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 _____	R-C 07/14/2026

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 07/08/2026, Surveyor conducted a standard licensure survey, 3 complaint investigations, and a verification visit at Wellington Place At Rib Mountain. Data was collected through 07/14/2026. Three of 3 complaints were substantiated. Twelve deficiencies were identified. One of the 12 deficiencies was a repeat deficiency. See Statement of Deficiency (SOD) WUGI12, dated 11/11/2024 and SOD WUGI13, dated 06/18/2025. Census: 24 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{N 000}		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate an injury of an unknown source for 1 of 1 resident reviewed who had an injury of an unknown source. Resident 1 had skin tears to his/her arms with unknown origin that was not investigated.	N 161		

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

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N 161	Continued From page 1 Findings include: On 07/08/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/23/2026. S/he had multiple diagnoses including: restlessness and agitation, dementia with other behavioral disturbances, anxiety, and wandering. Resident 1 was protectively placed and under guardianship. A staff note, dated 07/07/2026, read, in part: "When resident agreed to go in [his/her] room to change into [his/her] [pajamas] writer was informed by [staff] of residents x 2 opened skin tears on [his/her] left outer forearm with no known knowledge of how and when the incident happened but [staff] noticed the injury the previous Fri (Friday) on 07/03/26 when last on the floor. Resident allowed both writer and [staff] to assist with dressing along with applying proper ointment to [his/her] (x2) quarter size opened areas that resident immediately removed after making it to [his/her] room ..." On 07/13/2026, Surveyor emailed Administrator A and asked if s/he had any investigations into injuries of unknown source for Resident 1. On 07/13/2026, Administrator A responded, via email: "I did not do an investigation of any injuries of unknown origin the skin tear on 7/3 was treated and did not appear suspicious in nature and is in process of healing." On 07/13/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A and Chief Operating Officer (COO) B on the phone.	N 161		

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N 161	Continued From page 2 Surveyor asked about Resident 1's injuries. Administrator A told Surveyor Resident 1 had very thin skin and s/he did not think the wound appeared suspicious. Administrator A confirmed that s/he did not investigate where Resident 1 may have got the skin tears from.	N 161		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department each time Resident 1's whereabouts were unknown. Findings include: On 06/16/2026 and 06/24/2026, the Department received complaints related to residents eloping from the facility. On 07/07/2026, Surveyor completed an offsite prep for the survey and reviewed the provider's electronic file including their self-reports that have	N 163		

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N 163	Continued From page 3	N 163		

been submitted to the Department. The provider did submit a self-report that indicated Resident 1 eloped from the facility on 04/27/2026. The report read, in part: "At approximately 1pm after lunch resident was exit seeking going in and out the front door of the facility ... Resident is new to the facility and is in an adjustment period. Staff on shift was able to redirect resident back in to [sic] the facility, resident stated to staff [s/he] was going to [his/her] room to rest. resident [sic] went to [his/her] room. Staff received a call on facility phone approximately 15 min (minutes) later from a sheriff stating [s/he] believes [s/he] has one of our residents outside the facility trying to cross the street. Staff immediately went to residents [sic] room to check on [him/her], upon opening residents [sic] door staff noticed resident was not in [his/her] room and [his/her] window was up and screen of the window pushed out ... placed resident on 15 min checks."

On 07/08/2026 and 07/09/2026, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 04/23/2026. S/he had multiple diagnoses including: restlessness and agitation, dementia with other behavioral disturbances, anxiety, and wandering. Resident 1 was protectively placed and under guardianship.

On 05/03/2026, staff documented, in part: "At the start of shift at 2:00pm resident was asking to go outside but staff had to redirect [him/her] back in to [sic] building because the resident decided to walk off and try to leave ... After all that staff redirected [him/her] to [his/her] room when in the room [s/he] started flipping furniture and trying to leave out the window and banging on the window with [his/her] purse. Resident asked staff to leave

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N 163	Continued From page 4	N 163		

finally [s/he] sat down and started calming down. Staff [sic] later exited the room. Less than 5 minutes later, staff returned to check on [him/her] and observed [s/he] was no longer in [his/her] room. The window was found open. I immediately went outside and located the resident near the trash can ..."

