STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525656	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Winds Manor	303 S Jefferson St Verona, WI 53593

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility did not ensure that all alleged violations involving injuries of unknown source, are reported immediately, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 1 reportable incidents.On 10/27/25, 2 CNAs (Certified Nursing Assistants) observed a large bruise on R1's left upper arm. The 2 CNAs did not report the bruise. Upon further investigation, R1 had a non-displaced left humerus fracture.This is evidenced by:The facility's policy For Alleged Incidents of Abuse, Neglect, Misappropriation, Injuries of Unknown Origin, and Exploitation, dated 8/25, includes: All injuries, [sic] of unknown origin.will be immediately reported to the Director of Nursing or the Administrator/designee, in person or by phone and an investigation will be completed. The Administrator/designee will report all alleged violations immediately. If the events that cause the reasonable suspicion resulted in serious bodily injury to a resident, the covered individual must report the suspicion immediately. When any employee discovers an injuring of unknown origin.the employee's first priority is to protect the resident, and ensure the resident is safe. After establishing the resident's safety, they immediately report the observation to the supervisor on duty. Individual state reporting requirements will be adhered to. All allegations will be reported to the DQA (Department of Quality Assurance) immediately or not to exceed 24 hours or within 2 hours if an incident involves serious bodily injury.On 10/27/25 on the evening shift, CNA C (Certified Nursing Assistant) and CNA D provided cares for R1. CNA C and CNA D was assisting R1 after dinner. CNA C and CNA D noted a large, dark bruise on R1's left upper arm. CNA C and CNA D did not report this injury of unknown origin to their supervisor. On 10/28/25 at approximately 4:00 AM, CNA E noted a large bruise to R1's left upper arm. CNA E reported this bruise to LPN F (Licensed Practical Nurse). LPN F followed facility protocol to report the injury of unknown origin.On 11/6/25 at 10:50 AM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding R1's incident. NHA A indicated both CNA C and CNA D saw the bruise on 10/27/25 and did not report the bruise. NHA A indicated on 10/28/25, the night shift CNA (CNA E) reported the bruise to the nurse. NHA A indicated CNA C and CNA D should have reported the bruise immediately to their supervisor and did not.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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
	525656	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Winds Manor	303 S Jefferson St Verona, WI 53593

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (R2) reviewed for falls.R2's fall interventions were not in place when R2 had a fall resulting in a bloody nose.This is evidenced by:The facility's policy Comprehensive Care Planning, dated 4/23, includes: .will create an Initial Resident Baseline Care plan upon admission. Within 21 days and periodically a comprehensive, accurate, standardized assessment of each resident's function capacity is completed. The comprehensive assessment describes the resident's capability to perform daily life functions, strengths, and significant impairments in functional capacity. The results of the assessments . are used to develop, review, and revise the resident's comprehensive plan of care.R2 admitted to the facility on [DATE] with a diagnosis of Parkinson's (a progressive movement disorder with symptoms that include problems with movement, tremor, stiffness and impaired balance).R2's comprehensive care plan, dated 9/30/25, includes: Problem: Potential for injury related to fallsInterventions: Ensure my call light is within my reach before leaving my room. I have a mat on the floor next to my bedR2's Incident report, dated 10/3/25, includes:Incident type: Fall/Found on floorDate of Incident: 10/2/2025Time of Incident: 11:15 PMDescription of incident: CNA (Certified Nursing Assistant), [Name] discovered the resident lying face down on the floor beside the bed. Upon assessment, a small amount of blood was observed coming from the resident's nose, and the resident reported pain upon nasal palpitation.How/Where Resident Was Found: lying on floor face downCurrent Fall Precautions in place at time of incident: No no floor mat, call light was not within reached [sic]On 11/6/25 at 10:18 AM, Surveyor interviewed CNA G regarding fall interventions. CNA G indicated fall interventions are found in the resident's care plan and on the CNA care cards. CNA G indicated the CNA care cards are located in the resident's closet. CNA G indicated all interventions should be followed.On 11/6/25 at 10:20 AM, Surveyor interviewed CNA H regarding fall interventions. CNA H indicated resident's at risk for falling has a star on their name plate outside their room. CNA H indicated fall interventions are in the resident's closets and sometimes there are things written on the resident's whiteboard in their room. CNA H indicated fall interventions should be in place.On 11/6/25 at 10:30 AM, Surveyor interviewed RN I (Registered Nurse) regarding fall interventions. RN I indicated fall intervention are on the resident's care plan and the CNA care cards. RN I indicated fall interventions should be in place for residents per their care plans.On 11/6/25 at 10:50 AM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding fall interventions. NHA A indicated staff should have the resident's fall interventions in place. Surveyor asked NHA A about R2's fall and not having her fall mat in place when she fell on [DATE]. NHA A indicated she expects staff to follow the resident's care plan and R2 should have had all her interventions in place but did not.