STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019733	A. BUILDING: _____ B. WING _____	C 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NCHC ADULT CRISIS STABILIZATION FACILITY	1150 LAKE VIEW DR WAUSAU, WI 54403

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N 000	Initial Comments On 07/30/2025, Surveyor conducted a self-report investigation at NCHC Adult Crisis Stabilization Facility. Data was collected through 08/11/2025. One deficiency was identified. Census: 10	N 000		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not adequately supervise Resident 1. Resident 1 died by suicide. Findings include: The provider is licensed to care for up to 16 residents in the client groups of emotionally disturbed/mental illness, alcohol/drug dependent, physically disabled, and developmentally disabled. The provider's program statement read, in part: "The ACSF (Acute Crisis Stabilization Facility) provides a voluntary short-term residential program to monitor and support the	N 426		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 426	Continued From page 1	N 426		

recuperative process. The ACSF operates 24 hours/day, 7 days/week, and provides protective, supportive, and supervised residential services to individuals in need of monitoring and a temporary separation from their current living environment."

The provider's procedure titled, "ACS Patient Safety Check Procedure," dated 03/05/2025, read, in part: "The purpose of this procedure is to ensure the safety and well-being of patients under the care of North Central Health Care's Acute Care Services (ACS) programs, which include the Adult Crisis Stabilization Facility (ACSF) ...
Regular patient safety checks are essential for both the physical and mental well-being of the patients, contributing to a safe environment and timely identification of any needs or issues that may arise during their stay... Patient safety checks are designed to assess patients at regular intervals to ensure their physical and mental safety. These checks must be conducted consistently and at designated increments, per the requirements outlined for each program. Checks are to be documented in the patient's record to maintain accountability and transparency.
Importance of Patient Safety Checks:
Physical Safety: To identify and address any immediate medical or environmental risks (e.g., falls, injuries, self-harm, medication side effects, and signs of detox) ...
Sleeping Patients: When patients are sleeping, it is imperative to check for signs of life. This includes observing for chest rising or other visible signs of breathing to ensure the patient is alive and stable.
Mental Safety: To assess the patient's mental state, ensuring they are stable, comfortable, and supported. This includes identifying any signs of distress, agitation, or changes in behavior.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 426	Continued From page 2 Prevention: To identify potential risks or concerns early, allowing for timely interventions and reducing the likelihood of escalation. Patient safety checks should occur at the following intervals, depending on the program. These increments are designed to align with the level of care required and the potential risks associated with each patient. Adult Crisis Stabilization Facility (ACSF) ... Frequency: Every hour Purpose: These programs involve patients who may be more stable but still require regular monitoring to ensure safety ... Conducting the Safety Check The person conducting the check must: 1. Physically observe the patient to ensure that they are safe and not at risk of harm. This includes checking for signs of physical injury, distress, or changes in condition. The proper way to conduct patient safety checks involves laying eyes directly on the patient, which may involve actions such as opening the patient's door at night, walking away from a desk area to observe them more closely, or other similar methods to confirm their safety. 2. Check for signs of life when a patient is sleeping, such as visible chest rising or other signs of breathing, to ensure that the patient is alive and stable. 3. Engage with the patient, asking questions if necessary to assess their mental state and well-being. This could include asking how they feel, if they are in any discomfort, or if they have any concerns... Incident Reporting: If a safety check reveals a concern, such as potential self-harm, distress, or medical complications, the staff member should immediately notify the patient's nurse and other staff members of the treatment team, such as the charge nurse, clinical staff, or any available team	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 426	Continued From page 3	N 426		

members. Depending on the level of severity, the staff member may also need to initiate the appropriate emergency code to ensure the patient receives immediate care and attention ..."

On 07/30/2025, Surveyor reviewed Resident 1's record.

On 07/16/2025, Resident 1 was admitted to the facility. Previously Resident 1 was a voluntary patient at the adult inpatient behavioral health unit from 07/03/2025 until 07/16/2025. S/he had multiple psychiatric diagnoses including: Bipolar 1 disorder, generalized anxiety disorder, and chronic post-traumatic stress disorder.