On 06/13/2026, staff documented, in part: "resident became agitated after lunch. Resident [sic] stated [s/he] was looking for [his/her] vehicle and that someone took [his/her] keys ... resident went to [his/her] room as if [s/he] was calmed down. resident [sic] went out of [his/her] bedroom window and into the back yard wooded area. writer [sic] and another staff went in to get resident out. after [sic] several attempts resident agreed to come back int the facility ..."

On 07/13/2026, Surveyor reviewed the Department's electronic file for the provider. Surveyor did not locate self-reports for Resident 1's elopement out of his/her window on 05/03/2026 and 06/13/2026.

On 07/13/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A and Chief Operating Officer (COO) B on the phone. Surveyor asked about Resident 1's elopements and if they were reported to the Department. COO B told Surveyor s/he interviewed staff, and they told him/her that staff were always with Resident 1 when s/he would leave the facility. Surveyor explained concerns that when Resident 1 left out his/her window on 05/03/2026 and 06/13/2026, staff did not accompany Resident 1 out the window and therefore Resident 1's whereabouts were unknown at that time.

The provider did not report to the Department

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N 163	Continued From page 5 when Resident 1 eloped out his/her window on 05/03/2026 and 06/13/2026.	N 163		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the Department within 3 working days after Resident 1 fell, which resulted in a fractured wrist. Findings include: On 07/08/2026 and 07/09/2026, Surveyor reviewed Resident 1's record. An event report indicated Resident 1 had an unwitnessed fall on 06/19/2026. The report read, in part: "Writer entered resident's room to check on [him/her] and found the resident sitting on the floor by end of [his/her] bed. Resident stated that [s/he] had slipped and fallen because [his/her] foot came out of [his/her] slipper. Resident denied hitting [his/her] head during the fall. Resident complained of pain in [his/her] right wrist. Upon assessment, writer observed significant swelling to the residents [sic] right wrist. Range of motion (ROM) was completed, and no pain was noted in any area other than the right wrist. Vital signs were obtained and were all within normal limits.	N 165		

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N 165	Continued From page 6 Management was notified of the incident. Residents POA (power of attorney) was informed. Due to the swelling and pain in right wrist, the resident was transported via ambulance for further evaluation and treatment." The report indicated the fall resulted in a fractured right wrist. On 07/09/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A. Surveyor explained that a fall with a fracture was required to be reported to the Department and Surveyor did not locate a report for Resident 1's fall with fracture in the Department's electronic file for the provider. On 07/13/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A and Chief Operating Officer (COO) B on the phone. COO B told Surveyor they would be submitting a late report to the Department for Resident 1's fall with fracture as part of their plan of correction.	N 165		
{N 200}	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not notify the Department within 7 days after there was a change in administrator. This requirement is being cited for the third time. See Statement of Deficiency (SOD) WUGI12, dated 11/11/2024 and SOD WUGI13, dated 06/18/2025. Findings include:	{N 200}		

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{N 200}	Continued From page 7 On 07/07/2026, the Department received a complaint which included allegations the administrator did not have the knowledge to ensure the facility operated to ensure the safety and well-being of the residents. On 07/07/2026, Surveyor reviewed the provider's information with the Department, which indicated Administrator E was the administrator. On 07/08/2026 at 10:15 a.m., Surveyor met Staff Coordinator (SC) F. SC F told Surveyor Administrator A was the current administrator. SC F told Surveyor Administrator A would not be able to come to the facility today and Care Coordinator (CC) G would be in to assist with the survey. On 07/08/2026 at 10:50 a.m., Surveyor interviewed CC G. CC G told Surveyor Administrator E went to be the administrator at one of their other community-based residential facilities and Administrator A was hired as the administrator. On 07/08/2026 at 12:00 p.m., Administrator E came to the facility to assist with the survey. Surveyor interviewed Administrator E. Administrator E told Surveyor s/he was hired at their other facility in October 2025 to be the administrator there and that was the time Administrator A was hired as the administrator for this facility. Surveyor explained concerns that the Department did not receive notification of this change. At 3:30 p.m., Administrator E told Surveyor Chief Operating Officer (COO) B was looking for the email notification s/he sent to the Department regarding the administrator change. On 07/13/2026, COO B emailed Surveyor.	{N 200}		

