| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0014008 | A. BUILDING: _____ B. WING _____ | C 07/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATERFORD MEMORY CARE LLC | 301 S SIXTH ST WATERFORD, WI 53185 |

| (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<br><br>On 07/28/2023, Surveyor concluded a complaint investigation at Waterford Memory Care LLC.<br><br>One deficiency was identified.<br><br>One complaint was substantiated.<br><br>Census: 26 | N 000 | | |
| N 397 | 83.36(1)(b) Qualified staff in charge, on duty and awake.<br><br>The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility did not provide qualified resident care staff in | N 397 | | |

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 |
|---|---|---|---|
| | 0014008 | A. BUILDING: _____ B. WING _____ | C 07/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATERFORD MEMORY CARE LLC | 301 S SIXTH ST WATERFORD, WI 53185 |

| (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 397 | Continued From page 1 | N 397 | | |

charge on the premises at all times to ensure that 26 of 26 residents received safe and adequate care, treatment, and services. Three of 3 caregiving staff left the residents untended when they all left the building to attend a mandatory staff meeting in the neighboring facility.

Findings include:

The facility is a Class CNA (non-ambulatory) Community Based Residential Facility (CBRF), licensed to serve up to 31 residents in the population groups irreversible dementia/Alzheimer's, and advanced aged. There were 26 ambulatory and non-ambulatory residents moving freely throughout the facility at the time of Surveyor's visit.

On 07/27/2023 at 10:35 AM, Surveyor interviewed Family Member (FM) A. FM A stated s/he and FM B attempted to visit Resident 1 at 12:50 PM on 07/12/2023. After ringing the doorbell 3 times, an unidentified member of the housekeeping staff came to the front door, swiped their employee badge to open the door and left the area. As FM A and FM B walked through the facility, they observed several residents and a few visitors seated in the dining room and several more residents in the living room. They did not observe any staff. While FM B visited with Resident 1, FM A walked throughout the entire building searching for staff and did not find any. FM A stated s/he attempted calling the neighboring facility which is owned by the same company 4 times hoping to find staff, and no one answered there. FM A stated that at approximately 1:45 PM, s/he went to the front of the building still trying to find staff. At the front of the building, FM A encountered several visitors both inside trying to leave and outside trying to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0014008 | A. BUILDING: _____ B. WING _____ | C 07/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATERFORD MEMORY CARE LLC | 301 S SIXTH ST WATERFORD, WI 53185 |

| (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 397 | Continued From page 2 | N 397 | | |

enter. These individuals stated they had not left as without an employee badge they would activate the alarm. FM A stated that s/he decided to open the door, hoping the alarm would alert someone to come. FM A stated the alarm rang until 2:00 PM when CNA D arrived for his/her shift. FM A stated CNA D informed them that all of the facility staff were at the neighboring facility at a mandatory staff meeting. FM A added that after CNA D arrived, s/he proceeded to visit with Resident 1, and that after a while, an arriving unknown visitor informed him/her that they had just witnessed the staff at the nurse's station being yelled at by a manager for all leaving the facility at once.

On 07/27/2023 at 1:00 PM, Surveyor interviewed Activity Team Lead (ATL) H. ATL H stated that mandatory meetings for all staff were held periodically. S/He added that staff from all departments, nursing/caregiving, activities, dietary, and housekeeping were expected to attend. ATL H stated the company believed all staff were part of a team working together, so all staff were included. When Surveyor asked about training, ATL H stated s/he completed mandatory CBRF training for all staff, but nothing regarding how to care for the residents.

On 07/27/2023 at 1:15 PM, Surveyor interviewed Administrator C. Administrator C acknowledged there was an approximate 1-hour time period when all staff left the building to attend a mandatory staff meeting at the sister facility next door. Administrator C concurred with ATL H that all departments were expected to attend the meetings, but added their policy was that 2 staff from the memory care unit (MCU) would remain there. Administrator C stated it was usually caregiving staff who remained in the unit, but at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0014008 | A. BUILDING: _____ B. WING _____ | C 07/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATERFORD MEMORY CARE LLC | 301 S SIXTH ST WATERFORD, WI 53185 |

| (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 397 | Continued From page 3 | N 397 | | |

times a member of the activity department would stay.

Administrator C informed Surveyor that Caregiver E, Scheduler F, and Former Caregiver (FC) G were scheduled to work on the MCU at the time of the meeting. All 3 staff were required to attend a training about communication and company policies as a result of this incident and all 3 received written warnings that termination could occur for future policy violations. FC G was terminated the same day as this was his/her third rule infraction.

On 07/27/2023 at 1:30 PM, Surveyor reviewed staff records for Caregiver E, Scheduler F and FC G. Records for the 3 each included a disciplinary summary that concluded an investigation completed by Administrator C into the incident on 07/12/2023. Caregiver E, Scheduler F, and FC G were all found to have left the unit for the meeting without confirming the presence of another caregiver remaining on the memory care unit.

On 07/27/2023 at 1:45 PM, Surveyor interviewed Scheduler F. Scheduler F stated the 3 staff had not intentionally left the facility untended. S/He explained Caregiver E was the person who planned to attend the meeting, but at the start time was involved in resident cares. Scheduler F stated s/he assumed the cares would prevent Caregiver E from attending, so s/he went in Caregiver E's place. Once at the meeting started, Scheduler F observed FC G in the room, but did not think it was a problem as Caregiver E was still on the MCU. Scheduler F stated that after the meeting s/he found out Caregiver E also attended the meeting, as originally planned, as s/he did not realize both of the other 2 were already at the meeting. Scheduler F informed Surveyor that all 3

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0014008 | A. BUILDING: _____ B. WING _____ | C 07/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATERFORD MEMORY CARE LLC | 301 S SIXTH ST WATERFORD, WI 53185 |

| (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 397 | Continued From page 4<br>of the staff felt very badly about leaving the MCU without any staff and were grateful nothing happened to any of the residents during this time. | N 397 | | |