Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015204	A. BUILDING: _____ B. WING _____	C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD AT PLYMOUTH III (THE)	**2586 VALLEY RD PLYMOUTH, WI 53073**

(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 05/08/2024, Surveyors conducted a complaint investigation and a standard survey at Waterford at Plymouth III. As a result, 1 deficiency was identified. Complaint: Substantiated Census: 30	N 000		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure a written report was submitted to the department following an incident when a resident's whereabouts were unknown. Findings include: The facility is licensed to care for up to 34 residents who may be of advanced age and/or have irreversible dementia/ Alzheimer's.	N 163		

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

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N 163	Continued From page 1 The department received a complaint alleging the provider had an incident of elopement that required police intervention. POLICE REPORT: On 05/08/2024, at 3:54PM, Surveyor reviewed the Plymouth Police Department's Report - Incident P24-01881, dated 02/24/2024. The nature of the report was documented as, "Missing Person." The report stated Resident 1 left the building while Caregiver B was assisting another resident. Resident 1 was later located in New Holstein, Wisconsin, at his/her previous home. The report concluded Resident 1's family brought him/her back to the provider's location. According to Google Maps, the distance between Plymouth and New Holstein is approximately 17 miles. Information obtained on 05/08/2024 at 4:08PM from https://www.google.com/maps On 05/08/2024, at approximately 10:00 AM, Surveyors requested and reviewed Resident 1's records and noted the following: Resident 1 was admitted to the facility on 04/10/2023. INTERVIEW: On 05/08/2024, at approximately 10:30 AM, Surveyors interviewed Executive Director (ED A). ED A stated the regional nurse told him/her a self-report did not need to be reported to the department because it was not a locked memory care facility. ED A also stated s/he had a gut feeling the incident needed to be reported, but followed what the regional nurse told him/her to do as that is who s/he answers to.	N 163		