STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525098	A. Building B. Wing	11/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waunakee Valley Senior Living	801 Klein Dr Waunakee, WI 53597

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on record review and interviews, the facility did not ensure each resident received adequate supervision to prevent accidents from elopements for 1 of 3 residents (R4) reviewed for accidents. R4 was identified as a risk for wandering and has a Wanderguard attached to her walker. R4 eloped from the facility on 10/26/24 and the Wanderguard alarm system did not activate. The facility did not know R4 had left the building until local law enforcement contacted the facility. R4 traveled four (4) blocks and crossed a busy intersection. The facility's failure to provide adequate supervision created a reasonable likelihood for serious injury or harm leading to a finding of immediate jeopardy that began on 10/26/24. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on 10/30/24 at 12:54 PM. The immediate jeopardy was removed on 10/27/24 and corrected on 10/30/24. This is being cited as past noncompliance. Findings: The facility policy, Guideline for Elopement/Missing Resident, dated 12/31/23, states, in part; .To establish guidelines to report and investigate all reports of elopement/missing persons. It is the responsibility of all personnel to report any resident attempting to leave the premises or suspected of being missing to the charge nurse as soon as practical .2. Disoriented Resident (already deemed an elopement risk) observed exiting the campus door: .g. Complete an exit seeking event form h. Attach progress note to an open exit seeking event .3. Door Alarm Sounding/Missing Resident a. Staff should respond promptly to a sounding door alarm b. The charge nurse, facility supervisor or Executive Director should call staff to a central area and designate the following: i. A staff person to perform a facility head count to determine who may be missing . R4 was admitted to the facility on [DATE] with diagnoses including dementia, osteoarthritis, major depressive disorder, repeated falls, other abnormalities of gait and mobility, weakness, and permanent atrial fibrillation. R4's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/25/24, indicates R4 has a Brief Interview for Mental Status (BIMS) score of 11 indicating R4 is moderately impaired. R4 has an Activated Power of Attorney. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/11/2024
NAME OF PROVIDER OR SUPPLIER Waunakee Valley Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 801 Klein Dr Waunakee, WI 53597	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's Comprehensive Care Plan, states, in part; .Problem Start Date: 7/29/24 .R4 wanders without purpose. Goal R4's wandering behaviors will not result in injury to self. Approach Check wander guard for placement and function. Assess cognition with BIMS quarterly and prn. Encourage resident to participate in brief periods of structured activities. Encourage resident's family to visit on a schedule that meets the needs of the resident as appropriate. Maintain routine in resident's day including mealtime, activity, family visits, etc. monitor resident's cognitive functioning for significant fluctuations and refer to physician as needed. Observe for signs of increasing fatigue and offer frequent rest periods to prevent falls. Observe resident's wandering patterns and escort away from other residents or other resident's rooms as needed. Provide meaningful leisure activity as appropriate. R4's current order states in part; .start date 10/28/24 check placement of wandering system bracelet/device every shift to right wrist and walker. R4's elopement risk assessments state in part; .4/24/24 Elopement Risk Review Indicate if resident is an elopement risk YES, complete next questions. Resident has elopement risk, because of the following voices statements of leaving and exhibit periods of pacing, agitation or wandering toward an exit .select approaches to prevent elopement exit seeking alarm bracelet/device on resident, monitor placement of exit alarm bracelet/device every shift, and monitor function of exit alarm bracelet/device function daily. 10/27/24 Elopement Risk Review Indicate if resident is an elopement risk YES, complete next questions. Resident has elopement risk, because of the following history of exit seeking, exhibit periods of pacing, agitation or wandering toward an exit, resident has eloped within the last 3 months .select approaches to prevent elopement observe elopement attempts, 1:1 supervision, exit seeking alarm bracelet/device on resident, monitor placement of exit alarm bracelet/device every shift, and monitor function of exit alarm bracelet/device function daily . R4's Progress Note states in part; .10/25/24 .IDT (Interdisciplinary Team) review: resident remains appropriate for use of wander guard bracelet at this time for safety. Resident is able to move about the facility independently and can become confused at times. Provider and family are in agreement with con't (continued) use . 10/26/24 5:22 PM .facility staff alerted that resident was found to be walking off campus near manufacturing plant, police notified and returned resident to facility. Wander guard bracelet on and functioning. In room sitting in recliner at this time . 