Resident 1's assessment, Columbia-Suicide Severity rating Scale (CSSRS), dated 07/16/2025, indicated Resident 1 had a moderate suicide risk.

Resident 1's assessment, Patient Health Questionnaire (PHQ-9), dated 07/16/2025, indicated Resident 1 scored a 26. A score of 20 - 27 indicated severe depression.

On 07/18/2025, Social Worker (SW) C developed a Stanley - Brown Safety Plan with Resident 1. Resident 1's safety plan identified warning signs of: punching self, lying in bed a lot, getting agitated easily, and isolation. Resident 1's coping strategies included: hiking, listening to music, and rock picking. The plan did not identify any lethal means of suicide. The plan indicated Resident 1 stated s/he was likely to use the plan. The Stanley - Brown Safety Plan is described as: "A brief intervention to help those experiencing self-harm and suicidal thoughts with a concrete way to mitigate risk and increase safety." (retrieved from suicidesafetyplan.com on

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	0019733	A. BUILDING: _____ B. WING _____	C 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NCHC ADULT CRISIS STABILIZATION FACILITY	1150 LAKE VIEW DR WAUSAU, WI 54403

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N 426	Continued From page 4 08/11/2025). On 07/21/2025 at 4:00 a.m., Behavioral Health Professional (BHP) B documented the following hourly safety check for Resident 1: Patient Location: "Patient room" Patient Activity: "Eyes closed, lying down" Affect/Behavior: "Calm" On 07/22/2025, BHP B documented a late note for services on 07/21/2025. The note read: "Client was in [his/her] room at 0000 (12:00 a.m.) sleeping. Writer did hourly checks through out [sic] the shift. Writer noted client was in the shower at 0400 (4:00 a.m.), the bathroom light was on and shower running. Client's roommate alerted writer at 0405 (4:05 a.m.) that client was still in the shower but the bathroom light was off. Writer called ABHH (Acute Behavioral Health Hospital) for another tech to go in the bathroom with me to check on client. Writer waited a few minutes and no staff came. Writer called crisis asking for a crisis worker and security to come up noting how important the situation is and client not responding to writer or the roommate knocking on the bathroom door. Writer was told that it would be a few [sic] security was doing an admission. Writer decided they could not wait anymore and went to open the bathroom door with the key, writer had the roommate stand outside the door incase [sic] writer needed help with anything. Writer opened the door and noticed blood on the floor, at the same time the other staff was back on the unit and writer told [him/her] to call a rapid response, client was not visible from the doorway, at this time writer approached the shower where they found the client in the corner of the shower slunched [sic] over unresponsive, with visible lacerations to both arms and a belt around [his/her] neck. Writer	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019733	A. BUILDING: _____ B. WING _____	C 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NCHC ADULT CRISIS STABILIZATION FACILITY	1150 LAKE VIEW DR WAUSAU, WI 54403

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N 426	Continued From page 5 screamed for an ambulance to be called and for help. The clients [sic] roommate rushed to the bathroom to help writer loosen the belt until staff came with the rescue tool about 0415 (4:15 a.m.). Once the belt was removed client was pulled out of the bathroom where staff started CPR (cardiopulmonary resuscitation). Officers arrived on the scene with in [sic] 30 minutes followed by the paramedics who then took over CPR. Writer stayed in the room with the paramedics monitoring client for any changes. The paramedics called the DR (doctor) at 0500 (5:00 a.m.) to ask if they could call it, at 0505 (5:05 a.m.) client was pronounced deceased on the unit ..." Staff I documented the following timeline for 07/21/2025: "4:23AM - [BHP B] calls from ACSF stating the client has been in the shower 20 minutes and the lights are off now and [s/he] is not responding to knocking. [BHP B] stated [s/he] was not comfortable checking on [him/her] being [fe/male] and [him/her] being [fe/male]. Writer told [BHP B] [s/he] would be up in a second. 4:24 - Writer gets a phone call from ACSF and was told theres [sic] blood in the bathroom and writer needs to call a rapid response. Writer calls a rapid and then grabs gloves and heads upstairs. Writer meets nurse [Staff J] at the double doors of ACSF. There is yelling from the clients [sic] bathroom that 'we [sic] need the cutter'. [Staff J] rushes over with writer. Clients [sic] belt is cut off. Writer leaves the room to give space. Client is pulled out of the bathroom and nurse [Staff J] immediately begins compressions. Writer tells [BHP G] to call 911..." On 07/31/2025 at approximately 11:35 a.m., Surveyor interviewed BHP G on the phone. BHP	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019733	A. BUILDING: _____ B. WING _____	C 08/11/2025