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{N 200}	Continued From page 8 His/her email read, in part: "I have the form I filled out for [Administrator A] but not the email - It is possible I filled out the form and did not email - just being transparent about it - but I did find the form I filled out." The email included an attached form titled: "Assisted Living Administrator Notification" The form indicated Administrator A would be the administrator. Under qualifications, it read: "[Administrator A] is actively pursing [his/her] mandatory courses for [sic] to prepare for the administrator course. [S/he] has worked in the filed [sic] of CBRF at the current facility for 1 year as the care coordinator which functions as the assistant to the current administrator. [S/he] has worked with the current administrator and regional operations director with routine visits and oversight to get acclimated to the role as administrator - [S/he] is transitioning to the administrator role with a preceptor in place to provide oversight. [His/her] previous experience includes working at other CBRF in the area and has been a certified CBRF caregiver with courses complete since 2010." This form was signed 02/05/2026. On 07/13/2026, Surveyor reviewed the online Community-Based Care and Treatment training registry for Administrator A. Administrator A completed the prerequisite course, Assisted Living Survey Process, but was not on the registry as completing the administrator's course. On 07/13/2026, Surveyor emailed Administrator E and asked how much oversight s/he had with this facility, Wellington Place at Rib Mountain. On 07/13/2026, Administrator E replied, via email, which read: "I don't have any oversight at Rib Mountain since I have transitioned to my role here at [other CBRF]. Sometimes I am a resource to [sic] if [Administrator A] has questions."	{N 200}		

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{N 200}	Continued From page 9 On 07/13/2026, Surveyor and COO B emailed the following correspondences: Surveyor asked if Administrator A completed the administrator's course. COO B: "[S/he] has not - We continue to offer preceptorship time with myself and another licensed administrator [Administrator E]." Surveyor replied, via email, and explained that Administrator A could not be listed as the administrator as s/he was not qualified. COO B: "Ok - Let me talk to [Administrator E] to see if [s/he] is able to continue otherwise I am a licensed NHA (nursing home administrator) and I will ensure we have someone on the licensure." On 07/13/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A and COO B on the phone. COO B told Surveyor that Administrator E's name was "still on the wall" as the administrator at the facility. COO B said s/he would be placing his/her name "on the wall" as the administrator while Administrator A is in the process of completing the course. Surveyor asked about oversight of the facility since Administrator E left. COO B said s/he has weekly and at times bi-weekly check-ins with Administrator A.	{N 200}		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following:	N 310		

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N 310	Continued From page 10 (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's legal guardian signed and dated his/her admission agreement. Findings include: On 06/24/2026, the Department received a complaint that alleged the provider was not	N 310		

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N 310	Continued From page 11	N 310		

updating the legal guardian when a resident was eloping from the facility.

On 07/08/2026 and 07/29/2026, Surveyor reviewed Resident 1's record.

Resident 1's face sheet indicated s/he was admitted to the facility on 04/23/2026. The face sheet indicated Family Member (FM) H was Resident 1's legal representative. FM H signed Resident 1's admission agreement on 04/20/2026.

Resident 1 had multiple diagnoses including: restlessness and agitation, dementia with other behavioral disturbances, anxiety, and wandering.

Surveyor did not locate Resident 1's legal documentation in his/her electronic file or paper chart.

On 07/09/2026 at approximately 1:40 p.m., Surveyor requested additional documentation from Administrator A that Surveyor could not locate, including Resident 1's legal documents. At approximately 3:00 p.m., Surveyor was provided with a stack of papers including Resident 1's legal documents.

On 03/23/2026, Resident 1 was detained and emergently protectively placed at a hospital.

On 04/21/2026, Resident 1 was adjudicated incompetent, and the court appointed a legal guardian, Guardian I, as Resident 1's legal representative. The court protectively placed Resident 1 at Wellington Place at Rib Mountain.

On 07/13/2026 at approximately 1:00 p.m., Surveyor interviewed Guardian I on the phone.

