STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017456	A. BUILDING: _____ B. WING _____	R-C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWICK MOMENTS CLINTON	304 OGDEN AVE CLINTON, WI 53525

(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 02/17/2026, Surveyors conducted a verification visit at Willowick Moments Clinton, a CBRF in Clinton. Four deficiencies were identified. These are repeat deficiencies. See statement of deficiency (SOD) #ZTYX11, dated 12/13/2024, and SOD # 6W5N11, dated 01/17/2023. Three of the 7 deficiencies from SOD ZTYX11, dated 12/13/2024, were substantially corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 18	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication 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. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 5 residents reviewed received their medications as prescribed. Resident 12 did not receive his/her lisinopril as prescribed. Resident 13 did not receiver his/her rivastigmine as prescribed.	N 352		

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

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N 352	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) ZTYX11, dated 12/13/2024. Findings include: On 02/17/2026 at approximately 8:30 a.m., Surveyors arrived at the facility to conduct a verification visit. Surveyors requested a resident roster from Administrator C. Example 1- Resident 12 On 02/17/2026 at approximately 10:00 a.m., Surveyors completed a medication cart audit with Wellness Coordinator D. Surveyor observed that Resident 12 did not receive his/her lisinopril for the 8:00 a.m. dose on 02/17/2026. Wellness Coordinator D stated that Resident 12 often refused medications, or it was held due to vitals. Surveyor reviewed Resident 12's record. Resident 12 was admitted to the provider's facility on 12/29/2025 with a diagnosis of high blood pressure. Resident 12's physician order included the following: - Lisinopril 2.5 mg Take 1 tablet by mouth once daily. Hold for Sbp (systolic blood pressure) < 110 Surveyor reviewed the Medication Administration Record (MAR), dated 01/03/2026 through 02/17/2026. The MAR indicated that lisinopril was held 9 times for vitals higher than 110 on the dates following: -01/11/2026 MAR documented No pass per vitals of 125/45 -01/16/2026 MAR documented No pass per vitals of 130/50 -01/25/2026 MAR documented No pass per vitals	N 352		

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N 352	Continued From page 2 of 148/85 -02/01/2026 MAR documented No pass per vitals of 142/98 -02/02/2026 MAR documented No pass per vitals of 127/60 -02/05/2026 MAR documented No pass per vitals of 140/91 -02/12/2026 MAR documented No pass per vitals of 135/80 -02/13/2026 MAR documented No pass per vitals of 150/80 -02/17/2026 MAR documented No pass per vitals of 137/80 On 02/17/2026 at approximately 1:00 p.m., Surveyor interviewed LPN W. LPN W stated that the order for the lisinopril was that the medication was to be held with a systolic blood pressure lower than 110. Surveyor showed LPN W the MAR for 02/17/2026 that indicated the lisinopril was held for vitals that were 137/80. LPN W acknowledged that the medication should not have been held. On 02/17/2026 at approximately 2:30 p.m., Surveyors discussed concern with Administrator C, Wellness Coordinator D and LPN W of Resident 12's medication being held 9 times with a systolic blood pressure higher than 110. Wellness Coordinator D stated that s/he would update the MAR so that staff would read it more clearly. EXAMPLE 2 - Resident 13 On 02/17/2026 at approximately 10:00 a.m., Surveyors completed a medication cart audit with Wellness Coordinator D. Surveyor observed that Resident 13 had a full box of rivastigmine that was unopened and dated 01/29/2026. Wellness	N 352		