10/26/24 5:37 PM .Resident was returned to the facility at 4:15 PM by police. Her vital signs were stable upon return. Resident denies pain but says she is really tired. Writer assisted resident to her room and encouraged her to rest in her recliner. A check was completed with no abnormal findings. Staff will be doing 15-minute checks to ensure resident's location at all times . 10/26/24 9:45 PM .Resident has been placed on 15-minute checks following elopement event earlier this afternoon. She has made no further attempts to leave the building and is currently sleeping in her bed . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10/29/24 7:27 AM .IDT review of exit seeking event on 10/26/24 .Resident returned to facility per police department after exiting building and walking off campus with use of walker. Resident was dressed appropriately and wearing appropriate foot wear. Weather was sunny and 58 degrees outside at time of event . Case Report Summary from local law enforcement states in part; .Incident 10/26/24 15:57 (3:57 PM) . Dispatched information: At approximately 3:57pm, Sheriff's Office was dispatched to a found person at (Name of Manufacturing Company) .Dispatch stated an elderly female had been located there pounding on the door asking for help. Dispatch advised R4 did not know where she lived or any further information about herself. The deputy assigned to this case requested my assistance due to the likelihood that R4 was missing from somewhere in the village jurisdiction, since (Name of Manufacturing Company) is surrounded by village property. I responded to (Manufacturing Company Name) I arrived on scene and was waved down by the caller who was with the elderly female on a south facing side door of the main building at (Manufacturing Name). To get to this side door, you must cross a wooden decorative bridge. I made contact with the citizen and the elderly female who we later identified. R4 had her walker with her, but no identifying information. She stated her lips were dry and she was thirsty but was not injured or needing medical attention. R4 had no recollection of how she got to (Manufacturing Company Name) or how long she had been out walking. She didn't know where she lived or any of her identifying information .Sgt. called facility which is located just a couple blocks away. Staff confirmed their resident was missing. Staff was unaware R4 was missing until Sgt. had called. They requested R4 be given a ride back to their facility I spoke with the head nurse who stated he had no idea how R4 got out of the facility. I confirmed R4's wander guard was on her walker, but staff wasn't sure why the alarms didn't go off when she left. Head nurse stated another staff member mentioned an alarm going off to a door that went towards their assisted living facility. That staff member didn't see anyone around, so they shut off the alarm. Head nurse also mentioned that after they learned R4 left, they tested the doors and discovered one of the dining room doors didn't sound when it opened. Head nurse added he last saw R4 around 3pm, and he never saw her pass him to get to the dining room, so he is unsure how she got outside. Head nurse stated he had already spoken with director .after leaving the facility, I spoke with director over the phone. She stated she was trying to watch surveillance footage to determine how R4 escaped. I informed her of my findings at (Manufacturing Company Name) and specifically that due to the door R4 had gone to, no one would have likely found her until Monday if it wasn't for the citizen that did find her who happened to be hanging fliers in the area and heard R4 calling for help . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Surveyor on 10/28/24 at 3:15 PM, LPN I (Licensed Practical Nurse) indicated he was the nurse on duty on 10/26/24 when R4 eloped. LPN I indicated R4 was talking about wanting to go home. LPN I indicated R4 is at risk for wandering and elopement. LPN I indicated the last time he saw R4 was around 3:00 PM sitting on her walker in the hallway on 10/26/24. LPN I indicated he received a call from the police around 4:00 PM saying they had R4 and that she was found down the road. LPN I indicated there were no alarms that went off and he does not know of any previous issues with the Wanderguard system not working correctly. LPN I indicated he immediately called the NHA (Nursing Home Administrator). LPN I indicated he was instructed to collect written statements from everyone who was working. LPN I indicated R4 got back to the facility around 4:15 PM accompanied by the police officer. LPN I indicated R4 was tired and that he completed assessment and vitals. LPN I indicated R4 was put on 15-minute checks immediately and the 15-minute checks are currently still in place. LPN I indicated R4 previously had an elopement incident over the summer. LPN I indicated the Wanderguard alarm went off at that time and staff began looking for R4. LPN I indicated R4 was found in the parking lot during that incident but went back inside with staff assistance. LPN I indicated currently R4 is on 15-minute checks; secretary or assigned person is always at the nurse station as a double check in the event the Wanderguard system isn't working correctly. LPN