 2's February 2024 MAR documented the PRN Lorazepam was administered:<br>02/07 with no documented outcome<br>02/14 with documented outcome of "Better"<br>The MAR documented the Lorazepam had been given 2 times, where the narcotic count documented it had been administered 7 times.<br><br>On 03/04/2024, at approximately 12:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he was aware the narcotic count sheet did not match Resident 2's MARs and had been working with staff to understand the importance of proper documentation. | N 415 | | |
| N 452 | 83.41(3)(b) Food safety.<br><br>Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. | N 452 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 452 | Continued From page 22<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not store food under sanitary conditions. Surveyor found food items in the refrigerator that were not properly sealed and dated to avoid spoilage. The provider did not implement a system to identify when opened food was to be discarded for the prevention of food borne illnesses. Surveyor found expired dry goods.<br><br>Findings include:<br><br>On 03/04/2024, at approximately 11:00 AM, Surveyor toured facility and observed the following:<br><br>Refrigerator:<br>A blue plastic glass that contained a red liquid that was not sealed, nor dated.<br>A plastic bag of what appeared to be sliced onions that were not dated.<br>A plastic bag of what appeared to be sliced green peppers that were not dated.<br>A 32 ounce opened container of potato salad that was not dated.<br>A plastic bowl, with a blue lid, that contained what appeared to be refried beans, was not dated.<br>A plastic container, with a blue lid, that contained what appeared to be Spanish rice, was not dated.<br>A plastic bag that contained what appeared to be half a sandwich of meet and cheese that was not dated.<br><br>Popcorn Machine:<br>A 2.6-ounce container of sour cream & onion | N 452 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 452 | Continued From page 23 | N 452 | | |

flavored seasoning that had a best-by-date of 02/18/2022.
A 2.6-ounce container of ranch flavored seasoning that had a best-by-date of 03/16/2022.
A 2.6-ounce container of cheesy jalapeno flavored seasoning that had a best-by-date of 03/08/2021.
A 2.6-ounce container of cheesy caramel corn flavored seasoning that had a best-by-date of 02/28/2022.

On 03/04/2024, at approximately 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he was aware that food items should be dated and reviewed for expiration dates.

"Time/temperature control for safety (TCS) guidelines indicate food prepared in a food establishment and held longer than a 24 hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Refrigerated, RTE (ready-to-eat)/TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed or discarded." (US Food and Drug Administration (FDA) Food Code, 2017, Section 3-501.17)

"Ready-to-eat TCS food (foods that need time and temperature control for safety) can be stored

