STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018180	A. BUILDING: _____ B. WING _____	R-C 09/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWICK MOMENTS	3024 SOUTH BARTELLS DRIVE BELOIT, WI 53511

(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 From 09/21/2026 through 10/01/206, Surveyors conducted a verification visit and complaint investigation at Willowick Moments, a CBRF in Beloit. Two deficiencies were identified. Two of 2 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) Q3RV12, dated 05/13/2026 and SODLO6W11, dated 03/13/2024. One of the deficiencies from SOD Q3RV12, dated 05/13/2026 was corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 24	{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 1 of 3 residents reviewed received their medications as prescribed. Resident 6 did not receiver his/her polyethylene glycol 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 Deficiencies LO6W11, dated 03/13/2024. Findings include: On 09/21/2026 at approximately 8:45 AM, Surveyors arrived at the facility to conduct a verification visit and complaint investigation that alleged the facility was not passing medications as prescribed. Surveyors requested a resident roster from Executive Director A. On 09/21/2026 at approximately 10:40 AM, Surveyors completed a medication cart audit with Caregiver F. Surveyor observed that Resident 6 had a bottle of polyethylene glycol with a filled date of 04/28/2026. Surveyor did not observe any other bottles of polyethylene glycol in the medication cart for Resident 6. Caregiver F stated that Resident 6 usually took his/her medications as prescribed except for his/her pain patch. Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider's facility on 07/21/2026 with a diagnosis of Alzheimer's. Resident 6's physician order included: - Polyethylene glycol- Mix 17 grams in 4 to 8 ounces of liquid every day for constipation. Surveyor reviewed the Medication Administration Record (MAR), dated 08/01/2026 through 09/21/2026. The MAR indicated that the polyethylene glycol was administered daily. On 09/21/2026 at approximately 2:30 PM, Surveyor interviewed LPN B. LPN B stated that the s/he or Wellness Coordinator D monitored the medication carts at least monthly. LPN B was not	N 352		

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N 352	Continued From page 2 aware of Resident 6 missing any doses of the polyethylene glycol. LPN B stated that staff would call if there was a problem with the medication. On 09/21/2026 at approximately 3:30 PM, Surveyors discussed concern with Executive Director A, LPN B and Wellness Coordinator D that Resident 6 was not receiving his/her polyethylene glycol as prescribed. Wellness Coordinator D stated that the facility would look into the issue for Resident 6. On 10/01/2026 at 11:17 AM, Surveyor interviewed Pharmacy Tech G. Pharmacy Tech G confirmed that 1 bottle of the polyethylene glycol powder contained a 30-day dose. Pharmacy Tech G confirmed that the last order date for the medication was 07/21/2026.	N 352		
{N 388}	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and observation, the provider did not ensure the individual service plan (ISP) of 1 of 3 residents reviewed was followed. Resident 5's record indicated s/he was an elopement risk and was issued an air tag for monitoring. Observation indicated that Resident 5 was not wearing the air tag and tried to elope 3 times while Surveyors were in the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) Q3RV12, dated 05/13/2026 Findings include:	{N 388}		

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{N 388}	Continued From page 3 On 09/21/2026 at approximately 10:35 AM, Surveyor observed Resident 5 in the dining area. Resident 5 was walking towards the exit door with his/her friend. Resident 5 tried to exit. Caregiver F stated that Resident 5 had a hard time when his/her friends were leaving the building. On 09/21/2026 at approximately 11:16 AM, Surveyors observed a staff member yelling in the main hallway. The staff member was yelling down the hallway that Resident 5 had gotten out of the far exit. Surveyor observed staff go outside and bring Resident 5 back into the facility. On 09/21/2026 at approximately 11:41 AM, Surveyors observed Resident 5 trying to exit the fire exit. The alarm on the door went off but no staff came to the alarm for over 4 minutes. Resident 5 got distracted by Surveyors asking him/her questions. Surveyors did not observe an air tag on Resident 5. On 09/21/2026 at approximately 11:45 AM, Surveyors interviewed Assistant Director E. Assistant Director E stated that Resident 5 was not wearing the shoes that had the air tag. Assistant Director E stated that s/he would have staff get those shoes on Resident 5 because Resident 5 had tried to elope 3 times in the last hour. On 09/21/2026, Surveyor reviewed Resident 5's record. Resident was admitted to the provider's facility on 04/01/2026. Resident 5's ISP, dated 07/27/2026, indicated s/he was an elopement risk. The ISP stated that Resident 5 had an elopement: "4/27/26 Resident had an elopement and was walking down the street. Air tag was assigned to resident. 5/15/26 Care staff will	{N 388}		

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{N 388}	Continued From page 4 continue to monitor resident when resident appears to want to exit the community, and redirect resident." On 09/21/2026 at approximately 3:00 PM, Surveyors shared concern with staff following the ISP with Executive Director A, Licensee H and LPN B. Licensee H stated that s/he felt staff were following the plan because the staff had caught Resident 5 in the 11:16 AM elopement attempt. Licensee H acknowledged that 4 minutes was too long for caregivers to attend Resident 5 during an elopement attempt. LPN B stated that the air tag was issued as a safety tool and did not track Resident 5.	{N 388}		