I indicated receiving education recently regarding the facility elopement policy and Wanderguard system. During an interview with Surveyor on 10/28/24 at 3:36 PM, CNA K (Certified Nursing Assistant) indicated R4 is at risk for elopement and will wander throughout the building. CNA K indicated she was working on 10/26/24 when R4 eloped. CNA K indicated she was in another resident room and did not hear an alarm go off on 10/26/24. CNA K indicated she was working the evening over the summer when R4 was found in the parking lot. CNA K indicated the alarms did go off for that incident. CNA K indicated she does not know of any other incidents where the Wanderguard system didn't go off and it should have. CNA K indicated currently R4 is on 15-minute checks, has a Wanderguard on self, staff encourage R4 to hang out at the nurse's station where staff are present, and encourage activities. CNA K indicated R4 likes doing puzzles with staff. CNA K indicated she recently received education regarding elopement and Wanderguard system process through the app that the facility utilizes. Surveyor observed R4 throughout the day on 10/28/24. R4 was active in activities that were offered and went on a van ride with peers and staff. R4 was observed in dining room visiting with table mates and staff in dining room area for all meals. Surveyor observed R4 visiting at the nurse's station and walking with staff up and down R4's hallway. Surveyor observed no concerns with R4's supervision and supports throughout the day on 10/28/24. During an interview with Surveyor on 10/28/24 at 10:00 AM, LPN C (Licensed Practical Nurse) indicated she is aware of R4's elopement incident on 10/26/24. LPN C indicated R4 went out the back door near the nurse's station and that the Wanderguard alarm did not go off on 10/26/24. LPN C indicated R4 is now on 15-minute checks, the receptionist is now sitting at the nurse's station, and the kitchen and back doors are now shut. LPN C indicated she is not sure if R4 has had prior elopement incidents but knows R4 was at risk for wandering and elopement prior to incident. LPN C indicated they recently received education on elopement and reviewed facility policy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Surveyor on 10/28/24 at 11:30 AM, CNA F (Certified Nursing Assistant) indicated she was not working when R4 eloped, but she knows about the incident. CNA F indicated she thinks that R4 had previous attempts of elopement. CNA F indicated R4 left the building through the doors near the nurse's station. CNA F indicated the receptionist is now sitting at nurse's station, the doors are now closed, and they are expected to always keep an eye on R4. CNA F indicated she does not believe she received education recently on the facility elopement policy. It is important to note facility provided staff signature sheet to Surveyor and CNA F received education on elopement policy and exit seeking behaviors. During an interview with Surveyor on 10/28/24 at 12:06 PM, CNA E (Certified Nursing Assistant) indicated she is new to the nursing home side of the facility. CNA E indicated she recently did receive education regarding the facility elopement policy and to monitor residents who are at risk for wandering/elopement. CNA E indicated she recently received education through the app that the facility utilizes for communication and education. During an interview with Surveyor on 10/28/24 at 12:30 PM, CNA H (Certified Nursing Assistant) indicated she has recently received education regarding the facility elopement policy and the process for when the Wanderguard alarm goes off. CNA H indicated any time the Wanderguard goes off staff must locate residents who have a Wanderguard and not just turn the alarm off. CNA H indicated she received the education through the app that the facility utilizes for communication and education. CNA H indicated she received the education on 10/27/24. During an interview with Surveyor on 10/28/24 at 2:57 PM, CNA G (Certified Nursing Assistant) indicated R4 is at risk for elopement and wandering. CNA G indicated receiving education recently on elopement and Wanderguard alarm process. During an interview with Surveyor on 10/28/24 at 4:37 PM, US Q (Unit Secretary) indicated she is working from the nurse's station because R4 had an elopement incident on 10/26/24 and the Wanderguard alarm system didn't go off when R4 eloped. US Q indicated the alarm next to the nurse's station was the alarm that didn't go off when R4 walked past it on 10/26/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Surveyor on 10/28/24 at 4:30 PM, NHA A (Nursing Home Administrator) indicated she received the call from LPN I on 10/26/24 around 4:05PM. LPN I reported that R4 was found down the road and the Wanderguard alarm didn't go off. NHA A indicated R4 was put on 1:1 supervision and then 15-minute checks. NHA A indicated the Wanderguard system was immediately checked and no concerns were noted. NHA A indicated vitals and an assessment were completed, notifications were made, an audit was completed to ensure all residents were accounted for, Wanderguard company was contacted, a new Wanderguard was placed on R4's right wrist (prior to incident Wanderguard was on walker), cameras were reviewed, sensitivity levels for the sensor near the nurse's station