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N 310	Continued From page 12 Surveyor asked if the provider was updating him/her on Resident 1's incidents. Guardian I said s/he did get notifications, sometimes late as s/he explained there was some confusion into the guardianship. Guardian I explained Resident 1's children were still very involved in Resident 1's care. S/he said the provider would update Resident 1's family, and Resident 1's family would communicate this to Guardian I. Guardian I told Surveyor, Resident 1 was "too much for them to handle." S/he said s/he was working with the county to change Resident 1's protective placement to a locked unit and Resident 1 would be discharging from the facility soon. On 07/13/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A and Chief Operating Officer (COO) B on the phone. Surveyor explained concerns that Resident 1's record had conflicting information on who Resident 1's legal guardian was and that Resident 1's admission agreement was not signed by Resident 1's legal representative, Guardian I.	N 310		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the	N 387		

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development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the resident and/or the resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) and signed the plan acknowledging their involvement in, understanding of, and agreement with the plan for 2 of 3 resident records reviewed, that resided at the facility for longer than 30 days (Resident 1 and Resident 3).

Findings include:

On 07/08/2026 and 07/09/2026, Surveyor reviewed resident records, including the records for Resident 1 and Resident 3.

Resident 1 was admitted to the facility on 04/23/2026. S/he was protectively placed and had a legal guardian.

Resident 1's ISP, last reviewed/revised on 07/08/2026, did not contain any signatures.

Resident 3 was admitted to the facility on 03/26/2025. S/he had a legal guardian.

Resident 3's ISP, last reviewed/revised on 09/30/2025, did not contain any signatures.

On 07/13/2026 at approximately 3:00 p.m.,

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N 387	Continued From page 14 Surveyor interviewed Administrator A and Chief Operating Officer (COO) B on the phone. Surveyor asked what their process was for developing ISPs. Administrator A said s/he held a care conference with residents' legal representatives and their placing agency. Surveyor asked if they signed the ISP to acknowledge their participation and agreement with the plan. Administrator A said they did. Surveyor requested the signed form for Resident 1's ISP and Resident 3's ISP. On 07/13/2026, Administrator A emailed Surveyor with additional documentation. The email contained a signature page for Resident 3's ISP, which was only signed by the administrator. Surveyor did not receive a signature page for Resident 1's ISP.	N 387		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by:	N 389		

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N 389	Continued From page 15 Based on observation, record review, and interview, the provider did not ensure the individual service plan (ISP) was reviewed and revised for 2 of 3 residents reviewed, that resided at the facility longer than 30 days, (Resident 1 and Resident 5) when they had a change in their condition. Findings include: On 06/16/2026, the Department received a complaint related to residents eloping from the facility and falls. On 06/24/2026, the Department received an additional complaint related to elopements. On 07/08/2026 and 07/09/2026, Surveyor reviewed resident records, including Resident 1's and Resident 5's records. ELOPEMENT RISK Resident 1's hospital admission H & P (history and physical), dated 03/21/2026, read, in part: "[age] [fe/male] was brought in to [hospital name] via police escort due to dementia with aggression and wandering behaviors. Patient resides at home and has caregivers at [sic] help assist [him/her]. [S/he] has a new caregiver and today the patient has snuck out of [his/her] condo several times. Police were called to assist in looking for [him/her]. Once patient had returned to [his/her] condo [s/he] became aggressive with police officers. Ultimately patient was brought to the ER (emergency room) for evaluation of any acute illness or injury and will need placement due to [his/her] wandering behaviors ..." Resident 1 was admitted to the facility on 04/23/2026, s/he had multiple diagnoses including: restlessness and agitation, dementia	N 389		

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with other behavioral disturbance, anxiety, and wandering.

An elopement risk assessment, dated 04/23/2026, with a completed date of 05/06/2026, read, in part: "resident is high elopement risk states [s/he] wants to go home and exit seeks frequently." The intervention checked was "Frequent monitoring."