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N 426	Continued From page 6 G said s/he was working the overnight shift from 07/20/2025 into 07/21/2025. S/he said s/he left to go on a transport at approximately 12:30 a.m. - 1:00 a.m. and returned when BHP B was calling for assistance. Surveyor asked BHP G when s/he did rounds during the overnight hours if staff were to have eyes on the residents. BHP G said with no lights on in the room, s/he looked for body movement and the outline of their bodies in bed. Surveyor asked how often staff are alone on this unit at night. BHP G said s/he was alone after 10:00 p.m. "often." S/he said, "In my experience it's not the best to have only 1 person, especially with increased acuity." BHP G told Surveyor Resident 1 was on hourly safety check rounds. On 07/31/2025 at approximately 1:35 p.m., Surveyor interviewed Medical Examiner (ME) D on the phone. ME D confirmed s/he was the medical examiner on the scene for Resident 1 on 07/21/2025. ME D told Surveyor Resident 1's manner of death was suicide and s/he died from asphyxia, which is lack of oxygen to the brain. ME D said the estimated time of death would have been approximately 4:00 a.m. On 07/31/2025 at approximately 2:20 p.m., Surveyor interviewed Investigator E on the phone. Investigator E confirmed s/he was the lead investigator for Resident 1's case. Investigator E told Surveyor it was clear that this was a suicide. S/he said s/he interviewed Resident 1's roommate, Resident 2, and BHP B, who was working. Investigator E said both Resident 2 and BHP B were frustrated how long it took for other staff to come and assist when BHP B called for help. Surveyor asked if Resident 1 was deceased when s/he was found. Investigator E said, "No doubt."	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019733	A. BUILDING: _____ B. WING _____	C 08/11/2025

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N 426	Continued From page 7 On 07/31/2025, Surveyor emailed Director A and asked it there were any policies that would indicate a staff person to have a 2nd staff present when entering a locked bathroom or responding to emergencies. On 08/04/2025, Director A replied via email, which included policies and procedures for emergency situations. The email read, in part: "We also do not have a policy or procedure that directs staff to not enter a room, regardless of gender. I have confirmed with my entire leadership team and verified that this has never been communicated to staff. We have always directed our staff to immediately attend to an emergency per our procedures attached." On 08/04/2025, Surveyor reviewed the police reports. On 07/21/2025, Officer H documented s/he responded along with 2 other officers at approximately 4:28 a.m. The report read, in part: "CONTACT WITH [Resident 2] ... [Resident 2] described going to bed around 2300 hours (11:00 p.m.) on 07/20/2025. [Resident 1] at this time was up and down from bed. [Resident 2] woke up around 0400 hours (4:00 a.m.) on 07/21/2025 and heard the shower running, but the light was off. [Resident 2] said the light was a motion sensor light on a timer off about 4-5 minutes. [Resident 2] knocked on the door to check on [Resident 1], but did not get an answer. [Resident 2] proceeded to get help from staff. [BHP B] was the first staff member to arrive. [S/he] attempted to get in contact with [Resident 1] but was unsuccessful. [S/he] unlocked the door ... [BHP B] called for a rapid response approximately 0424 (4:24 a.m.) according to the security staff who responded on camera ..."	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019733	A. BUILDING: _____ B. WING _____	C 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NCHC ADULT CRISIS STABILIZATION FACILITY	1150 LAKE VIEW DR WAUSAU, WI 54403

