

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/29/2024
NAME OF PROVIDER OR SUPPLIER WILLOW WINDS IV		STREET ADDRESS, CITY, STATE, ZIP CODE N 348 TWINKLING STAR RD WHITEWATER, WI 53190		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	INITIAL COMMENTS On 03/26/2024, with information gathered through 03/29/2024, Surveyor conducted a verification visit at Willow Winds IV. Two deficiencies were identified. Four of the 7 deficiencies were repeat violations (see Statement of Deficiency (SOD) Z7JO11). Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 4	{M 000}		
M 438	88.07(2)(b) SERVICES DIRECTED TO GOALS Services shall be directed to the goal of assisting, teaching and supporting the resident to promote his or her health, well-being, self-esteem, independence and quality of life. The services shall include but are not limited to: This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not provide services specified in 1 of 1 resident Individual Service Plan (ISP) and/or Behavior Support Plan (BSP). Resident 8's ISP and/or BSP identified s/he required cueing for cleaning and/or daily tasks, which were not received. Findings include: On 03/26/2024, from approximately 1:35 PM to 2:45 PM, Surveyor toured the home and observed Resident 8's room which displayed: -Beverage bottles laying on the floor	M 438		

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/29/2024
NAME OF PROVIDER OR SUPPLIER WILLOW WINDS IV			STREET ADDRESS, CITY, STATE, ZIP CODE N 348 TWINKLING STAR RD WHITEWATER, WI 53190		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
M 438	Continued From page 1 -Bag of garbage tipped over onto the floor -What appeared to be food spilled out onto the floor -Mattress pad had what appeared to be blood circular stains. The bed did not have a bedsheet. -Pillow had a brown and red circular pattern where one would rest his/her head -Soiled peri pads were lying on the floor -Laundry baskets full of clothing stacked up in the closet -Toilet had what appeared to be blood stains along the rim On 03/26/2024, Surveyor reviewed Resident 8's record. Resident 8 moved into the home, 12/31/2019, with diagnoses including developmental disability, anxiety, and depression. Resident 8's ISP, dated 08/24/2023, documented: "Activities of Daily Living: Cleaning - Needs Supervision" Resident 8's BSP, dated 08/10/2023, documented: "Review the schedule with [Resident 8]: Help [Resident 8] to understand the daily schedule. Praise [Resident 8] for positive/appropriate behavior - even the small things." On 03/26/2024, at approximately 2:30 PM, Surveyor toured Resident 8's room with Caregiver E. Caregiver E stated that staff should be assisting Resident 8 in maintaining his/her room. On 03/29/2024 at 10:12 AM, Surveyor informed Administrator B that the condition of Resident 8's room was concerning. Administrator B stated, "The issue with [Resident 8's] room has been	M 438			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/29/2024
NAME OF PROVIDER OR SUPPLIER WILLOW WINDS IV		STREET ADDRESS, CITY, STATE, ZIP CODE N 348 TWINKLING STAR RD WHITEWATER, WI 53190		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 438	Continued From page 2 addressed."	M 438		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on observation and interview, the licensee did not maintain the records for 1 of 2 resident records reviewed in a secure location within the home. Resident 3's current Individual Service Plans (ISPs) was not accessible to scheduled care staff. Findings include: On 03/26/2024, from approximately 1:35 PM to 2:45 PM, Surveyor toured the home, while Resident 3 came in and out of the home. At approximately 2:00 PM, Caregiver E arrived. Surveyor asked if Resident 3 is allowed to come and go from the home. Caregiver E stated, "[Resident 3] usually goes next door, sometimes to one of the other homes." On 03/26/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 03/14/2022 and has a guardian.	M 482		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/29/2024
NAME OF PROVIDER OR SUPPLIER WILLOW WINDS IV		STREET ADDRESS, CITY, STATE, ZIP CODE N 348 TWINKLING STAR RD WHITEWATER, WI 53190		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 482	Continued From page 3 Resident 3's record did not contain an ISP. On 03/26/2024, at approximately 2:25 PM, Surveyor interviewed Caregiver E. Surveyor asked if Resident 3's had an ISP available in the home. Caregiver E stated, "If the ISP is not in the binder then it is because [Administrator B] is updating it and hasn't gotten the updated version back into the binder." On 03/29/2024 at 10:12 AM, Surveyor informed Administrator B that Resident 3's ISP was not available during the onsite survey. Administrator B stated, "[Resident 3] was hospitalized for pneumonia. And my staff must have sent out [his/her] ISP instead of a face sheet and did not let me know."	M 482		