STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012025	A. BUILDING: _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE OF FORT ATKINSON	200 S WATER ST WEST FORT ATKINSON, WI 53538

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N 000	Initial Comments On 05/16/2024, with information gathered through 06/04/2024, Surveyor conducted two complaint investigations at Wellington Place of Fort Atkinson. Two deficiencies were identified. Complaints were substantiated. Census: 18	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were safeguarded from environmental hazards. Resident 1 and Resident 2 eloped from the facility without staff being alerted due to the facility's door failing to alarm. Findings include: On 03/31/2024, the Department received a concern alleging residents were able to exit the facility without staff acknowledgement. On 05/16/2024, Surveyor reviewed the police report which was submitted with the complaint	N 358		

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

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N 358	Continued From page 1	N 358		

that documented:
"03/31/2024 18:44:45 (6:44 PM) - Elderly [fe/male] (Resident 1) not wearing a coat was wandering outside. [Community Member] has [him/her] in [his/her] vehicle at location. Subject carrying an Easter basket and an older photo of a [girl/boy]. [Community Member] saw [him/her] pass the PD (police department, then turned around and followed [him/her] and subject was going into various yards. ... will attempt contact at nursing home ... staff confirmed ... turned over to [Resident Assistant B]."

On 05/16/2024, Surveyor reviewed the department's facility file which contained written reports, dated 04/01/2024, that documented Resident 1 and Resident 2 had eloped from the facility.

On 05/16/2024 at 4:52 PM, Surveyor requested the internal investigation into the elopements from Administrator A. Administrator A provided the following statement:
"On 03/31/2024 at 7:12 PM, Writer (Administrator A) was notified by [Resident Assistant B] that [Resident 1] had eloped. ... The same day at 7:22 PM, [Resident Assistant B] reported to writer that [Resident 2] had eloped as well. ... It had been reported on 03/31/2024 that the door alarm on the left wing was only partially working. Writer tested the door alarm and verified that it was only sounding every couple of times the door was opened. ..."

On 05/20/2024 at 10:47 AM, Surveyor emailed Administrator A and asked how staff determined that Resident 1 and Resident 2 had exited through the left wing door and are staff required to monitor doors for operation. Administrator A stated, "The alarms on the right wing, back door,

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N 358	Continued From page 2 and front door were all working when tested that evening after the residents came back. Both resident's rooms are also on the left wing. Had they gone out the front door, they would have passed the medication room. [Resident Assistant B] that was reportedly charting in the med room should have been able to see them walk past the door for the med room as well as out the window going up the driveway. The front and back doors are used daily so we hear those alarms. The alarms on the doors at the end of the hallway have been replaced and are checked at least weekly on Tuesdays." The temperature on 03/31/2024 at 6:53 PM was 46 degrees Fahrenheit. (Source: National Weather Service website, https://www.wunderground.com/history (retrieval date - 04/20/2024).)	N 358		
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 interview and record review, the provider did not ensure supervision appropriate	N 426		

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N 426	Continued From page 3 for 2 of 2 residents. Resident 1 and Resident 2 eloped from the facility and staff were not aware they had eloped until law enforcement contact. Findings include: On 03/31/2024, the Department received a concern alleging residents were able to exit the facility without staff acknowledgement. On 05/16/2024, Surveyor reviewed the police report which was submitted with the complaint that documented: "03/31/2024 18:44:45 (6:44 PM) - Elderly [fe/male] (Resident 1) not wearing a coat was wandering outside. [Community Member] has [him/her] in [his/her] vehicle at location. Subject carrying an Easter basket and an older photo of a [girl/boy]. [Community Member] saw [him/her] pass the PD (police department, then turned around and followed [him/her] and subject was going into various yards. ... will attempt contact at nursing home ... staff confirmed ... 18:59 (6:59 PM) turned over to [Resident Assistant (RA) B]." On 05/16/2024, Surveyor reviewed the department's facility file which contained written reports, dated 04/01/2024, that documented Resident 1 and Resident 2 had eloped from the facility on 03/31/2024. On 05/16/2024, at approximately 3:00 PM, Surveyor interviewed Caregiver D. Caregiver D stated, "The residents eloped when staff were busy attending to other residents. The door alarms are difficult to hear if you are not in the common area, but the door alarms have been replaced and we can easily hear them."	N 426		

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N 426	Continued From page 4 On 05/16/2024 at 4:52 PM, Surveyor requested the internal investigation into the elopements from Administrator A. Administrator A provided the following statement: "On 03/31/2024 at 7:12 PM, Writer (Administrator A) was notified by [RA B] that [Resident 1] had eloped. Per [RA B], resident was observed by a community member walking outside, was taken to the local police station, and returned to the facility by law enforcement. [RA B] reported the staff they were working with, [RA C], was giving another resident a shower and [RA B] had just put the resident to bed approximately 15 minutes ago. ... The same day at 7:22 PM, [RA B] reported to writer that [Resident 2] had eloped as well. It was reported that resident was observed by local law enforcement walking outside. Law enforcement called the facility to verify if a resident was missing, and once verified, they returned resident to the facility. ... Writer talked with [RA C] regarding the event. [RA C] verified that at the time of the event they were giving [Resident 3] a shower and stated the last time they had seen [RA B] had been in the medication room doing shift documentation. [RA C] stated that several residents had been in the dining room and could verify that [RA B] had been in the medication room. Writer spoke with [Resident 4] and [Resident 5] who stated that [RA B] had been observed in the medication room the majority of that shift. It had been reported on 03/31/2024 that the door alarm on the left wing was only partially working. Writer tested the door alarm and verified that it was only sounding every couple of times the door was opened." On 05/20/2024, Surveyor reviewed Resident 1's and Resident 2's record.	N 426		

