STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 08/21/2024, the Department conducted an abbreviated survey at Tradewinds Residence Inc. Data was collected through 08/29/2024. Eight deficiencies were identified. Census: 16	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees sampled, obtained from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse, a screen for clinically apparent communicable disease, including tuberculosis, as required, within 90 days before the start of employment. Findings include:	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
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 The provider is licensed to care for 20 residents in the client groups alcohol/drug dependent, correctional clients, and emotionally disturbed/mental illness. On 8/21/2024, Surveyors reviewed 3 employee records. Caregiver F had a hire date of 03/04/2024. The record contained a document with vital signs but did not contain a screen for communicable disease. On 8/21/2024 at approximately 3:45 PM, Program Director (PD) A stated s/he can guarantee the communicable disease screen did not exist. PD A stated that Former Administrator (FA) D was a registered nurse (RN) and had been responsible for communicable disease screens, including tuberculosis, and that they currently did not have a RN on staff. PD A stated s/he had plans to contract with a vendor to assist with communicable disease screens. The provider did not ensure all staff were screened for communicable disease, including tuberculosis.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and	N 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 2 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 employees sampled, had completed orientation training prior to assuming job duties. Findings include: The provider is licensed to care for 20 residents in the client groups alcohol/drug dependent, correctional clients, and emotionally disturbed/mental illness. On 8/21/2024, Surveyors reviewed 3 staff records. Caregiver F, hired 03/04/2024, did not have documentation of training in abuse and neglect, policies and procedures, and responding to changes in condition. Caregiver E, hired 06/10/2023, did not have documentation of training in job responsibilities, abuse and neglect, needs of individuals in care, emergency plans, policies and procedures, and responding to changes in condition. At approximately 1:00 PM, Surveyors interviewed Program Director (PD) A, who stated that if s/he located additional training documents, s/he would email them. As of 08/22/2024, Surveyor had not	N 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 received additional training documentation. The provider did not ensure orientation training was completed for 2 of 3 employees.	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 243	Continued From page 4 training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 employees reviewed, obtained all employee training as required, within 90 days after starting employment. Caregiver E and Caregiver F did not have training in resident rights within 90 days after starting employment. Caregiver E and Caregiver F did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment. Caregiver E did not have training in required client groups within 90 days after starting employment. Findings include: On 08/21/2024, Surveyors conducted a review of 3 employees to verify compliance with all employee training requirements. Surveyors requested training records from Program Director (PD) A for Caregiver C, E, and F.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 243	Continued From page 5 Resident Rights The record for Caregiver E, hired 06/10/2023, did not contain evidence of training, or evidence of meeting an exemption for resident rights, within 90 days of hire. Caregiver E completed Resident Rights training 02/28/2024, approximately 7 months after hire. The record for Caregiver F, hired 03/04/2024, did not contain evidence of training or evidence of meeting an exemption for resident rights, within 90 days of hire. Caregiver F completed Resident Rights training on 06/29/2024, approximately 26 days after hire. On 08/11/2024 at approximately 3:45 PM, Surveyors interviewed Program Director (PD) A. PD A confirmed the provider did not have evidence Caregiver E or Caregiver F completed resident rights training within 90 days. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver E, hired 06/10/2023, did not contain evidence of training, or evidence of meeting an exemption for, challenging behaviors training. The record for Caregiver F, hired 03/04/2024, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 08/21/2024 at approximately 3:45 PM, Surveyors interviewed PD A. PD A confirmed the provider did not have evidence Caregiver E or Caregiver F completed, or met an exemption for, challenging behaviors training.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 243	Continued From page 6 Client Group The facility was licensed to provide care and services to residents within the client groups of alcohol/drug dependent, correctional clients, and emotionally disturbed/mental illness. The record for Caregiver E, hired 06/10/2023, did not contain evidence of training, or evidence of meeting an exemption for, client group training within 90 days of hire. Caregiver E completed client group training on 01/24/2024, approximately 17 months after hire. On 08/21/2024 at approximately 3:45 PM, Surveyors interviewed PD A. PD A confirmed the provider did not have evidence Caregiver E completed or met an exemption for client group training within 90 days of hire. On 08/22/2024 at 3:18 PM, PD A sent an email communication that read, in part, that s/he had not found any additional documentation of training.	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 247	Continued From page 7 development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees obtained all task specific training. Findings include: Caregiver E, who performs dietary duties, did not have training in dietary services within 90 days after assuming these job duties. On 8/21/2024, at approximately 2:45 PM, Surveyor reviewed Caregiver E's employee	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 247	Continued From page 8 record. Caregiver E, hired 6/10/2023, did not have training in dietary services until 4/23/2024, almost 1 year after assuming job duties. On 8/21/2024 at approximately 4:00 PM, Surveyor interviewed Program Director (PD) A. PD A confirmed that the provider did not have evidence that Caregiver E completed or met an exemption for dietary training within 90 days of assuming these job duties. As of 08/22/2024, Surveyor had not received any additional training documentation.	N 247		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need	N 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 404	Continued From page 9 physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a physician, pharmacist, or registered nurse conduct an onsite review of the provider ' s medication administration and medication storage systems. Findings include: The provider is licensed to care for 20 residents in the client groups alcohol/drug dependent, correctional clients, and emotionally disturbed/mental illness. On 8/21/2024, Surveyors requested the completed annual reviews for the past 2 years, for the medication administration and storage systems. Program Director (PD) A provided an annual medication administration and storage system review, dated 12/14/2021, and said s/he would look through additional files and email Surveyor if s/he located the annual reviews for 2022 and 2023. On 08/22/2024 at 10:12 AM, Surveyor received an email that included an annual medication administration and storage review, dated 08/22/2024, the day after the survey. As of 08/29/2024, Surveyor had not received additional documentation. The provider did not ensure annual medication administration and storage reviews were completed.	N 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 443	83.39(5) Pets vaccinated. The CBRF shall ensure that pets are vaccinated against diseases, including rabies, if appropriate. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure pets were vaccinated against diseases, including rabies, for a cat that resided in the facility. Findings include: The provider is licensed to care for 20 residents in the client groups alcohol/drug dependent, correctional clients, and emotionally disturbed/mental illness. On 8/21/2024 at 12:10 PM, Surveyor observed 1 cat at the facility. On 8/21/2024 at 1:05 PM, Surveyor requested the provider's pet vaccination records. Program Director (PD) A stated the cat was a stray and they had taken it to the vet for a rabies vaccination after the program decided to adopt it. PD A stated s/he was unable to locate the vet records. PD A stated the vaccination records used to be posted in the administrative office but when the office was repainted the vaccination record was lost. On 8/21/2024 at approximately 3:50 PM, PD A stated s/he will take the cat to a new veterinarian and get the cat vaccinated and retain the records. The provider did not ensure the program cat was vaccinated.	N 443		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 496	Continued From page 11	N 496		
N 496	83.45(1)(e) Electrical, mechanical, water supply	N 496		