were tested and adjusted by maintenance, maintenance conducted an elopement drill on 10/27/24, and education for all staff was provided. NHA A indicated the unit secretary is working out of the nurse's station to provide another set of eyes while the facility waited for a mag lock to be installed on the doors near nurse's station. NHA A indicated when reviewing the cameras R4 left the facility at 3:37 PM. NHA A indicated that R4 loves to walk and will walk up and down the hallways. NHA A indicated that recently R4 is becoming more difficult to redirect and the team is scheduling a care conference meeting to discuss the possibility of a memory care unit. NHA A indicated R4 has not had any previous elopement incidents and that she will wander in the facility. NHA A indicated she sent out education to all staff through the facility app. NHA A indicated she sent out the elopement policy to review and Wanderguard system expectations to all staff on 10/27/24. During an interview with Surveyor on 10/28/24 at 5:26 PM, CNA L (Certified Nursing Assistant) indicated R4 is at risk for elopement. CNA L indicated R4 likes to walk and will be on the go from the time she wakes up in the morning. CNA L indicated eyes need to be on R4 at all times once she's up for the day. CNA L indicated currently they are providing activities for R4, keeping her near the nurse's station, and offering snacks. CNA L indicated she recently received education regarding elopement. CNA L indicated any time the Wanderguard alarm goes off staff are to immediately look for R4. During an interview with Surveyor on 10/28/24 at 5:37 PM, US M (Unit Secretary) M indicated she is the evening secretary at the facility. US M indicated there was an incident a few months ago regarding R4 eloping. US M indicated she cannot remember the date of the incident, but it was summer and warm out. US M indicated the incident occurred sometime after dinner. US M indicated she was walking to the nurse's station and heard the Wanderguard alarm going off. US M indicated she started looking for R4 and staff began searching as well. US M indicated DSS N (Director of Social Services) was backing out of the parking lot and saw R4 in the parking lot. Staff then brought R4 back in the building. During an interview with Surveyor on 10/28/24 at 5:45 PM, DSS N (Director of Social Services) indicated she does not remember the exact date she found R4 in the facility parking lot. DSS N indicated she knows it was summer months and in the evening hours. DSS N indicated she was backing out of the parking lot and saw R4 in the parking lot. DSS N talked with R4 and assisted R4 back inside. DSS N indicated NHA A was notified of the incident. On 10/30/24 at 8:40 AM, DSS N indicated the incident with R4 in the summer months was not viewed as an elopement but rather wandering and possibly taking a wrong turn. DSS N indicated education was sent out and provided to all staff after the incident as a refresher. DSS N indicated an elopement drill was conducted as well. Documentation regarding education and elopement drill was provided to Surveyor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Surveyor on 10/30/24 at 9:30 AM, LPN O (Licensed Practical Nurse) indicated R4 is at risk for elopement. LPN O indicated R4 enjoys activities, time with her family, and going outside for walks. LPN O indicated she does not know of any previous incidents where R4 eloped. LPN O indicated there were issues with the Wanderguard alarm sensor closest to the nurse's station. LPN O indicated this was reported to maintenance. LPN O indicated the Wanderguard company has now been at the facility after incident on 10/26/24. LPN O indicated receiving education on elopement through the facility app. LPN O indicated there is now someone sitting at the nurse's station, R4 is on 15-minute checks, and there was an elopement drill that was conducted on 10/27/24. During an interview with Surveyor on 10/30/24 at 2:15 PM, PSA P (Plant Services Assistant) indicated there have not been any recent issues with the Wanderguard system. PSA P indicated the system is checked monthly and this is documented. PSA P provided Surveyor documentation. PSA P indicated the Wanderguard company has been out to the facility, a mag lock is being installed, maintenance conducted an elopement drill, and maintenance installed a second sensor near the nurse's station. Surveyor observed the second sensor in place. PSA P indicated it is the expectation if there are maintenance concerns that staff document the needed repair in their computer tracking system or staff will verbally report concerns to PSA P as well. Surveyor reviewed documentation, Episodic Event Form, which states in part; .Date form completed 10/26/24 .Event: Resident exited the campus on 10/26/24. The resident was last seen leaving the facility at 3:37pm and was observed walking by a community member at approximately 3:55. The community member contacted the police, and the resident was returned to the campus without incident. Nursing assessment was completed with no injuries or discomfort noted. Resident immediately placed on 1:1 observation upon return. Family and MD were notified. Root of cause analysis: Alarm did not sound when resident walked through sensor. Like Residents: Ensured all campus residents were accounted