STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018760	A. BUILDING: _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - STRATFORD I	213721 LEGION ST STRATFORD, WI 54484

(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 05/29/2024, Surveyor conducted a standard licensure survey, complaint investigation, and self-report investigation at Vitacare Living - Stratford I. Data collection continued through 06/03/2024. Two deficiencies were identified. The complaint was unsubstantiated. Census: 11	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 safeguard Resident 1 from hazards s/he was likely to be exposed to, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents' conditions or disabilities. Resident 1 was considered a "wanderer" and "elopement risk." Resident 1 cut off his/her wander guard a few days prior to eloping on 05/18/2024. The provider was aware Resident 1	N 358		

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

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N 358	Continued From page 1	N 358		

removed his/her wander guard and did not replace it.

Findings include:

On 05/20/2024, the Department received a self-report indicating Resident 1 eloped on 05/18/2024 (Time of incident: 3:00 AM) and was located at 3:15 AM in the backyard of the facility.

The provider is licensed to serve up to 16 residents in the following client groups: terminally ill, advanced aged, physically disabled, and irreversible dementia/Alzheimer's Disease.

On 05/29/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 08/24/2023. Resident 1 expired on 05/27/2024. Resident 1's individual service plan (ISP}, dated 02/24/2024, noted Resident 1 wandered and staff were to "perform a visual check of the resident to ensure their safety and well-being. Check to make sure wander Guard [sic] is still on shoe." A self -report, dated 03/18/2024, indicated Resident 1 walked outside at 4:00 PM and staff ran after him/her. The self-report noted Resident 1 fell outside and was "yelling out that [s/he] wanted to go to the store" In response to the elopement, Resident 1 was placed on 15-minute checks and given a wander guard bracelet to wear. Resident 1 eloped on 05/18/2024. A self-report, dated 05/20/2024, read, in part: "Resident was in bed at 2 am on Nightly checks. Checked on [him/her] again at 3 am and resident was not in [his/her] room. Staff checked building [sic] could not find [Resident 1]. Staff called the Director and 911. Director came to the building. Director and [Caregiver C] went looking for the resident. We found resident in the backyard. By [sic] apartment complex. Sent to Er [sic] to check [him/her] over. Resident returned

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N 358	Continued From page 2	N 358		

back to facility with no injuries."

On 05/30/2024 at approximately 9:00 AM, Surveyor interviewed Caregiver B via telephone. Caregiver B reported Resident 1 eloped on 05/18/2024 (sometime between 2:00 AM and 3:00 AM). Caregiver B stated s/he worked alone during the overnight shift on 05/17/2024 because "[Caregiver D] called in and did not show up." Caregiver B indicated that Resident 1 did not have his/her wander guard on his/her shoe at the time of elopement because Resident 1 had cut it off a few days prior to 05/18/2024. Caregiver B reported Resident 1 kept cutting off his/her wander guard, but the wander guard should have been replaced because Resident 1 was an "elopement risk." Caregiver B commented that if 2 staff were working the overnight shift on 05/17/2024, Resident 1 might not have eloped.

On 06/03/2024 at approximately 8:40 AM, Surveyor interviewed Director A via telephone. Director A reported Resident 1 eloped on 05/18/2024 and was not wearing a wander guard. Director A stated Resident 1 cut off at least 4 wander guards between 03/22/2024 and 05/18/2024, Resident 1 cut off his/her wander guard a few days prior to eloping on 05/18/2024, and the wander guard was not replaced. Director A confirmed Resident 1's ISP, dated 02/02/2024, noted, "Check to make sure wander Guard [sic] is still on shoe." Director A stated that Resident 1 wandered in the facility and was considered to be an elopement risk. Director A admitted Resident 1's wander guard should have been replaced. Surveyor asked Director A about staffing. Director A stated two staff were scheduled to work the overnight shift on 05/17/2024 but one staff called in and did not work. Director A commented, "I preferred having two staff work the overnight shift

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N 358	Continued From page 3 because [Resident 1] liked to wander inside the facility and [s/he] was an elopement risk." The provider did not safeguard Resident 1 from environmental hazards and conditions s/he would likely be exposed to. The provider viewed Resident 1 as a "wanderer" and "elopement risk" and was aware Resident 1 cut off his/her wander guard and did not replace it.	N 358		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was followed as written. Resident 1 was not wearing a wander guard and eloped on 05/18/2024. Findings include: On 05/20/2024, the Department received a self-report indicating Resident 1 eloped on 05/18/2024 (time of incident: 3:00 AM) and was located at 3:15 AM in the backyard of the facility. The facility is licensed to serve up to 16 residents in the following client groups: terminally ill, advanced aged, physically disabled, and irreversible dementia/Alzheimer's Disease. On 05/29/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 08/24/2023. Resident 1 expired on 05/27/2024. Resident 1's ISP, dated 02/24/2024, indicated Resident 1	N 388		

