

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

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015204	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/09/2025
NAME OF PROVIDER OR SUPPLIER WATERFORD AT PLYMOUTH III (THE)		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{Y3235}	Continued From page 1 Based on observation and interview, the provider did not ensure the privacy of each resident. This is a repeat violation. See Statement of Deficiency (SOD) Q10E11, dated 09/24/2024. Findings include: On 04/03/2025 at approximately 12:30 PM, Surveyor interviewed Executive Director (ED) B. ED B confirmed the locks/keys for resident rooms had not been corrected yet. ED B stated s/he is working with a vendor, but they do not have a timeline for the locks/keys to be corrected. ED B emailed Surveyor a copy of the email from the company they were working with. The email stated, "We are working on this and once I have a firm date I will let you know." ED B acknowledged s/he did not request an extension to allow additional time to correct this tag. The provider did not ensure the privacy of each resident by providing residents with keys specifically keyed to each individual room.	{Y3235}		