STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015654	A. BUILDING: _____ B. WING _____	C 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD AT HARTFORD (THE)	**1025 BELL AVE HARTFORD, WI 53027**

(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
U 000	INITIAL COMMENTS On 09/23/2025, Surveyor conducted a complaint investigation at Waterford at Hartford, a Residential Care Apartment Complex (RCAC) in Hartford, WI. One deficiency identified. Complaint substantiated. Census: 26	U 000		
U 267	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order. This Rule is not met as evidenced by:	U 267		

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

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U 267	Continued From page 1	U 267		

Based on record review and interview, the Residential Care Apartment Complex (RCAC) did not ensure Resident 1 received all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician was given when managing Tenant 1's medications. Tenant 1 received 4 medications that were not prescribed to him/her.

Findings include:

On 09/03/2025, the Department received a complaint alleging a resident was given the wrong medications and was sent out to the hospital.

On 09/23/2025 at 11:30 AM, Surveyor reviewed Tenant 1's record and identified the following:

-Tenant 1 was admitted to the facility on 11/01/2024.
-Tenant 1's incident report dated on 09/02/2025 at 7:30AM stated Medication Error: "The resident received medications that were not [his/her] own. The resident received two psychotropic medications and two other prescribed medications by mistake. The med passer did realize right away of the mistake and called the MD for further instructions. The triage nurse did hang up the call before the caregiver could get answers. Another caregiver called and left a message for the MD call back asap. The MD did call back roughly around 10:30 AM with instructions to watch for such side effects such as increased lethargy, feeling out of sorts, confusion. The staff did complete 30 minute checks to include blood pressure and heart rate monitoring. The care staff did notify the family to inform them of the incident that occurred."
-Tenant 1's observation note dated 09/02/2025 at 1:05 PM stated "...the care staff was in apartment

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U 267	Continued From page 2	U 267		

to assist the resident to the restroom at 4:30 PM. Care staff received a page from the resident to be toileted. The resident was assisted in the restroom by two caregivers. The resident was alert to staff while sitting on toilet. Prior to getting the bathroom the [family member] was at bedside and reported that the resident could not hold a conversation or sentence with [him/her] and was concerned. Once the resident was assisted off the toilet vitals were completed and documented. The [family member] did request a medication list of meds that were given to the resident earlier that day. The Wellness Director did provide the medication list to the [family member]. The [family member] then did request to have the resident sent to the ER for further evaluation to increased lethargy and lower blood pressure and heart rate slowly dipping down."
-Tenant's 1 observation note dated 09/02/2025 at 1:12 PM stated "...the incident was documented and all parties were notified of the incident. The care staff did call 911 around 4:30 PM and the resident was sent to the ER around at approx 4:45-4:50 PM due to increased lethargy and lower heart rate and blood pressure. The [family member] did follow the ambulance to the hospital. The hospital was contacted around 9:00 PM on 09/02/2025 from care staff to get an update on the resident. The nurse was busy and could not speak to the writer, but did indicate that the resident was going to be admitted to the hospital.
-Tenant 1's hospital paperwork on 09/02/2025 stated, "Chief Complaint/Reason for Admission: Accidental medication ingestion. Lethargy, EKG abnormality. History of Present Illness: This morning at around 7:30 AM [s/he] received another residents medications. [S/he] took Wellbutrin XL 150 mg, duloxetine 60 mg, pregabalin 100 mg, and Zetia 10 mg. [S/he] has never received any of these medications before.

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U 267	Continued From page 3 The patient is rather lethargic right now. [His/her children] stated that [s/he] has been this way all day today. [S/he] seemed more confused today and [s/he] had slurred speech. [S/he] usually is able to ambulate with [his/her] walker but today [s/he] could hardly even stand on [his/her] own. [Tenant 1] is going to be admitted for further evaluation of [his/her] abnormal EKG and lethargy." On 09/23/2025 at 11:43 AM, Surveyor interviewed Executive Director A. Executive Director A stated Tenant 1 did receive another tenant's medication on 09/02/2025 which resulted in him/her being admitted to the hospital for observation. Executive Director A and Assistant Executive Director B stated the caregiver that passed the medications that day has been pulled from the medication cart and will have re-education and be re-delegated to before going back to passing medications.	U 267		