STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018302	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT RIB MOUNTAIN	149500 COUNTY ROAD NN WAUSAU, WI 54401

(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 01/14/2025, Surveyor conducted a complaint (x2) investigation and self-report investigation at Wellington Place at Rib Mountain. Data collection continued through 01/22/2025. One of 2 complaints was substantiated. One deficiency was identified. Census: 24	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 ensure supervision appropriate to meet the needs of Resident 1 and Resident 2. Findings include: The Department received a self-report on 07/29/2024 reporting a resident eloped on 07/25/2024 and was returned by the police. The Department received a complaint on 12/05/2024 alleging the following concerns: a resident eloped	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		

a few times in September 2024, the same resident was not receiving showers, and the resident's room was not being cleaned.

The provider is licensed to care for 30 residents in the client groups advanced aged, physically disabled, and irreversible dementia/Alzheimer's.

The provider is located in a residential area next to a main highway that connects to the Interstate and local businesses (community ski hill, golf course, restaurants, shopping and church).

Resident 1

On 01/14/2025, Surveyor reviewed Resident 1's file. Resident 1 was admitted on 03/10/2021. Resident 1's individual service plan (ISP), dated 11/26/2024, noted:

- Problem Start Date: 08/29/2023

"Elopement: I am a high risk for elopement. I enjoy time sitting outside and like to take walks daily in the facility parking lot. **On 08/21/2023 I was sitting outside with other residents and I went on a walk and left the facility. Staff were unable to locate me and law enforcement was notified. I was located by law enforcement and brought back to the facility. 04/12/2024: I also have exited the facility on 07/25/2024 & 10/5/2024 and eloped down the road without notifying staff. I have also went [sic] for a walk in the yard on 7/29/2024. I am a high elopement risk due to confusion and not being oriented to place and time: [sic] because of my high elopements staff are to have line of site on me and fill out 15 minute checks on me everyday [sic]."

Resident 1's progress notes (07/01/2024 - 01/14/2025) indicated Resident 1 was outside the

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N 426	Continued From page 2	N 426		

facility/eloped on the following days: 07/08/2024, 07/25/2024 and 10/05/2024. The provider self reported to the Department Resident 1's elopements on 07/25/2024 and 10/05/2024.

On 07/082024, Resident 1's progress note read, in part, "Resident was seen walking up the driveway through the parking lot towards the highway in a different change of clothes again since lunch. Writer yelled out to resident to refocus [him/her] back towards the facility."

According to a self-report, dated 07/25/2024, it was noted that Resident 1 "was wearing a gray T-shirt, blue jeans and blue slide on slippers when last seen. The temperature outside was 76 degrees."

On 10/05/2024, Caregiver B noted in Resident 1's progress notes, "Resident was found down by the golf course wandering around and was transported back to the facility by the Sheriff Department. After returning and following up with Care Coordinator resident is currently on 15 min [sic] checks until further notice."

Resident 2

On 01/14/025, Surveyor reviewed Resident 2's file. Resident 2 was admitted on 08/01/2024. Resident 2 discharged on 10/07/2024. Resident 2's temporary individual service plan (ISP), dated 08/01/2024, noted, "Wandering Risk: Resident will go outside in parking lot and has opened another persons [sic] car door." Under Elopement Risk, the provider noted that Resident 2 was not an elopement risk.

According to Resident 2's progress notes (08/01/2024 - 10/07/2024), Resident 2 was

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outside of the facility/eloped on the following days: 08/26/2024, 09/18/2024, 09/20/2024 and 09/24/2024. The Department does not have record of the provider self-reporting elopements for Resident 2.

On 08/26/2024, Resident 2's progress note read, in part, "Writer noticed res [sic] outside the front of the facility. Writer informed staff that res [sic] was outside. Staff then went outside and was able to redirect the res [sic] back into the building."

On 09/18/2024, Resident 2's progress note read, in part, "Writer was going outside to make a phone call that had been missed and resident was laying on the ground in front of another staff member's vehicle."

On 09/20/2024, Resident 2's progress note indicated that Resident 2 was outside the facility, "walking up the hill" and was returned by a family friend.

On 09/24/2024 (3:12 PM), Resident 2's progress note indicated that Resident 2 was "wandering and exit seeking in and out of the building since before breakfast" (words omitted) "resident continued to exit seek wandering in the parking lot attempting to enter each vehicle [s/he] walked up to."

On 09/24/2024, Caregiver B noted in Resident 2's progress notes, ..."As writer was gathering everyone for lunch resident wandered off and ended up off the premises going down the road and had to be driven back to the facility by another staff member on the floor at that time. Resident is currently in front common area by the television while staff is keeping a closer eye on

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N 426	Continued From page 4 [him/her] at this point." On 01/15/2025 at approximately 4:19 PM, Surveyor interviewed Caregiver B via telephone. Surveyor asked Caregiver B about Resident 1's elopements. Caregiver B stated, "I was here each time [Resident 1] eloped. [S/He] walks outside when [s/he] gets frustrated." Caregiver B reported that each time Resident 1 eloped, "We did not know until we either got a call from the police or [s/he] was returned to the facility (by the police)." On 01/15/2025, Surveyor interviewed Caregiver B about Resident 2's elopements. Caregiver B reported, "[S/He] eloped several times; [S/He] was adamant - [s/he] was going to leave." Caregiver B stated that Resident 2 got outside the facility at least 2 to 4 times without staff knowing. On 01/22/2025 at approximately 4:28 PM, Surveyor interviewed Director of Operations (DOO) A via telephone. DOO A verified Resident 1's elopements as noted in progress notes. DOO A confirmed that Resident 1 did not receive the supervision necessary on 07/08/2024, 07/25/2024, 07/27/2024, 07/29/2024, 09/16/2024 and 10/05/2024. On 01/22/2025, Surveyor interviewed DOO A about Resident 2's elopements. DOO A verified Resident 2's elopements as noted in progress notes. DOO A stated that there were at least 8 staff working when Resident 2 eloped on 09/24/2024. DOO A reported that DOO A would ensure adequate supervision moving forward.	N 426		