Resident 1's ISP, last reviewed/revised on 07/08/2026, included the following:
"Problem Start Date: 04/23/2026 Wandering
Current Status I am adjusting to a new facility and I like to wander in and out of the facility trying to find my way back home
Short Term Goal Target Date: 05/25/2027
Resident wants to remain comfortable and familiar with current surroundings and not wander x 365 days
Approach Start Date: 04/23/2026 Staff will assist in redirecting and offering one on one time as well as taking resident on walks
Approach Start Date: 04/23/2026 Staff will monitor daily for changes in this behavior and will document."

Resident 1's progress notes indicated the following:
04/23/2026 - " ...resident is a high elopement risk due to trying to leave the hospital [his/her] stay there before coming to the facility ..."

04/23/2026 - "Resident has to have multiple redirecting [sic] from staff on shift due to resident constantly trying to pack [his/her] things and exit the building ..."

04/24/2026 - "resident was up right away at shift change exit seeking and trying to leave out the

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N 389	Continued From page 17 building ..." 04/24/2026 - "Resident was very anxious upon arrival. After multiple redirection resident became very aggressive to the point writer tried calling [daughter/son]. After talking to the [daughter/son] resident continued to go out the front door. When writer went after resident and asked resident to come back inside, resident turned around looked at writer and starting [sic] walking fastly [sic] towards the street through the field towards the right. Resident was waving down cars screaming we are keeping [him/her] hostage and [s/he] did not live here ..." 04/26/2026 - "Upon writer's arrival around 1800 pm (6:00 p.m.) yesterday evening shift after supper resident begin [sic] to exit seek out of the front of the building ..." 04/26/2026 - "I observed the resident through a window walking west into the wooded area. I immediately attended to [him/her] to redirect [him/her] back into the facility safely ... Staff will continue to do hourly checks on resident." 04/27/2026 - " ... shortly after lunch residents [sic] became a 1 on 1 due to constant exit seeking. writer [sic] kept an eye on resident at all times. resident [sic] kept trying to get out of the facility ... resident received all medications and a PRN (as needed medication) for anxiety in which it was non effective. resident [sic] stated [s/he] was going to [his/her] room to rest. within [sic] 15 minutes later a sheriff called the house phone stating that [s/he] has one of our residents trying to cross the street right outside the parking lot. writer [sic] went to check resident room to find [his/her] window up and screen completely out. writer [sic] met sheriff in the parking lot and	N 389		

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walked resident back into the facility. resident [sic] continued to exit seek staff continued to monitor residents [sic] whereabouts at all times. writer [sic] was placed on every 15 minutes checks ..."

04/29/2026 - Resident since have been [sic] at facility has been exit seeking and being verbally combative toward staff. Resident has damaged 2 windows which have been replaced and broken one tv. Resident has eloped from the facility through [his/her] window and has threaten [sic] to do it again. Staff also found resident was placing [his/her] anxiety medication in [his/her] pocket or putting medications in [his/her] drawer in [his/her] room. Resident was placed on 15 minute checks resident also had a wander guard placed on [his/her] ankle (which [s/he] cut off with scissors) but writer replaced with a new wanderguard [sic]. Writer placed safety locks on windows they are able to open but not as far to be [sic] able to exit. Facility has done one on one noticing the resident likes puzzles and reading as [s/he] use [sic] to be a teacher. Staff also have been ensuring resident is swallowing all of [his/her] medications as well as redirecting resident when resident feels anxious."

04/29/2026 - "Resident got out front door around 8:45 and headed toward main roads followed by writer. Resident was waving down traffic and was insisted [sic] going to neighbors to call the police ..."

04/30/2026 - "Resident attempted to leave the facility foot [sic] at 4:15 PM. Staff immediately approached [him/her] and re directed [sic] [him/her] inside ..."