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 452 | Continued From page 24<br>for only seven days if it is held at 41 degrees Fahrenheit or lower. The count begins on the day the food was prepared or a commercial container was open. TCS foods includes milk and dairy products, eggs, meat (beef, pork, and lamb), poultry, fish, shellfish and crustaceans, baked potatoes, tofu or other soy protein, sprouts and sprout seeds, sliced melons, cut tomatoes, cut leafy greens, untreated garlic-and-oil mixtures, and cooked rice, beans, and vegetables." (ServSafe Coursebook, 7th edition, 2017, p. 1-7, p. 1-8, and p. 7-3). | N 452 | | |
| N 499 | 83.45(3) Toxic substances.<br><br>Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were stored in a secured area.<br><br>Findings include:<br><br>The provider is licensed to care for a maximum of 11 residents within the client group advanced aged.<br><br>On 03/04/2024, at approximately 11:20 AM, Surveyor toured the facility and observed the following:<br><br>Kitchen sink cabinet<br>-32 fluid ounce bottle of multi surface cleaner<br>-9.7 ounce spray can of furniture polish | N 499 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 499 | Continued From page 25<br>-17 ounce spray can of stainless steel cleaner & polish<br>-16 ounce spray can of fire suppressant<br>-24 fluid ounce bottle of hardwood floor cleaner<br>-16 ounce spray can of stainless steel polish<br>-15 ounce bottle of cook-top cleaner<br>-32 fluid ounce bottle of glass cleaner<br><br>Kitchen cabinet<br>-96 pac container of dishwasher pacs - fresh scent<br><br>Kitchen countertop<br>-40 fluid ounce bottle of window cleaner<br>-32 fluid ounce bottle of cleaner with bleach<br>-24 fluid ounce bottle of disinfectant, deodorizer & cleaner<br><br>Common Area<br>-24 fluid ounce bottle of disinfectant, deodorizer & cleaner sitting next to the popcorn maker<br><br>Resident Bathroom<br>-29.4 ounce box of septic system maintenance<br>-24 fluid ounce bottle of clinging bleach gel - toilet bowl cleaner<br>-32 fluid ounce bottle of all purpose cleaner<br>-32 fluid ounce bottle of cleaner with bleach<br>-32 fluid ounce bottle of bathroom cleaner - fresh scent<br>Surveyor opened a drawer on the bathrooms sink vanity and observed what appeared to be mouse feces on top of a Depends and a bag of epsom salt.<br><br>Salon Area<br>-24 fluid ounce bottle of disinfectant, deodorizer & cleaner<br>-32 fluid ounce bottle of bathroom cleaner - fresh scent | N 499 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 499 | Continued From page 26<br>-(2) 6 fluid ounce bottle of nail polish remover<br><br>These areas were accessible to all residents. Residents were observed moving freely throughout the facility.<br><br>On 03/04/2024, at approximately 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he was aware that the cleaning supplies should have been securely stored. | N 499 | | |
| N 511 | 83.46(3) Public water supply or well water test.<br><br>Public water supply. The CBRF shall use a public water supply when available. If a public water supply is not available, the CBRF shall have a well that is approved by the state department of natural resources. The CBRF shall have the well water tested at least annually by the state laboratory of hygiene or other laboratory approved under ch. HFS 165. The CBRF shall maintain documentation of annual testing results.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the well water was tested annually by the state laboratory of hygiene or other laboratory approved under ch. HFS 165.<br><br>Findings include:<br><br>The facility had a private well for water.<br><br>On 03/04/2024, Surveyor requested safety reports to review, including the annual well water | N 511 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 511 | Continued From page 27<br>tests for 2022 and 2023. Surveyor was given a report dated 07/12/2022.<br><br>On 03/04/2024, at approximately 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he was unaware if the well water had been tested in 2023.<br><br>As of 03/11/2024 at 4:30 PM, Surveyor did not receive any additional documentation. | N 511 | | |
| N 525 | 83.47(2)(d) Fire drills.<br><br>Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.<br><br>This Rule is not met as evidenced by: | N 525 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 525 | Continued From page 28<br><br>Based on record review and interview, the provider did not conduct quarterly fire drills (including at least one fire evacuation drill simulating the conditions during usual sleeping hours) with both employees and residents in 2022 and 2023.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) OS9011, dated 03/12/2018.<br><br>Findings include:<br><br>The provider is licensed to care for a maximum of 11 residents within the client group advanced aged.<br><br>On 03/04/2024, Surveyor reviewed the facility's fire drills for 2022 and 2023:<br>03/06/2022 - no time of day documented<br>11/30/2022 - no time of day documented<br>04/18/2023 - 10:00 AM<br><br>On 03/04/2024, at approximately 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated these were the only fire drills s/he was able to locate for 2022 and 2023.<br><br>As of 03/11/2024 at 4:30 PM, Surveyor did not receive any additional documentation.<br><br>On 03/11/2024, Surveyor reviewed the Department file and was unable to locate a waiver filed by the provider for fire drills. | N 525 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 526 | Continued From page 29 | N 526 | | |
| N 526 | 83.47(2)(e) Other evacuation drills.<br><br>Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure evacuation drills, such as tornado, flooding or other emergency or disaster, were completed at least semi-annually. The provider's record did not include any drills for 2022 and 2023.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 6KJH11, dated 06/28/2022, and SOD OS9011, dated 03/12/2018.<br><br>Findings include:<br><br>The provider is licensed to care for a maximum of 11 residents within the client group advanced aged.<br><br>On 03/04/2024, at approximately 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he was unable to locate any other evacuation drills for 2022 and 2023.<br><br>As of 03/11/2024 at 4:30 PM, Surveyor did not receive any additional documentation.<br><br>On 03/11/2024, Surveyor reviewed the Department file and was unable to locate a waiver filed by the provider for other evacuation | N 526 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 526 | Continued From page 30<br>drills. | N 526 | | |
| N 535 | 83.48(1)(b) Smoke and heat detectors per NFPA 72.<br><br>Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure that CBRF (Community-Based Residential Facility) personnel tested and maintained documentation of checking the smoke and heat detection system at least once every other month.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 6KJH11, dated 06/28/2022.<br><br>Findings include:<br><br>The provider is licensed to care for a maximum of 11 residents within the client group advanced aged.<br><br>On 03/07/2024 at 6:00 PM, Surveyor emailed Licensee A and requested the provider's 2022 and 2023 smoke detector testing.<br><br>As of 03/11/2024 at 4:30 PM, Surveyor did not | N 535 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING WILLOWS | W4517 WILLOW BEND RD ELKHORN, WI 53121 |

| (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 535 | Continued From page 31<br>receive any additional documentation. | N 535 | | |
| N 539 | 83.48(3)(b) Sensitivity testing performed<br><br>Sensitivity testing shall be performed at intervals in accordance with NFPA 72.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the smoke and heat detection system had sensitivity testing for each device performed at intervals in accordance with NFPA (National Fire Alarm and Signaling Code) 72 requirements.<br><br>Findings include:<br><br>On 03/04/2024, Surveyor reviewed the provider's facility life safety code documentation.<br><br>There was no documentation found that the smoke and heat detection system had sensitivity testing in 2022 or 2023.<br><br>On 03/04/2024, at approximately 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN C stated that Licensee A had been on vacation for the past several months and Administrator B was on medical leave, so s/he was currently the staff member in charge. LPN C stated s/he was unable to locate the requested documentation.<br><br>On 03/07/2024 at 6:00 PM, Surveyor emailed Licensee A and requested the provider's 2022 or 2023 sensitivity testing of the smoke detection system.<br><br>As of 03/11/2024 at 4:30 PM, Surveyor did not | N 539 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 310585 | A. BUILDING: _____ B. WING _____ | C 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WHISPERING WILLOWS** | **W4517 WILLOW BEND RD ELKHORN, WI 53121** |

| (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 539 | Continued From page 32<br>receive any additional documentation. | N 539 | | |