STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015201	A. BUILDING: _____ B. WING _____	C 09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD AT PLYMOUTH I (THE)	**2581 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 09/24/2024, Surveyors conducted a standard survey and one (1) complaint investigation at Waterford at Plymouth I (#15201). Additional information was gathered through 09/30/2024. As a result of the survey, 9 deficiencies were identified and 1 complaint was unsubstantiated. One of 9 deficiencies was a repeat violation. Census: 19	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating 2 of 2 employees reviewed were screened for clinically apparent communicable disease within 90 days before the start of employment.	N 220		

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

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N 220	Continued From page 1 Findings include: On 09/24/2024 at approximately 3:05 PM, Surveyors requested Caregiver D's and Caregiver E's employee records from Associate Administrator (AA) A and Executive Director (ED) B. Caregiver D had a hire date of 12/01/2021. Caregiver D's record did not have documentation that Caregiver D had been screened for clinically apparent communicable disease within 90 days before the start of employment. Caregiver E had a hire date of 05/01/2024. Caregiver E's record did not have documentation that Caregiver E had been screened for clinically apparent communicable disease within 90 days before the start of employment. On 09/24/2024 at 4:08 PM, Surveyors interviewed AA A and ED B. ED B stated s/he was unable to locate documentation for Caregiver D and Caregiver E reflecting they had been screened for clinically apparent communicable disease within 90 days before the start of employment. On 09/24/2024, Surveyors reviewed department records and verified the provider did not have any approved waivers related to Employee Communicable Disease Screening.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and	N 230		

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N 230	Continued From page 2 reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review, observation and interview, the provider did not ensure prior to performing job duties, 1 of 2 employees (Caregiver E) were provided with orientation training. Orientation training includes, (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures; (5) Community based residential facilities (CBRF) policies and procedures; (6) Recognizing and responding to resident changes of condition. Findings include: The facility is licensed to provide services for up to 22 residents who are advanced aged and/or have irreversible dementia/Alzheimer's. On 09/24/2024 at 3:05 PM, Surveyors requested Caregiver E's employee records from Associate Administrator (AA) A and Executive Director (ED) B. ED B provided Surveyors with Caregiver E's employee record.	N 230		

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N 230	Continued From page 3 Caregiver E had a hire date of 05/01/2024. Caregiver E's employee file had no evidence Caregiver E had all required orientation upon hire and before performing any job duties. There was no evidence Caregiver E was orientated in information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures; recognizing and responding to resident changes of condition. 09/24/2024, Surveyors reviewed the staff schedule for 08/01/2024 - 08/31/2024. Surveyors observed Caregiver E was on the schedule for 35 shifts. On 09/24/2024 at 3:30 PM, ED B stated Caregiver E was hired on 05/01/2024. Caregiver E "ghosted" them and then reached out to complete orientation on 05/17/2024. Caregiver E's first day working the floor was 06/02/2024. ED B confirmed Caregiver E did not touch his/her Relias training. ED B acknowledged s/he did not have the orientation records for Caregiver E and that Caregiver E was being pulled off the floor today. The provider did not ensure prior to performing job duties staff completed orientation. Cross reference DHS 83.21(1)-(3) All Employee Training	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following:	N 243		

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N 243	Continued From page 4 Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.	N 243		

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N 243	Continued From page 5 This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 2 employees reviewed obtained all training as required within 90 days after starting employment. Caregiver E did not have training in resident rights within 90 days after starting employment. Caregiver E did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment. Caregiver E did not have training in required client groups within 90 days after starting employment. Findings include: On 09/24/2024, Surveyors conducted a review of employees to verify compliance with all employee training requirements. Surveyor requested training records from Associate Administrator (AA) A for Caregiver E. Resident Rights The record for Caregiver E, hired 01/25/2024, did not contain evidence of training or evidence of meeting an exemption for resident rights. On 09/24/2024, at 3:30 PM, Surveyors interviewed Executive Director (ED) B. ED B confirmed the provider did not have evidence Caregiver E completed or met an exemption for resident rights training.	N 243		

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N 243	Continued From page 6 Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver E, hired 01/25/2024, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 09/24/2024 at 3:30 PM, Surveyors interviewed ED B. ED B confirmed the provider did not have evidence Caregiver E completed or met an exemption for challenging behaviors training. Client Group The facility was licensed to provide care and services to residents with advanced aged and/or irreversible dementia/Alzheimer's. The record for Caregiver E, hired 01/25/2024, did not contain evidence of training or evidence of meeting an exemption for client group training. On 09/24/2024, at 3:30 PM, Surveyors interviewed ED B. ED B confirmed the provider did not have evidence Caregiver E completed or met an exemption for client group training specific to advanced aged and/or irreversible dementia/Alzheimer's. Cross reference DHS 83.19 Orientation	N 243		
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	N 389		