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N 352	Continued From page 3 Coordinator D stated that the previous pharmacy delivered several extra boxes, so they were working through those first. Surveyor reviewed Resident 13's record. Resident 13 was admitted to the provider's facility on 05/23/2023 with a diagnosis of dementia. Resident 13's physician order included the following: -Rivastigmine Dis 9.5 mg /24 Apply 1 patch topically every day Surveyor reviewed the Medication Administration Record (MAR), dated 01/03/2026 through 02/17/2026. The MAR indicated that rivastigmine was passed every day from 01/03/2026 through 02/17/2026. On 02/17/2026 at approximately 11:30 a.m., Surveyor interviewed Pharmacy Tech X. Pharmacy Tech X stated that rivastigmine was dispensed on 01/29/2026 and 12/30/2025. Pharmacy Tech X stated that they had just started delivering medications at the beginning of the year. On 02/17/2026 at approximately 11:45 a.m., Surveyor interviewed Pharmacy Tech Y. Pharmacy Tech Y stated that Resident 13 had been on the rivastigmine since 2024. Pharmacy Tech Y stated that they had delivered 9 total boxes for the entire year 2025. Pharmacy Tech Y stated that since there were 12 months in 2025 and only 9 boxes delivered s/he was unaware of any extra boxes. On 02/17/2026 at 12:00 p.m., Surveyors observed Resident 13 with no rivastigmine patch on. Surveyors observed his/her arms, upper and	N 352		

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N 352	Continued From page 4 lower back. On 02/17/2026 at approximately 12:05 p.m., Surveyors interviewed Med Passer Z. Med Passer Z stated that s/he could not remember if s/he had used the last patch today for Resident 13. Surveyor asked Med Passer Z to locate the patches in the med cart to review from the morning med pass. Med Passer Z did not remember where in the med cart the patches were stored. Med Passer Z acknowledged that there was a full unopened box of rivastigmine in the med cart that was delivered on 01/29/2026. On 02/17/2026 at approximately 2:30 p.m., Surveyors discussed concern with Administrator C, Wellness Coordinator D and LPN W of Resident 13's rivastigmine not being passed as indicated. Administrator C stated that there were extra boxes of the medication. Surveyor indicated that pharmacy confirmed that only 9 boxes being delivered for 2025. Administrator C stated that s/he disagreed with the pharmacy. Administrator C stated that Resident 13 may have removed the patch.	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes 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	N 389		

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N 389	Continued From page 5 individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure an individual service plan (ISP) was updated when there was a change in condition or need for 2 of 5 residents reviewed. Resident 15's ISP was not updated to indicate s/he required increased assistance with mobility or the use of repositioning bars. Resident 16's ISP was not updated to indicate that s/he did not sleep on a bed. This is a repeat violation. See Statement of Deficiency (SOD), ZTYX11, dated 12/13/2024 and SOD 6W5N11, dated 01/17/2023. Findings include: EXAMPLE 1- Resident 15 On 02/17/2026 at approximately 9:10 AM, Surveyors toured the facility. Surveyors observed Resident 15's apartment and noted a variety of durable medical equipment, including a wheelchair, and bilateral repositioning bars on the bed. On 02/17/2026 at approximately 12:33 PM, Surveyor interviewed Med Passer Z. Med Passer Z stated Resident 15 completed pivot transfers and was not walking anymore.	N 389		

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N 389	Continued From page 6 On 02/17/2026 at approximately 12:56 PM, Surveyor interviewed Caregiver AA. Caregiver AA stated s/he had only been working for the provider for roughly 1 month, and Resident 15 had been transferring as a 1 assist pivot and utilizing a wheelchair and the bilateral repositioning bars the entire time. On 02/17/2026 Surveyor reviewed Resident 15's record and identified the following: Resident 15 admitted to the facility on 08/30/2021. Resident 15's ISP, dated 01/22/2026, documented: Mobility Status: Independent with mobility utilizes walker. Need for Adaptive Equipment: Resident utilizes a walker for ambulating. The ISP did not include Resident 15's increased mobility needs or repositioning bars. On 02/17/2026 at approximately 2:15 PM, Surveyors discussed concerns with Administrator C, Wellness Coordinator D and LPN W. Administrator C stated Resident 15's mobility/transfer status varied based on how strong s/he was feeling each day. Administrator C did agree Resident 15 had been pivot transferring and using the wheelchair often, and acknowledged the ISP was missing those details. EXAMPLE 2 - Resident 16 On 02/17/2026 at approximately 09: 00 a.m., Surveyors toured the facility and interviewed Resident 16. Surveyors observed Resident 16 in his/her apartment. Resident 16 did not have a bed in his/her room. Resident 16 had a couch with a sheet over the cushions. Resident 16	N 389		