for. Assessed all residents for exit seeking risk. Wanderguards in place and functioning properly for residents with Wanderguards. Wanderguard system tested and functioning properly at all locations. Assessed all residents for elopement risk; no new residents identified. Reviewed care plans to ensure appropriate interventions are in place for those at risk for elopement. Assessed Wanderguard placement. Plan of Action and Systematic Changes Made: Staff educated on elopement. Installation of additional Wanderguard sensors and mag locks on staff exit doors on 10/28/24. Auditing/compliance: Auditing Wanderguard hourly to ensure its functioning properly. Resident is currently a 1:1 when up and on 15-minute checks when sleeping. Gauge staff understanding of the process. Audit residents that are at risk for elopement to ensure Wanderguard is in place and functioning properly. Ad HOC QAPI. 10/29/24 addendum: door alarm function checked at least hourly upon resident return until resident went to bed on 10/26. DPO (Director of Plant Operations) arrived 10/27/24 and confirmed alarm system was working correctly. RF technologies contacted to confirm that door/wandering system is functioning properly and request for additional mag lock system to the double doors by the nurse's station as well as a keypad lock to be added to employee entrance. RF technologies arrived 10/28/24 and confirmed system was working properly and returned 10/29/24 to work on installation of the mag lock. Door guard in place to monitor the doors by the nurse's station and R4 remains on 15-minute checks until the mag lock is installed. Door alarm function checked, and no issues noted ongoing interviews with random staff re: elopement and what to do if finding a resident outside being conducted. 10/30/24 addendum: Mag lock to double doors by the nurse's station installed and functioning. Surveyor reviewed staff written statement forms, 15-minute check documentation, maintenance logs, and staff education with staff signature sheets and time stamps for the facility app. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to provide adequate supervision of R4 who is at risk for elopement and exit seeking created a reasonable likelihood for serious harm, thus leading to a finding of Immediate Jeopardy. The facility removed the immediate jeopardy on 10/27/24 and corrected the deficient practice on 10/30/24 when it completed the following: Nursing Assessment completed for R4. Placed on 1:1 and then 15-minute checks. Notifications of MD and responsible party made. Wanderguard placed on wrist. Facility head count was completed all residents accounted for. Director of Plants Operation assessed Wanderguard system and all other campus egress doors all found functioning properly. Door monitor placed at the nurse station. Repair company was contacted to assess Wanderguard system and to install a keycode pad/mag lock for the employee entrance/exit door. All residents reviewed for elopement risk. Wandering and elopement care plans were reviewed by the DON (Director of Nursing) on 10/27/24. All elopement binders reviewed by DON on 10/27/24. Elopement drill was conducted on 10/27/24. Education initiated on 10/27/24. Education on 10/29-10/30 including: Policy Review related to increasing exit seeking behaviors and what to do if resident found outside. Audit on Wanderguard function 5 times weekly for 4 weeks. Audit 5 staff members what to do if resident is observed an increase in exit seeking behaviors 5 times weekly for 4 weeks and then randomly thereafter. Elopement drills will be completed at least quarterly. DON will audit residents who are currently an elopement risk twice weekly x 30 days to ensure appropriate interventions are in place. All audits submitted to the QAPI Committee for further review.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 41788 Based on interview and record review, the facility did not ensure Certified Nursing Assistant (CNA) staff received a performance review at least every 12 months for 5 of 5 staff members selected for review. CNA T was hired on 3/1/23 and has not had an evaluation in the past 12 months. CNA U was hired on 3/1/23 and has not had an evaluation in the past 12 months. CNA S was hired on 3/1/23 and has not had an evaluation in the past 12 months. CNA R was hired on 3/1/23 and has not had an evaluation in the past 12 months. CNA H was hired on 8/17/23 and has not had an evaluation in the past 12 months. Evidenced by: The facility does not have a Policy and Procedure in place for CNA performance evaluations. Example 1 CNA T was hired on 3/1/23 and has not had an evaluation in the past 12 months. CNA T was due for an evaluation on or around 3/1/24. Example 2 CNA U was hired on 3/1/23 and has not had an evaluation in the past 12 months. CNA U was due for an evaluation on or around 3/1/24. Example 3 CNA S was hired on 3/1/23 and has not had an evaluation in the past 12 months. CNA S was due for an evaluation on or around 3/1/24. Example 4 CNA R was hired on 3/1/23 and has not had an evaluation in the past 12 months. CNA R was due for an evaluation on or around 3/1/24. Example 5 CNA H was hired on 3/1/23 and has not had an evaluation in the past 12 months. CNA H was due for an evaluation on or around 3/1/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/11/2024