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N 426	Continued From page 5 Resident 1 moved into the facility, 04/03/2023. Resident 1's "Progress Notes" documented: "03/31/2024 - Resident was good all day until family came to visit for East right before supper time. Residents' family was here for about an hour and the residents [daughter/son] brought a [wo/man] with and resident kept saying "I'm scared of [him/her]" "I don't like [him/her]." When they were leaving the writer (PA B) had to hold on to resident so they wouldn't try to go with their family. Once the family left writer put resident in bed and put on the resident's favorite movie. 10 or 15 minutes later writer is trying to do some work and a cop shows up in the parking lot. Writer went out of the med room and asked the police asked [sic] if I knew "residents name" and I said yes I do the resident is in bed and they had informed me that the resident is currently at the police station and needed someone to pick them up. Writer was shocked so writer went to the resident's room to see if resident was in the room and they were not. ..." Resident 1's individual service plan, dated 05/05/2023, documented: "Wandering/Exit Seeking Behaviors: Resident has wandering and exit seeking behaviors. Interventions - activities, redirection, reality orientation, 1 on 1, offer snack/fluids, encourage rest, toileting." "Communication Skills/Interaction With Others: Resident has a hard time communicating [his/her] needs to staff. [S/he] has a lot of confusion and has forgotten how to do simple tasks. Resident will communicate feelings of fear and express feeling of safety. Allow resident to have control over situations, if possible. Assess if mood endangers the resident and/or others. Encourage to verbalize feelings, concerns, fears, etc. Clarify	N 426		

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misconceptions. Provide 1:1 sessions with resident. Support appropriate moods/behavior."

Resident 2 moved into the facility, 08/22/2023, with diagnoses including dementia, psychotic disturbance, mood disturbance, and anxiety.

Resident 2's "Progress Notes" documented:
"After dinner around 6:50 PM, Writer (PA C) was in the med room with another resident who also wandered away from the facility, when the writer revived [sic: received] a call from a police officer that a citizen found the resident wandering around the neighborhood confused and was in the same areas as the other resident where the officers found them. The police officer asked if we were missing any other residents. Writer was confused as this all happed [sic: happened] during the writer giving another resident a shower and told officers they would do a quick sweep through. The writer quickly did a sweep through the building come and find out the resident was missing. The officers brought the resident back to the facility. ...."

Resident 2's individual service plan, dated 03/07/2024, documented:
"Wandering/Exit Seeking Behavior: Resident has wandering and exit seeking behaviors. Resident often is confused thinking that [s/he] has somewhere to go and will attempt to leave the facility. Intervention - Resident will go on walks outside, weather permitting, accompanied by staff. Every other day and PRN (as needed) if resident is showing signs of restlessness. Activities, redirection, reality orientation, 1 on 1, offer snack/fluids, encourage rest, toileting."

On 05/20/2024 at 10:47 AM, Surveyor emailed Administrator A and asked if, during the internal

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investigation, staff were able to determine how long the residents were missing from the facility. Administrator A stated, "It is assumed the residents were only outside the facility for no more than 15 minutes based on staff reports of putting residents to bed 10-15 minutes prior to law enforcement bringing the residents to the facility." Surveyor asked when staff did a head count of all residents on 03/31/2024. Administrator A stated after Resident 2 was returned to the facility.

Surveyor determined that it was a 9-minute walk from the facility to the police department per MapQuest. Based on the police report, Resident 1 was there for at least 14 minutes.

On 06/03/2024, the Department received a police report that Resident 1 had eloped from the building which documented:
"06/02/2024 19:55 (7:55 PM) - brought in an elderly [fe/male] who appeared very confused and was found wandering around their yard across the street from the PD (police department). They walked the [fe/male] over to the PD. The [fe/male] stated [his/her] name was [Resident 1]. [S/he] was wearing one shoe, had on a black jacket, pink pants and was carrying a bedsheet, wash cloth and a stuffed animal. Dispatch attempted a call to [provider] with no answer received. ... 20:12 (8:12 PM) [Resident 1] was turned over to staff at [provider's]."

On 06/05/2024 at 2:06 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was conducting an internal investigation. Administrator A stated, "It is believed that [s/he] went out the front door. It was documented that [s/he] received [his/her] medications at 7:24 PM and I received a call at 8:07 PM stating that [s/he]

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N 426	Continued From page 8 had been returned to the facility. We are currently working on a behavior service plan for [his/her] elopements."	N 426		