STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016849	A. BUILDING: _____ B. WING _____	C 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEATHERLY HOUSE	**4139 SAVANNAH DR DE FOREST, WI 53532**

(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 08/19/2025, Surveyor conducted a complaint investigation at Weatherly House, a CBRF in DeForest. One deficiency was identified. The complaint was substantiated. Census: 8	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 observation, record review and interview, the provider did not ensure supervision appropriate to meet resident needs was provided. Resident 1 eloped from the facility on 08/04/2025, was absent from the facility for approximately 1 hour and transported to a local hospital after being observed in the median of a highway by individuals passing by. Findings include: On 08/19/2025, Surveyor conducted a complaint	N 426		

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

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N 426	Continued From page 1	N 426		

investigation alleging a resident eloped from the facility.

On 08/19/2025 at 8:00 a.m., Surveyor reviewed the department's facility's records. The facility is licensed to provide care for up to 8 residents with diagnoses including physically disabled, advanced age, traumatic brain injury, irreversible dementia/Alzheimer's, terminally ill and emotionally disturbed/mental illness. The provider's program statement states the facility's services include 24-hour supervision and security measures, including alarmed exits for protection against wandering or elopement. The record included a self-report, dated 08/07/2025, that stated Caregiver B was informed at approximately 6:15 p.m. by another resident of the facility that Resident 1 had walked out the facility door. The report indicated management was informed of the elopement at 6:30 p.m., law enforcement was informed of the elopement at 6:59 p.m. and shortly after 6:59 p.m. the facility learned Resident 1 had been found and transported to a local hospital.

On 08/19/2025 at 9:00 a.m., Surveyor reviewed a police report, obtained by Surveyor. The police report, dated 08/04/2025, stated law enforcement dispatched to the provider's facility at approximately 7:03 p.m. for report of a missing adult. The report stated local emergency medical services (EMS) and county sheriff had dispatched to the area of a 4-lane highway and interstate at 6:31 p.m. for report of Resident 1 wandering and falling down in a median, where the highway had a speed limit of 45 mph. The report stated the area Resident 1 was found by EMS was a minimum of 2500 feet in a straight line from the facility, streets were not straight, and roads were under construction. The report stated it was

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suspected Resident 1 had been missing from the facility for at least 1 hour before law enforcement was contacted. The report indicated Resident 1 had been transported to a local hospital for evaluation.

On 08/19/2025 at 10:10 a.m., Surveyor interviewed House Lead C and asked if the facility had any residents that were elopement risks. House Lead C stated Resident 1 was new to the facility, had a history of asking when s/he would be leaving and had 1 incident of elopement. House Lead C stated Resident 2 had a past history of wandering/elopement attempts as well.

On 08/19/2025 at 10:30 a.m., Surveyor reviewed resident records with Manager A. Records documented the following:

- Resident 1 was admitted to the provider's facility on 07/31/2025 with diagnosis of dementia. Resident 1's pre-admission assessment did not identify him/her as an elopement/wandering risk. Resident 1's individual service plan (ISP), was updated on 08/04/2025 at 12:45 p.m. to state, "[Resident 1] may occasionally wander throughout the house, especially in the evening ... While [s/he] may at times attempt to wander outside, [Resident 1] is very easily redirected back inside with a calm and friendly approach. Any changes in the frequency, pattern, or response to redirection related to wandering should be promptly reported to management. The ISP was then updated on 08/05/2025 and stated Resident 1 had eloped from the patio with new interventions including GPS tracker, door monitoring/signage and staff monitoring of exits.

- Resident 2 was admitted to the provider's facility on 02/27/2025. Resident 2's ISP identified

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him/her as a wander risk and listed redirection as an intervention.

On 08/19/2025 at 10:40 a.m., Surveyor reviewed the provider's investigation related to Resident 1's 08/04/2025 elopement, provided by Manager A. The report indicated Caregiver B had been completing cares in resident rooms and recalled Resident 3's call light going off at 6:00 p.m. or a little after, which Caregiver B addressed and disengaged. Caregiver B stated s/he was then informed by another resident that Resident 1 had walked outside. Caregiver B reported looking around the house and being unable to locate Resident 1. Caregiver B reported contacting management regarding Resident 1 missing and was notified at approximately 7:10 p.m. that Resident 1 had been located.

On 08/19/2025 at 10:55 a.m., Surveyor interviewed Manager A regarding Resident 1's elopement. Manager A stated based on interviews, Resident 1 exited out the provider's patio door, which would alarm. Manager A explained that the exit doors and resident call light alarms use the same system and disengage with the same code. Manager A stated the assumption was that Caregiver B disengaged the alarm system without noting that both Resident 3's call light and the patio door were alarming. Surveyor and Manager A then tested the provider's alarm system, first engaging the exit door and then engaging the call light of a resident room. Surveyor noted it was difficult to differentiate that 2 alarms were sounding rather than 1, but did note that the panel, used to disengage the alarm, noted both the resident room and exit door were engaged.

On 08/19/2025 at approximately 11:15 a.m.,

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N 426	Continued From page 4 Surveyor reviewed concern with Manager A that adequate supervision was not provided on 08/04/2025. Surveyor reviewed that the provider's staff disengaged an alarm without confirming what alarms were engaged and without ensuring all residents were accounted for while 2 identified elopement risks resided at the facility.	N 426		