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wandered. The ISP noted, "Perform a visual check of the resident to ensure their safety and well-being. Check to make sure wander Guard [sic] is still on shoe." A self -report, dated 03/18/2024, indicated Resident 1 walked outside at 4:00 PM and staff ran after him/her. The self -report noted Resident 1 fell outside and was "yelling out that [s/he] wanted to go to the store." In response to the elopement, Resident 1 was placed on 15-minute checks and was given a wander guard bracelet to wear. A self-report, dated 05/20/2024, read, in part: "Resident was in bed at 2 am on Nightly checks. Checked on [him/her] again at 3 am and resident was not in [his/her] room. Staff checked building [sic] could not find [Resident 1]. Staff called the Director and 911. Director came to the building. Director and [Caregiver C] went looking for the resident. We found resident in the back yard. By [sic] apartment complex. Sent to Er [sic] to check [him/her] over. Resdent [sic] returned back to facility with no injuries."

According to accuweather.com (retrieval date - 05/29/2024), at the time Resident 1 eloped (2:00 AM - 3:00 AM on 05/18/2024), the outside temperature was 59 degrees. The facility is located in a residential area and borders a farm field and apartment complex. A main highway is located several blocks away. Resident 1 was dressed and had shoes on when found at approximately 3:15 AM. Resident 1's wander guard was not on his/her shoe.

On 05/30/2024 at approximately 9:00 AM, surveyor interviewed Caregiver B via telephone. Caregiver B reported that Caregiver B worked by himself/herself during the overnight shift on 05/17/2024 to 05/18/2024 (10 PM to 6 AM). Caregiver B reported that Caregiver D was

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supposed to work the overnight shift with him/her on 05/17/2024, but Caregiver D "called in and did not show up for work." Surveyor asked Caregiver B about staffing and Resident 1's elopement on 05/18/2024. Caregiver B stated, "I usually work with someone and sometimes we are singled staffed during the overnight shift; I usually work alone on the weekends." Caregiver B reported, "[Resident 1] was an elopement risk and I checked on [him/her] at 2:00 AM on 05/18/2024 and then again at 3:00 AM. [Resident 1] was not in [his/her] room at 3:00 AM." Caregiver B stated that Resident 1 was found unharmed in the parking lot next to the facility around 3:15 AM. Caregiver B indicated, "[Resident 1] had a wander guard but [s/he] cut it off and it was not replaced." Caregiver B could not recall the exact date Resident 1 cut off his/her wander guard bracelet, but thought it was a few days prior to 05/18/2024. Caregiver B stated, "We should have had 2 staff working the overnight shift on 05/17/2024 because [Resident 1] was an elopement risk." Caregiver B indicated that Resident 1's wander guard should have been replaced and put back on his/her shoe, but it was not.

On 06/03/2024 at approximately 8:40 AM, surveyor interviewed Director A via telephone. Director A verified Caregiver B worked the overnight shift alone on 05/17/2024 and Caregiver D was scheduled to work but called in and did not work the shift. Director A reported that Resident 1 cut off his/her wander guard a few days prior to eloping on 05/18/2024. Director A stated, "[Resident 1] did not have a wander guard on when s/he eloped on 05/18/2024." Director A confirmed that staff were to perform visual safety checks (at least every 2 hours) on Resident 1 and check to make sure Resident 1's wander guard

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N 388	Continued From page 6 was on his/her shoe. Director A reported that Resident 1 had at least 4 wander guards between 03/22/2024 and 05/18/2024, and Resident 1 kept cutting the wander guards off. Director A reported, "[Resident 1] did not have [his/her] wander guard on 05/18/2024; [S/He] cut it off a few days prior and it was not replaced." Director A noted that Resident 1 was not a wanderer when [s/he] first moved in but really started wandering over the last 6 months. Director A reported that Director A preferred 2 staff working the overnight shift because Resident 1 "liked to wander inside the facility and [s/he] was an elopement risk." On 06/04/2024 at 4:00 PM, Surveyor interviewed Director A. Director A reported that Resident 1 wandered in the facility but was easily redirected. Director A stated Resident 1 cut off at least 4 wander guards and was not wearing a wander guard when s/he eloped on 05/18/2024. Director A reported the wander guard used to be applied to Resident 1's ankle but s/he cut it off so the wander guard was attached to Resident 1's shoe. Director A stated s/he preferred to have 2 staff working the overnight shift because Resident 1 wandered but felt 1 staff person was able to meet the resident needs during an overnight shift because most of the residents slept and no resident required the use of a mechanical lift. Director A confirmed there were no changes to Resident 1's ISP, dated 02/24/2024. Director A stated Resident 1 should have had a wander guard in place when s/he eloped on 05/18/2024. The provider did not follow Resident 1's ISP as written and did not ensure Resident 1's wander guard was in place.	N 388		