STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016909	A. BUILDING: _____ B. WING _____	R-C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDY OAKS	**11831 120TH CT KENOSHA, WI 53158**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 07/31/2024, Surveyor conducted a verification visit and 1 complaint investigation. Three deficiencies were identified. Two of 3 deficiencies were repeat violations (see statement of deficiency TROT11 dated 02/02/2023). One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
{N 284}	83.26(2) Orientation, continuing education documented Employee orientation and hours of continuing education shall be documented in the employee ' s file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each employee's required continuing education (CE) training was documented for 2 of 2 employees reviewed (Administrator A and Caregiver C). Administrator A's and Caregiver C's record did not include documentation of 2023's CE training. This is a repeat deficiency. See Statement of Deficiency (SOD) TROT11, dated 02/02/2023. Findings include: On 07/31/2023, at 11:55 AM, Surveyor reviewed employee records and identified the following: -Administrator A was hired on 12/07/2017. Administrator A's record did not include	{N 284}		

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

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{N 284}	Continued From page 1 documentation of CE training for 2023. -Caregiver C was hired on 08/21/2018. Caregiver C's record did not include documentation of CE training for 2023. On 07/31/2024, at 2:35 PM, Surveyor interviewed Administrator A regarding employee continuing education. Administrator A confirmed continuing education had not been completed, stating, "We just haven't done it. It's in the works."	{N 284}		
N 449	83.41(2)(b) Nutrition: meals Meals. 1. The CBRF shall provide meals that are routinely served family or restaurant style, unless contraindicated in a resident ' s individual service plan or for short-term medical needs. 2. The CBRF shall provide at least 3 meals a day, unless otherwise arranged according to the program statement or the resident ' s individual service plan. A nutritious snack shall be offered in the evening or more often as consistent with the resident ' s dietary needs. 3. If a resident is away from the CBRF during the time a meal is served, the CBRF shall offer food to the resident on the resident ' s return. This Rule is not met as evidenced by: Based on observation and interviews, the provider did not offer nutritious snacks to meet the needs of 8 of 8 residents (Residents 2, 3, 4, 5, 6, 7, 8 and 9). Findings include: The provider is licensed to care for 8 residents in	N 449		

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N 449	Continued From page 2 the client group developmentally disabled. On 07/16/2024, the Department received a complaint related to residents not being allowed to access food outside of mealtimes. On 07/31/2024, Surveyor toured the facility's kitchen and observed no food available on the kitchen counter. A key was required to access food in the kitchen cabinet. On 07/31/2024 at approximately 10:30 AM, Surveyor interviewed Administrator A about the reason for keeping the food pantry locked. Administrator A stated they did this to keep the residents from eating all day long. Surveyor asked what staff was trained to do if a resident says they were hungry. Administrator A stated, "We encourage them to wait until the meal is ready." Surveyor asked if there was ever a fruit bowl, or any other snacks left out for between meals or during the evening. Administrator A stated, "No, I didn't know that was a requirement."	N 449		
{N 543}	83.48(4)(c) Smoke detectors not more 30 feet apart Pursuant to s. 50.035(2)(b), Stats., all facilities shall have at least one smoke detector located at each of the following locations: Spaced not more than 30 feet apart in every corridor, and not further than 15 feet from any wall or in accordance with the manufacturer ' s separation specifications. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure smoke detectors were placed in the required locations. The corridor between	{N 543}		

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{N 543}	Continued From page 3 Resident 3's bedroom and kitchen did not contain a smoke detector. This is a repeat deficiency. See Statement of Deficiency (SOD) TROT11, dated 02/02/2023. Findings include: The facility was licensed on 03/01/2019 as a class AA (Ambulatory) facility to serve 8 residents. On 07/31/2024, at 10:00 AM, Surveyor toured the facility and observed the corridor between Resident 3's bedroom and kitchen did not contain a smoke detector. On 07/01/2024, at 2:35 PM, Surveyor interviewed Administrator A. Administrator A stated, "I thought the previous surveyor said we had to install a smoke detector in the storage closet so that's what I had done. I will install another one in the hallway."	{N 543}		