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N 389	Continued From page 7 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 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 interview, the provider did not ensure 1 of 2 residents' (Resident 2) Individual Service Plans (ISPs) was signed by the resident or resident's legal representative acknowledging their involvement in, understanding of, and agreement with the resident's ISP. This is a repeat deficiency. See statement of deficiency (SOD) FFBD11, 01/22/2021 Findings include: On 09/24/2024 at approximately 3:30 PM, Surveyors reviewed resident files and observed the following: Resident 2 was admitted on 11/15/2022. Resident 2 has an activated health care power of attorney (HCPOA). Resident 2's ISP was updated 05/28/2024. Resident 2's ISP did not contain any signatures, including a signature of agreement with the ISP by Resident 2's HCPOA. On 09/24/2024 at approximately 4:00 PM, Surveyors interviewed Associate Administrator	N 389		

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N 389	Continued From page 8 (AA) A and Executive Director (ED) B. AA A reported that ED B completes all resident ISPs. ED B confirmed that some ISPs do not have signatures, and this is being worked on.	N 389		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents were evaluated for evacuation capabilities within 3 days of the residents' admission. Findings include: On 09/24/2024 at approximately 3:30 PM, Surveyors requested to review Resident 1's and Resident 2's records. Resident 1 had an admission date of 08/03/2024. Resident 1's file contained a Resident Evaluation Assessment, DQA Form F-62373 that was completed and dated 08/15/2024.	N 393		

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N 393	Continued From page 9 Resident 2 had an admission date of 11/15/2022. Resident 2's file contained a Resident Evaluation Assessment, DQA Form F-62373 that was completed and dated 12/13/2022. On 09/24/2024 at approximately 4:00 PM, Surveyors interviewed Executive Director (ED) B. ED B completes all Resident Evacuation Assessments. ED B acknowledged the forms should be completed within 3 days of resident admission but did not provide an explanation for why they were not completed within this time frame.	N 393		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name,	N 406		

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N 406	Continued From page 10 strength and amount. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure outdated medications were separated from other medications in current use in the facility and disposed of. Findings include: On 09/24/2024 at approximately 2:30 PM, Surveyors observed the med carts with Associate Administrator (AA) A. Surveyors observed: Resident 5 * 24 Tablets Lorazepam 0.5 MG Tab; Take 1 Tablet By Mouth Every 8 Hours As Needed For Anxiety/Agitation; Use By: 08/20/24 * 60 Tablets Acetamin 325 MG Tab; Take 2 Tablets (650MG) By Mouth Daily And Take 2 Tablets (650MG) By Mouth Every Four Hours As Needed For Pain/Fever; Use By 09/14/24 * 46 Tablets Acetamin 325 MG Tab; Take 2 Tablets (650MG) By Mouth Daily And Take 2 Tablets (650MG) By Mouth Every Four Hours As Needed For Pain/Fever; Use By 09/14/24 Resident 6 * 1 Tablet Alprazolam 0.5 MG Tab; Take 1 Tablet By Mouth Every Morning And Take 1 Table By Mouth Daily As Needed In Mid-To-Late Afternoon; Use By 09/07/24 Resident 7 * 10 Tablets Senexon-S Tab 8.6/50MG; Take 1 Tablet By Mouth Twice A Day For Constipation; Med card stated "Order Dc'd (now take 2, 2x a	N 406		

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N 406	Continued From page 11 day [sic]; Exp 08/03/2024 Resident 8 * 15 Capsules Loperamide 2 MG Cap; Take 1 Capsule By Mouth Four Times A Day As Needed For Diarrhea; Use By: 08/24/24 AA A acknowledged the expired medications. AA A stated s/he would provide Surveyors with medication administration records (MARs) for Resident 5, Resident 6, Resident 7 and Resident 8. AA A was unable to provide information on Resident 7's Senexon, and the date the order was changed. Surveyors reviewed the MARs and confirmed 4 of 4 residents had not received any expired medications. On 09/24/2024 at 3:05 PM, Surveyors interviewed Executive Director (ED) B and shared medication observations. ED B stated they just hired a new Wellness Director and s/he will be responsible for auditing the med carts. ED B stated s/he had been auditing the cart prior to the new Wellness Director. ED B stated "usually staff is better than that." The provider did not ensure 4 residents' medications were disposed of after the expiration date.	N 406		
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	N 525		

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N 525	Continued From page 12	N 525		

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 evacuation drills were conducted at least quarterly with both employees and residents.

