STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018623	A. BUILDING: _____ B. WING _____	R-C 04/28/2025

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{N 000}	Initial Comments On 04/28/2025, Surveyor conducted a verification visit, standard survey and two complaint investigations at Waterford Place, a Community-Based Residential Facility (CBRF) in Waterford, WI. Six deficiencies identified. One of 6 deficiencies is a repeat deficiency. Two of 2 complaints unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 50	{N 000}		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 staff received at least 15 hours per calendar year of continuing education in calendar year 2024. Caregiver F did	N 277		

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

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N 277	Continued From page 1 not have evidence of 15 hours of continuing education in 2024. Findings include: On 04/28/2025, at approximately 10:00 AM, Surveyor reviewed Caregiver F's record. Caregiver F was hired on 07/25/2023. Caregiver F only had 1-1.5 hours of continuing education in delegated tasks. On 04/28/2025 at approximately 3:57 PM, Surveyor interviewed Administrator E. Administrator E stated s/he could not locate any other continuing education hours for Caregiver F for calendar year 2024.	N 277		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by:	N 302		

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N 302	Continued From page 2 Based on record review and interview, the provider did not ensure 2 of 2 residents reviewed (Resident 1 and Resident 3) was screened for clinically apparent communicable disease, including tuberculosis (TB), by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before or 7 days after admission. Findings include: On 04/28/2025, Surveyor reviewed resident records and identified the following: Resident 1 was admitted on 09/12/2023. The documents provided to Surveyor from Resident 1's record did not contain the results of a TB test. Resident 3 was admitted on 04/24/2023. The documents provided to Surveyor from Resident 3's record did not contain the results of a TB test. On 04/28/2025 at 1:30 PM, Surveyor interviewed Regional Wellness Director D. Regional Wellness Director D stated s/he could not locate a TB skin test for Resident 1 and Resident 3.	N 302		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or	{N 389}		

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{N 389}	Continued From page 3 resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not update the Individual Service Plan (ISP) when 1 of 1 resident (Resident 2) had a pressure ulcer and wound care. This is a repeat deficiency. See Statement of Deficiency (SOD) INCB11, dated 09/19/2024. Findings include: On 04/28/2025 at approximately 9:45 AM, Surveyor interviewed Regional Wellness Director D. Wellness Director D stated Resident 2 received hospice services and did have wound care services. On 04/28/2025, Surveyor reviewed Resident 2's record. Surveyors identified the following: -Resident 2 was admitted to the facility on 05/26/2023. -Resident 2's current ISP was dated 01/29/2025 and stated the following: "Nursing Procedures-Skin Care: Not applicable. Nursing Procedures-Health Care Providers, Wellness Monitoring: [Resident 2] receives additional assistance and services provided by St. Croix Hospice as of 01/29/2025." -Resident 2's observation notes stated the following:	{N 389}		

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{N 389}	Continued From page 4 "02/11/25 at 10:45 AM, pressure ulcer noted to left heel. Hospice updated. To apply heel boots when in bed. Repo (reposition) side to side. When up in chair apply pillow under calves to keep pressure off heels." "03/06/2025 at 9:15 AM, pressure ulcer second medial toe from hammer toe. Hospice to provide wound care twice weekly thin layer of Neosporin and band aide to cover. Hospice provided wound care orders and updated [family]." "03/17/2025 at 5:15 PM, left foot second toe swollen, red, warm and tender to touch. Started antibiotic with no adverse reactions noted. Afebrile. Wound bed marbleized pink tissue with white slough. Old dressing from hospice had tegaderm over it which in turn kept the toe very moist. Foul odor when removing dressing. Hospice updated with new order." "03/19/2025 at 2:45 PM, writer has not seen hospice as of yet today. Dressing left foot second toe falling off. Writer redressed per order. Second toe remains slightly swollen and tender. Less red. Notably improving. Remains on antibiotic. No adverse reactions noted." "03/20/2025 at 6:30 PM, writer also contacted hospice regarding behaviors and the fact that writer has not seen hospice this week to change bandages to right foot. Dressing changes are 3 times weekly by hospice and PRN. Dressing changed by writer yesterday and is clean dry and intact today." "03/31/25 at 9:15 AM, St. Croix Hospice now treating wound to left second toe with Dakin's, medi-honey to wound bed followed by Xeroform gauze and a non adherent dressing, followed by ABD (large, extra absorbent) pad and secured with suresite transparent dressing. Treating left heel with Dakins followed by iodine swab, to cover healthy tissue with Xerofoam gauze and cover entire wound with ABD pad and secure with	{N 389}		