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N 389	Continued From page 7 stated that s/he sleeps there. On 02/17/2026 at approximately 10:30 a.m., Surveyors reviewed Resident 16's record. S/he was admitted to the facility on 07/29/2025. The ISP, dated 01/09/2026, included no documentation that documented Resident 16's preferred method of sleeping. On 02/17/2026 at approximately 1:00 p.m., Surveyors interviewed Wellness Coordinator D. Wellness Coordinator D stated that Resident 16 preferred to sleep on the couch. Wellness Coordinator D stated that Resident 16 has slept on the couch since s/he moved in. Wellness Coordinator D was not sure why Resident 16's preferred sleeping method was not stated in the ISP. On 02/17/2026 at approximately 2:30 p.m., Surveyors discussed concern with Administrator C, Wellness Coordinator D and LPN W of Resident 16's preferred sleeping method not being updated in the ISP. Wellness Coordinator D stated that s/he updated the ISP to include that Resident 16 prefers to sleep on his/her couch.	N 389		
{N 408}	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF 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	{N 408}		

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{N 408}	Continued From page 8 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that prescribed PRN (as needed) psychotropic medications were documented on the Individualized Service Plan (ISP) with a rationale for use, nor a detailed description of the behaviors, which indicate the need for administration. Resident 14 took PRN hydroxyzine for anxiety. Resident 14's ISP did not include information about the medication. This is a repeat deficiency. See statement of deficiency (SOD) ZTYX11, dated 12/13/2024. Findings include: On 02/17/2026 Surveyor reviewed Resident 14's record which documented the following: Resident 14 was admitted to the provider's facility on 03/04/2025 with diagnosis including anxiety and shortness of breath. Resident 14's physician orders included: Hydroxyzine Hcl Tablet 25 mg- Take 1 tablet by mouth every 6 hours as needed for anxiety. Resident 14's ISP did not include information	{N 408}		

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{N 408}	Continued From page 9 about the hydroxyzine. On 02/17/2026 at approximately 2:15 PM, Surveyors discussed concerns with Administrator C, Wellness Coordinator D and LPN W. All confirmed knowledge of knowing to add PRN psychotropics into an ISP. No one was able to explain why Resident 14's ISP did not include the required information about the medication.	{N 408}		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interviews, the provider did not make reasonable efforts to keep all rooms clean and odor free. Resident 16 had feces running down the side of his/her toilet. Resident 17 had several piles of unwashed laundry in the bathroom, brown spots on the bedroom carpet, and a significant foul odor throughout the room. Resident 18 had a strong odor of urine and there were feces on the toilet, floor, shower stall and door. Resident 19 had 2 dirty garbage baskets with no bags, feces smeared down the front of the toilet bowl, soiled linens on the floor, and had a brown substance spread on the recliner. Findings include:	N 489		

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N 489	Continued From page 10 On 02/17/2026 at approximately 8:45 a.m., Surveyors toured the facility and observed the following: - Resident 16's bathroom was dirty with toilet paper on the floor. There was a large piece of feces that slid down the side of the toilet and was on the floor. The garbage can needed to be emptied in the bathroom. -Resident 17 had 1 large pile of soiled linens on the floor of his/her shower, soiled clothing and linens overflowing from a laundry basket under his/her bathroom sink. The bedroom carpet had brown spots across the center of the floor and in front of the recliner. The room had a very strong foul odor. -Resident 18 had a strong odor of urine and feces. Surveyor observed feces smeared all over the toilet seat and shower chair. Feces were on the bathroom floor and smeared on the main living room door. The garbage can needed to be emptied in the bathroom. -Resident 19 had 2 garbage cans, 1 near the bathroom door, and 1 near the recliner. Both were dirty with garbage in them and a dried yellow-brown substance dripped down the side and dried at the bottom. There was a soiled chuck pad on the floor. There was a brown substance smeared on the seat of the recliner. At approximately 1:30 p.m., Surveyor toured the facility, and the resident rooms had not been cleaned. Surveyors observed the rooms in the same condition as the 8:45 a.m. tour. At approximately 2:30 p.m., Surveyor interviewed Administrator C about the condition of the facility. Administrator C acknowledged the pictures that Surveyors showed. Administrator C	N 489		

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N 489	Continued From page 11 acknowledged the concern but did not have a reason as to why the rooms were not clean and odor free.	N 489		