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N 426	Continued From page 8 On 07/25/2025, Investigator E, documented, in part: "Scene Description: "A silver, metal pencil sharpener was located on the bathroom sink. A small screw was located at [Resident 1's] feet and the razor blade from the sharpener was on the floor of the shower. It appeared [Resident 1] had disassembled the sharpener to gain access to the razor blade inside ... Body examination with medical examiner: ... I noted both vertical and horizontal cuts on the inside of both of [Resident 1's] arms. I did not manipulate the bandage placed on [Resident 1's] right arm but was told an additional cut was under the bandage. The majority of the cuts to [Resident 1's] arms appeared to be superficial ... Interview of [BHP B] ... [BHP B] said [s/he] recalled hearing the shower running and thought it was strange but not initially concerning. [BHP B] was alerted by [Resident 2] that something was wrong because the bathroom door was locked and the light was turned off. [BHP B] told me [s/he] is not allowed to enter [fe/male] patient's rooms without another staff member for safety reasons. [BHP B] called for a 'rapid response' but said no one responded. [BHP B] said [s/he] was told [s/he] would need to wait. Eventually, [BHP B] and [Resident 2] entered the room and [BHP B] unlocked the bathroom door. Although it was against policy [BHP B] decided to enter the room because [s/he] was concerned about [Resident 1's] welfare. [BHP B] said [Resident 1] was seated in the shower with the belt around [his/her] neck. The belt was around [Resident 1's] neck but not otherwise attached to anything. [BHP B] said the belt was very tight and also very wet. [Resident 2] tried to get the belt off [Resident 1's] neck, however, [BHP B] described removing the belt as very difficult ... Preliminary autopsy Results: On July 22, 2025, [Doctor F] performed an autopsy of [Resident 1's] body at	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019733	A. BUILDING: _____ B. WING _____	C 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 426	Continued From page 9	N 426		

the Marathon County Medical Examiner's Office. The final autopsy report is not completed, however, all preliminary findings support suicide by ligature strangulation. The cuts to [Resident 1's] arms are believed to be non-fatal."

On 08/04/2025, Surveyor emailed Director A and requested additional information, including: An explanation of why BHP B documented Resident 1's eyes were closed, and s/he was calm at 4:00 a.m. Later, BHP B documented a late note indicating Resident 1 was in the shower at 4:00 a.m. Surveyor also requested a timeline for each call BHP B made for assistance.

On 08/05/2025, Director A emailed Surveyor, which read, in part: "I am unsure why [s/he] documented that, [s/he] is the only one who can speak to that. We have given [him/her] the direction to reach out to call you." Director A also stated s/he was gathering information as to the times each phone call took place.

On 08/05/2025 at approximately 4:00 p.m., Surveyor interviewed BHP B on the phone. BHP B told Surveyor Resident 1 was on hourly rounds. S/he said his/her co-worker, BHP G, would have done the 3:15 a.m. round and said Resident 1 could have been in the shower anytime after that. Surveyor asked for clarification as BHP G told Surveyor s/he left the unit around 12:30 - 1: 00 a.m. to go on a transport and did not return until BHP B was calling for assistance. BHP B told Surveyor s/he was not sure on the time. BHP B said Resident 1 was in the shower with the lights on at 4:00 a.m. Surveyor asked if s/he had his/her eyes on Resident 1 during this check. BHP B told Surveyor s/he did not. Surveyor asked why s/he charted that Resident 1 was calm and his/her eyes were closed. BHP B told Surveyor s/he