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{N 389}	Continued From page 5 gauze and tape. To coccyx area to cleanse with normal saline, pat dry and apply a small amount of zinic barrier cream to wound bed followed by bordered foam dressing. Hospice to provide wound care 2x's weekly." "03/31/25 at 1:45 PM, seen by hospice RN this morning. Dressings to left foot and buttock changed by RN and reported wounds deteriorating. Order obtained for doxycycline 100 mg twice daily for 10 days. St. Croix hospice RN states they will be adjusting [his/her] treatment again and sending over stage 4 air mattress." "04/03/25 at 7:45 AM, remains on antibiotic for left foot infection. No adverse reactions noted. Afebrile. Daily visits from hospice due to wounds and recent decline." Resident 2's hospice comprehensive assessment and plan of care stated the following: "04/01/2025, [Resident 2] has chronic stage 2 to coccyx, stable at this time, [Resident 2] has stage 4 to second toe on left foot, wound appears infected. This IDG (interdisciplinary group) period (purulent drainage, foul odor, erythema surrounding wound, fever, tachycardia, hallucinations, shaky). [Resident 2] has unstagable DTI (deep tissue injury) to left heel covered with dry stable eschar. New order for topical lidocaine to use on stage 4 PI (pressure injury) due to severe pain with wound care. [Resident 2] placed on daily visits 4/1 due to decreased appetite, increased lethargy, hallucinations, fever, shivering, change in mentation and LOC (level of consciousness). AP (alternating pressure) mattress ordered due to multiple pressure injuries and [Resident 2] spending majority of day in bed." On 04/28/2025 at approximately 1:30 PM, Surveyor interviewed Regional Wellness Director	{N 389}		

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{N 389}	Continued From page 6 D. Regional Wellness Director D acknowledged there was nothing in Resident 2's ISP identifying s/he needed wound care from hospice. Regional Wellness Director D stated the ISP dated 01/29/2025 was the current ISP and it did not identify Resident 2's wounds.	{N 389}		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider could not provide documentation to show that the heating system has been maintained in a safe and properly functioning condition for 1 of 1 furnace. The provider could not find evidence the gas furnace has been serviced at least once every 3 years. Findings include: On 04/28/2025, Surveyor requested most recent documentation of the furnace being inspected. No furnace inspection was provided.	N 504		

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N 504	Continued From page 7 On 04/28/2025, at approximately 3:57 PM, Surveyor interviewed Administrator E. Administrator E stated s/he could not locate a recent furnace inspection.	N 504		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted quarterly and at least one drill simulated the conditions during usual sleeping hours for 1 of 1 year reviewed (2024). There was not a fire drill conducted in quarter three of 2024 and there was not a drill which simulated the conditions during sleeping hours in 2024.	N 525		

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N 525	Continued From page 8 Findings include: On 04/28/2025, at approximately 10:30 AM, Surveyor reviewed facility fire drills for calendar year 2024 and identified the following: Fire drills were conducted on 01/22/2024, 02/27/2024, 03/27/2024, 04/30/2024, 05/30/2024 and 11/26/2024. None of these fire drills were simulated conditions during usual sleeping hours or in the third quarter of calendar year 2024. On 04/28/2025 at 4:04 PM, Surveyor interviewed Administrator E. Administrator E confirmed fire drills needed to be completed every quarter and one drill should be a simulated drill with conditions during usual sleep hours. Administrator E stated s/he could not locate a fire drill in the third quarter of 2024 or a fire drill during usual sleep hours for 2024.	N 525		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure the fire detection system was inspected for 1 of 1 calendar year (2024). Findings include: On 04/29/2025 at approximately 10:00 AM,	N 538		

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N 538	Continued From page 9 Surveyor requested from Administrator E the annual fire detection system inspection for calendar year 2024. Administrator E gave Surveyor a binder which did not have the annual fire detection system inspection for calendar year 2024. On 04/28/2025 at approximately 3:57 PM, Surveyor interviewed Administrator E. Administrator E stated s/he could not locate an annual fire detection system for calendar year 2024.	N 538		