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Waunakee Valley Senior Living	801 Klein Dr Waunakee, WI 53597

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/11/24, at 11:00 AM, Surveyor interviewed ADVP V (Assistant Divisional [NAME] President) who indicated the facility does not do yearly evaluations for CNAs. ADVP V indicated the facility does quarterly wage increases. ADVP V indicated the facility does do PIPs (Performance Improvement Plans) when indicated by disciplinary actions. Surveyor referred ADVP V to the State Operations Manual that indicates facilities are to complete performance reviews of every nurse aide at least once every 12 months.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on interview and record review, the facility did not provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 4 residents reviewed (R3). R3 did not receive Acetaminophen, Aspirin, and Lacosamide medications as scheduled on 10 separate days in August 2024. Evidenced by: The facility policy, Preparation and General Guidelines IIA2: Medication Administration-General Guidelines, revised date 11/18, indicates, in part: .B. Administration .2) Medications are administered in accordance with written orders of the prescriber .11) .Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility .C. Refusal of Medication .4) Continuous medication refusal must be reported to the prescriber and there must be documentation of prescriber notification of such . Of note, the facility provided Surveyors with a typed document that indicates, Med Pass Times: 6a - 10a; 12p; 4p-6p; and 8p. Example 1 R3 was admitted to the facility on [DATE] with diagnoses that include, in part: Unspecified atrial fibrillation (irregular heart beat), hemiplegia (paralysis of one side of the body) and hemiparesis (one sided muscle weakness) ., Epilepsy, and Pain in left hip. R3's August 2024 Medication Administration Record (MAR) indicates the following, in part: Acetaminophen tablet; 500mg .oral .Give 2 tablets (=1000mg) by mouth three times a daily for pain. Administration times on the MAR indicate: 6:00 AM - 10:00 AM; 2:00 PM -- 5:00 PM; 6:30 PM - 8:30 PM. Aspirin tablet, chewable; 81mg .oral .Give 1 tablet by mouth once daily. Administration times on the MAR indicate: 6:00 AM - 10:00 AM. Lacosamide tablet; 100mg .oral .Give 1 tablet by mouth twice daily. Administration times on the MAR indicate: 6:00 AM - 10:00 AM and 6:30 PM - 8:30 PM. On 8/4/24, 8/7/24, 8/11/24, 8/12/24, 8/23/24, 8/24/24, 8/26/24, 8/27/24, 8/28/24, and 8/31/24 these medications were administered outside of the 6:00 AM - 10:00 AM administration time range. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 10:30 AM Surveyors interviewed LPN C (Licensed Practical Nurse) regarding R3's August 2024 MAR and why there were multiple morning medications, with scheduled administration times of 6:00 AM - 10:00 AM during the month, documented as charted late. LPN C indicated that sometimes R3 will refuse the morning medications because she wants to take them after breakfast. LPN C indicated that her charting was wrong and that the medications were administered late and not just charted late for the 6:00 AM - 10:00 AM medications she documented. LPN C indicated that the actual administration time would be the date and time under the column labeled Charted Date. LPN C indicated she did not contact the provider to inform them the medications were late due to refusals. LPN C indicated that she should have contacted the provider to get a time change for the orders for a time when R3 will take them because she won't take them until after breakfast. On 10/29/24 at 12:06 PM, Surveyor interviewed DON B (Director of Nursing) with DHS D (Director of Health Services) present. Surveyor reviewed R3's August MAR with DON B and DHS D who stated they had been made aware today that the documentation was incorrect and that the medications were in fact given late not just charted late. DON B indicated the expectation is for medications to be given as ordered and if it cannot be the provider should be called.

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NAME OF PROVIDER OR SUPPLIER: Waunakee Valley Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 801 Klein Dr Waunakee, WI 53597	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44552 Based on observation, interview, and record review, the facility did not ensure that all residents receive food at a palatable temperature for 1 of 1 test trays. A test tray was found to outside of acceptable temperature range and not palatable. Evidenced by: The facility policy, Food Production Guidelines, dated 1/24, states, in part; .Procedures 5. Food is served as soon after preparation as possible and is held at the following temperature: Hold food- HOT= 135F or above. Hold food- COLD= 41F or below . On 10/28/24 at 1:20 PM, Surveyor requested to temp the last tray on the meal cart. Meat and noodles temped at 123.8 F, corn temped at 125.8 F and milk 41.7 F. The meat was difficult to chew, and meat and noodles were cold. The corn was cold and milk was warm. On 10/28/24 at 1:30 PM, Director of Food Services J indicated hot foods should be served hot and cold foods served cold. Director of Food Services J indicated understanding on the concern with the temperatures of the food on the meal tray.