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N 426	Continued From page 10 entered the wrong entry. BHP B told Surveyor that at 4:10 a.m., Resident 2 told BHP B the shower was running, and the motion light was off. BHP B said because s/he was the only fe/male on the unit, s/he called inpatient for a second staff. S/he said s/he waited a "few minutes." Surveyor asked what a few minutes was. BHP B said about 5 - 10 minutes. BHP B said s/he then called the crisis unit, and they told him/her s/he would have to wait. BHP B said s/he entered the bathroom by him/herself, and this was the same time BHP G arrived back to the unit. Surveyor asked what time this took place. BHP B said it was approximately 4:25 a.m. - 4:30 a.m. Surveyor asked BHP B if there was policy on not entering a locked bathroom of the opposite gender or responding to an emergent situation without a second person present. BHP B said there was no policy, but s/he did not want to walk in on him/her in the shower. BHP B said s/he saw blood and yelled for a rapid response. BHP B said s/he then observed Resident 1 in the shower, and s/he yelled for an ambulance. BHP B said it took 3 staff to get the belt off Resident 1's neck. S/he said CPR was started at approximately 4:30 a.m. BHP B said the room next to Resident 1's room was on 15-minute checks for their sleep pattern. S/he said that when s/he did those checks at 3:45 a.m., s/he did not hear the shower running in Resident 1's bathroom. Surveyor asked if it was normal for Resident 1 to shower in the middle of the night or early morning hours. BHP B said the residents could shower when they want to. Surveyor asked BHP B when they do their hourly safety check rounds and a resident is in the shower, are they supposed to open the door and physically observe the resident. BHP B said they	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019733	A. BUILDING: _____ B. WING _____	C 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NCHC ADULT CRISIS STABILIZATION FACILITY	1150 LAKE VIEW DR WAUSAU, WI 54403

(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 426	Continued From page 11	N 426		

did not need to observe the resident on this unit. S/he said that if it was the inpatient unit, they would need to open the door to ensure they were ok. Surveyor asked if the documentation of Resident 1's hourly safety check at 4:00 a.m. was not accurate. BHP B said, "Correct."

On 08/07/2025, Director A emailed Surveyor with additional information, which read, in part: "We are unable to locate any of these calls on our phone system. We were able to deduce based on cameras that [s/he] called the Adult Behavioral Health Hospital (ABHH) prior to 0417. Per the statements [s/he] gave, [s/he] talked to [staff] ABHH nurse and we see a ABHH Behavioral Health Professional badge swipe into the nurses station at approximately 04:17 and then go to the Youth Behavioral Health Hospital. We believe that there was a miscommunication as to where the help was being asked to go and the BHP went to the wrong location. We are unable to locate any Crisis calls due to an intermittent IT (internet technology) issue that was identified after the incident. Multiple staff reports indicate that the call was made from ACSF to Crisis after the call to the ABHH, which would have been after 04:19 ... Staff reported that the rapid response was called at 04:24 and a nurse responded within 1 minute and began compressions immediately." Director A's email indicated it took approximately 14 minutes for the motion light to turn off in the bathroom.

At 4:00 a.m., BHP B's documentation indicated Resident 1 was in the shower with the light on and shower running. BHP B did not physically observe Resident 1, check for signs of life, or engage with Resident 1 to ensure his/her physical and mental well-being according to the provider's policy and procedure. At 4:05 a.m., BHP B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019733	A. BUILDING: _____ B. WING _____	C 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NCHC ADULT CRISIS STABILIZATION FACILITY	1150 LAKE VIEW DR WAUSAU, WI 54403

(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 426	Continued From page 12 documented that s/he was alerted by Resident 2 that the motion light was off in the bathroom and the shower was on. Per Director A's email, the motion light turns off in approximately 14 minutes, therefore Resident 1 would have been motionless for approximately 14 minutes at 4:05 a.m. At 4:17 a.m., BHP B called for assistance and waited. At 4:23 a.m., BHP B called the crisis unit for assistance (per Staff I's timeline). At 4:24 a.m., BHP B called for a rapid response which was when BHP B unlocked the bathroom door and entered. Per the above timeline it took approximately 20 minutes for BHP B to respond to Resident 1. BHP B did not follow the provider's procedure, "ACS Patient Safety Check," which stated: "If a safety check reveals a concern, such as potential self-harm, distress, or medical complications, the staff member should immediately notify the patient's nurse and other staff members of the treatment team, such as the charge nurse, clinical staff, or any available team members. Depending on the level of severity, the staff member may also need to initiate the appropriate emergency code to ensure the patient receives immediate care and attention." BHP B did not ensure Resident 1 received immediate care and attention as s/he waited approximately 20 minutes after Resident 1 was not responding and the motion light was off. BHP B did not provide supervision adequate to meet Resident 1's needs. Resident 1 died of suicide.	N 426		