Systems. The CBRF shall maintain all electrical, mechanical, water supply, plumbing, fire protection and sewage disposal systems in a safe and functioning condition.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not maintain the electrical system in a safe and functioning condition.

Findings include:

The provider is licensed to care for residents in the client groups alcohol/drug dependent, correctional clients, and emotionally disturbed/mental illness.

On 08/21/2024 at approximately 4:35 PM, Surveyors observed a water gutter connected to the roof. There was a gray colored electrical cord coming out of the rain downspout located about 8 inches from the ground and extending up to approximately waist high to a covered electrical outlet where the gray cord was plugged in.

Administrator A stated s/he believed the electrical cord ran up through the gutter to the roof, along the roof line where it connected to a camera. Administrator A stated s/he knew this was not safe and guessed that a maintenance person no longer employed installed the camera and ran the electrical cord through the rain gutter. Administrator A confirmed the camera was in use. Administrator A stated s/he would ensure that the electrical cord was removed from the gutter and would provide by email any additional information s/he uncovered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 496	Continued From page 12 On 08/22/2024 at 3:18 PM, Surveyor received an email from Administrator A that read s/he had not found any additional information regarding the electrical cord in the rain gutter. The provider did not ensure the electrical system was maintained in a safe manner.	N 496		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that at least two other emergency or disaster evacuation drills were conducted at least semi-annually. Findings include: The provider is licensed to care for 20 residents in the client groups alcohol/drug dependent, correctional clients, and emotionally disturbed/mental illness. On 8/21/2024 at approximately 1:30 PM, Surveyor reviewed the provider's emergency evacuation drills for 2022 and 2023, and did not find records of two other evacuation or disaster drills. On 8/21/2024 at approximately 3:55 PM, Surveyor interviewed Program Director (PD) A, who stated they had not been completing other emergency or disaster drills. PD A stated Former Administrator (FA) D was in charge of completing	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510325	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADEWINDS RESIDENCE INC	1601 N 16TH ST SUPERIOR, WI 54880

(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 13 these drills. PD A acknowledged that 2 other evacuation drills need to be completed each year. The provider did not ensure that at least two other emergency or disaster evacuation drills were conducted at least semi-annually.	N 526		