STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018316	A. BUILDING: _____ B. WING _____	C 11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERSTONE MEMORY CARE INC	5100 SCHMIDT LANE GRAND CHUTE, WI 54913

(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 11/08/2024, Surveyor conducted a complaint investigation at Silverstone Memory Care Inc. One deficiency was identified. The complaint was substantiated. Census: 44	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were safeguarded from environmental hazards. Resident 1 eloped from the facility without staff being alerted due to the provider's alarm system failing. Findings include: The provider is licensed to care up to 44 residents in the following client groups: advanced age, irreversible dementia/Alzheimer's, and terminally ill. On 09/03/2024, the Department received a	N 358		

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

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N 358	Continued From page 1 concern alleging concerns with continued elopements. On 11/08/2024, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 08/28/2024. Resident 1 is over 90 and has diagnosis of dementia. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) with an unknown date documented: "Wandering Risk: Resident has been identified as an elopement risk. Is in a room with window access to gated patio. Wears a wander guard and is on 1 hour checks. Keep [him/her] engaged." Surveyor reviewed Grand Chute Police Department incident #G24018231 dated 08/31/2024. This report documented: " On 08/31/2024, ...dispatched to welfare check complaint at 1410 hours located at Walgreens ....Dispatch notes stated a [fe/male] was found lying in the grass. The [fe/male] provided the reporting parting [his/her] name as [Resident 1] and [s/he] was walking to Hortonville. While enroute to the scene, I conducted an in-house search of "[Resident 1]. I located an entry for [fe/male] born [Resident 1's date of birth] with an in-house alert for dementia ....Additionally, I located an attachment for the Appleton Police Department Safe Response Packet completed earlier this year. The packet stated [Resident 1] lived with [his/her] [wife/husband] at [previous address]. I located a phone number for [Spouse C] and made contact by phone. [Spouse C] advised that [Resident 1] was moved to [provider's name] on Wednesday, 08/28/2024. [Spouse C] was unaware [Resident 1] had left the facility.	N 358		

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N 358	Continued From page 2 I was notified ...that staff at [provider's name] were unaware [Resident 1] had left the facility. I entered the business and made contact with [Resident 1]. [Resident 1] advised [s/he] saw an accident and had to help. While speaking with [Resident 1] it was clear [s/he] was unaware where [s/he] was and did not have a bearing on where [s/he] was going. I explained to [Resident 1] I would give [him/her] a ride home .....[Resident 1] asked what we were doing there. [Resident 1] would later ask why we were at the grocery store, referring to [provider's name] ....I spoke with [Caregiver D], one of the staff members at [provider's name]. [Caregiver D] advised there was not a supervisor on duty. [Caregiver D] stated all staff on site currently were second shift and all started at 1400 hours. Based on [Resident 1's] age and the distance to Walgreens, [s/he] would have had to leave prior to 1400 hours. [Caregiver D] stated [Resident 1] would have left sometime during first shift and staff did not act accordingly. I asked [Caregiver D] about the doors, as to my knowledge everyone must be scanned in and out. [Caregiver D] stated if inside the facility if you push on the doors for 15 seconds they will open and an alarm would sound. This included the two gates on the rear fence of the building. Supplement: ....I made phone contact with [provider's name]. They were clearly unaware that [Resident 1] walked off until I called them. It should be noted when I saw [Resident 1], [s/he] matched the photo that I reviewed in in-house records ....It is concerning that a [Resident 1's age] year old individual with dementia was able to walk away from the facility without staff noticing. In addition, it was a hot day, and the facility is not far from a busy roadway."	N 358		

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N 358	Continued From page 3	N 358		

Resident 1's incident report dated 08/31/2024 documented:
"Writer received a call around 2:10pm from the local police department, with them stating that resident had eloped and was down at the Walgreens, approximately less than a mile away from the facility. Writer spoke with the police department and they stated they would be transporting resident back to the facility. When resident arrived back at the facility, [s/he] was evaluated for any injuries. None noted. Writer is unsure the time resident eloped. On call and POA notified. Resident continued to exit seek throughout the night, but did eventually calm down."

Surveyor reviewed the interval investigation into Resident 1's elopement on 08/31/2024. The following was noted: "On Saturday August 31st, 2024, [Resident 1] was returned to the facility by law enforcement. [Resident 1] exited through a delayed egress mag locked gate in the exterior courtyard and was found a short distance from the facility by a convenience store employee. Based on [Resident 1's] location, we believe [s/he] was gone from the facility for about 45 minutes. Staff were not aware that [s/he] had eloped ....After thoroughly investigating this incident, we determined that the exterior gate that [Resident 1] used to exit functioned properly as [s/he] pushed on the crash bar for 15 seconds and the mag locks released as it's supposed to do. However, the emergency alert notification system that transmits an audible and visual alert to staff pagers and the wander vision computer screen did not function properly."

The temperature on 08/31/2024 at 1:30 PM was 82 degrees Fahrenheit. (Source: National Weather Service website,

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N 358	Continued From page 4 https://www.wunderground.com/history (retrieval date - 11/13/2024).) Surveyor note: The Walgreens parking lot is approximately .4 miles from the entrance of the facility and is located at 1305 N Casaloma Dr Grand Chute, WI. Resident 1 traveled through business parking lots which were next to a heavily traveled divided 4 lane highway 96 with a speed limit of 35 MPH. According to the Wisconsin Department of Transportation, the average daily traffic count at that location was last known to be 16,000 vehicles/day. Source: https://wisdot.maps.arcgis.com/apps/webappviewer/index.html?id=2e12a4f051de4ea9bc865ec6393731f8, retrieval date 11/13/2024. On 11/08/2024 at 11:15 AM, Surveyor interviewed Administrator B regarding Resident 1's elopement on 08/31/2024. Surveyor asked if the provider had a system in place for testing the alarm system. Administrator B reported the provider did not have a system in place to periodically check the alarms since it was externally serviced. Administrator B confirmed the provider's alarm system did not alert staff after Resident 1 had eloped on 08/31/2024 and s/he reached out to their alarm provider shortly after. Administrator B noted their alarm company contributed the malfunction to a bad battery on the courtyard gate. Administrator B shared emails with their alarm system provider that documented on 09/04/2024 at 9:37 AM: "Hi ...we had an elopement on Aug. 31st, in which the gates did not alarm at the pagers or in the facility. I have attached a picture of the resident at the time [s/he] was spotted outside the facility at 1:30pm. I have also attached a photo of the report I ran, that stated the back gate did NOT go off. Could	N 358		

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N 358	Continued From page 5 you and your team please look into and let me know the reasoning for this happened." Administrator B sent the 2nd email on 09/04/2024 at 1:20 PM: "Hi ....Just had another elopement, Pager did NOT go off, however it showed up on the computer. Can you please let me know the plan is moving forward as we have significant exit seekers and we need this working ASAP. This is for our residents health and safety!" On 11/08/2024 at 2:00 PM, Surveyor interviewed Administrator A and Administrator B. Surveyor expressed concern the provider did not have an established system to check and replace batteries to ensure the system continues to be functional and safe for residents. Surveyor noted the significant potential for outcome with the heat and proximity to a busy highway. Administrator A reported the alarm system was serviced semi-annually. Administrator B stated their current alarm company "wasn't that great." Administrator A reported the provider completed elopement drills but was unsure of when the alarm was previously tested as s/he did not know if staff kept track. Both staff stated they would be adding a monthly check to alarm doors and gates to ensure their emergency alert notification system transmits alerts to staff pagers and their computer system.	N 358		