Findings include:

The facility is licensed to provide services for up to 22 residents who are advanced aged and/or have irreversible dementia/Alzheimer's.

On 09/24/2024 at approximately 3:00 PM, Surveyors reviewed the provider's documentation of quarterly fire drills for 2024. Monthly fire drills were conducted, but each monthly record indicated residents were not involved. Quarterly fire drills for 2024 include those conducted on the following dates: 01/31/2024, 05/31/2024, and 07/31/2024.

On 09/24/2024 at approximately 3:20 PM, Surveyors interviewed Associate Administrator (AA) A, Executive Director (ED) B, and Maintenance Director (MD) C. MD C is responsible for conducting fire drills. MD C stated

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N 525	Continued From page 13 residents are involved in file drills twice a year - once in spring and once in fall. S/he was unaware that residents are required to participate quarterly. When asked to show documentation of resident participation in the spring 2024 fire drill, MD C was unable to locate documentation and stated it had not been recorded. ED B indicated residents will participate in the next fire drill. MD C acknowledged the quarterly participation requirement will be put into place going forward.	N 525		
N 631	83.59(1)(a) Class AS, ANA, CS, CNA 2 grade level exits All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Class AS, class ANA, class CS and class CNA CBRFs shall have at least 2 grade level or ramped exits to grade. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the Community Based Residential Facility (CBRF) had at least 2 exits providing unobstructed travel to the outside. Findings include: The provider is licensed as a Class CNA (non-ambulatory) CBRF able to serve up to 22 residents who are advanced aged and/or have irreversible dementia/Alzheimer's. On 09/24/2024 at approximately 2:00 PM,	N 631		

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(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 631	Continued From page 14 Surveyors toured the facility with Associate Administrator (AA) A. AA A acknowledged the 2 obstructed exits with illuminated exit signs observed by Surveyor: * Patio exit had delayed egress to the patio. On the patio, Surveyors observed a chain on the gate. Surveyors had to unhook and unwrap the chain to open the gate. * East exit to a hallway to the outside and the attached garage. Surveyors observed the door handle to have a keypad. Surveyors were unable to open the door by turning the handle or putting pressure on the door. AA A put in a door code which allowed Surveyors to open the door. Surveyors observed the outside door to have delayed egress and applied pressure on the door and the door opened in 15 seconds. On 09/24/2024 at 3:05 PM, Surveyors interviewed Executive Director (ED) B. ED B stated s/he did not believe the patio was considered an exit. Surveyors shared observations that all 3 exits had illuminated exit signs above the doors, and that the east side exit was obstructed with a keyed door, delayed egress and a chair obstructing the path away from the building. ED B stated the east exit door had been like that since the building was purchased. ED B stated s/he will talk to maintenance regarding 2 of 3 obstructed exits.	N 631		
Y3235	50.09(1)(f) Privacy (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to:	Y3235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015201	A. BUILDING: _____ B. WING _____	C 09/30/2024

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Y3235	Continued From page 15 (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to: This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the privacy of each resident. Findings include: On 09/25/2024 at approximately 2:00 PM, Surveyors toured the facility and interviewed Resident 3. Resident 3 stated s/he had keys for his/her room. Resident 3 gave his/her key to Surveyors and Surveyors locked Resident 3's door and were able to unlock and open door with the key. Surveyors proceeded to check Resident 4's room and mechanical room doors. Resident 3's key unlocked each door. On 09/25/2024 at approximately 2:30 PM, Surveyors interviewed Associate Administrator (AA) A. AA A observed Surveyors opening Resident 3's room door, Resident 4's room door and mechanical room door with Resident 3's room key. AA A stated s/he was unaware the resident rooms and mechanical rooms were not keyed different. On 09/25/2024 at approximately 4:00 PM,	Y3235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y3235	Continued From page 16 Surveyors interviewed Executive Director (ED) B and Associate Administrator (AA) A. Surveyors asked about residents receiving keys to their rooms. ED B stated residents do have keys to their rooms. ED B stated s/he was unaware the resident rooms were not keyed individually. The provider did not ensure the privacy of each resident by providing residents with keys specifically keyed to each individual room.	Y3235		