04/30/2026 - At approximately 5:25 pm resident

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N 389	Continued From page 19 became very upset because [s/he] wanted to leave the facility. Resident refused [his/her] supper and was wandering restlessly around the main dining area amongst all other residents who were eating in the dining area. Resident began throwing [his/her] purse against the facility window inside and was breaking the glass until it was completely shattered ..." 04/30/2026 - "Resident had walked out the front door of the facility at approximately 6:40 PM. Writer had walked right behind [him/her] to approach [him/her] and work on redirecting [him/her] back inside ..." 05/03/2026 - "At the start of the shift at 2:00pm resident was asking to go outside but staff had to redirect [him/her] back in to the building because the resident decided to walk off and try to leave. When back in the building the resident started throwing objects and resident stated '[explicative] get out my face' 'Let me leave, I'm not supposed to be here.' After all that staff redirected [him/her] in [his/her] room when in the room [s/he] started flipping furniture and trying to leave out the window and banging on the window with [his/her] purse. Resident asked staff to leave and finally [s/he] sat down and started calming down. staff later exited the room. Less than 5 minutes later, staff returned to check on [him/her] and observed [s/he] was no longer in [his/her] room. The window was found open. I immediately went outside and located the resident near the trash can ..." 05/06/2026 - "RN (registered nurse) Admission Assessment completed/Resident is an elopement risk. 15 minute checks and wander guard are in place ..."	N 389		

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N 389	Continued From page 20 06/13/2026 - " ... resident went to [his/her] room as if [s/he] was calmed down. resident went out of [his/her] bedroom window and into the back yard wooded area. writer and another staff went in to get resident out. after several attempts resident agreed to come back into the facility to sit in the commons area to read [his/her] book ..." 06/14/2026 - "writer noticed resident was walking toward the main road towards the golf course during med (medication) pass. Writer walked with resident trying several times to redirect resident. Resident got all the way down to the restaurant which resident used restaurant phone to call for a ride which resident never got a hold of anyone. Resident finally agreed to get a ride back to the facility ..." 06/15/2026 - During supper writer noticed resident going towards the main road. Writer followed resident and tried to redirect resident several times which was unsuccessful. Resident walked to the restaurant ... Writer stayed with resident until [daughter/son] picked resident up and gave [him/her] a ride back to the facility ..." 06/16/2026 - "After lunch time was over everything seems to be normal [sic] till resident stated [s/he] wanted to go home and started walking out the main entrance doors. Resident started walking saying I'm going home leave me alone stop following me I mean it [sic] try to bring [him/her] back but started going off on me and [s/he] kept walking tours [sic] the golf course was in the middle of the parking lot resident started walking to [restaurant] went inside they try [sic] to calm [him/her] down and from there they kept [him/her] till [his/her] [daughter/son] went to pick [him/her] up [sic] I walk back to the building."	N 389		

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N 389	Continued From page 21 06/17/2026 - "RN was at facility on Monday 6/15/26 for a home health visit upon leaving and driving down the road that the facility is on, saw caregiver walking behind resident. Resident was talking to someone who had pulled over in their car to help resident. RN pulled over and tried to redirect resident to take them back to the facility. Resident stated 'If you take me back to that place I will sue you!' RN was able to redirect resident into parking lot of [restaurant] ..." 06/18/2026 - "During med (medication) pass writer noticed resident heading towards the door and started walking towards the main road writer quickly followered [sic] resident. Writer and resident walked to the restaurant where resident agreed to get a ride back to the facility ..." 06/24/2026 - " ... After resident was awaken [sic] and administered [his/her] HS (hour of sleep) medications around 7 pm resident had made [his/her] way out the building into the parking lot heading up to the entrance. Writer was informed by another family member coming in to visit that resident was attempting to leave the premises. Writer attempted to refocus resident back to the facility and was unsuccessful with all attempts. Writer then called down to Wellington for the second staff on shift to come and switch off due to resident becoming verbally aggressive and calling writer 'dumb [explicative]' and that writer needed to 'leave [her/him] the [explicative] alone' and swung on writer with [his/her] fractured (R) wrist while storming off walking up the street towards the [restaurant] refusing to turn around. After over an hour resident allowed a family visitor from the facility to give [him/her] a ride back ..." Resident 1's ISP was not updated with 15 minute checks and wander guard. His/her ISP was not	N 389		

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reviewed and revised after interventions were not effective in preventing Resident 1 from eloping from the facility.

On 07/09/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A. Surveyor explained concerns that Resident 1's ISP was not reviewed and revised to include the 15 minute checks and wander guard. Surveyor also explained concerns that the ISP indicated Resident 1 was a wanderer but did not identify Resident 1 as an elopement risk. Administrator A told Surveyor Resident 1 would be discharging and moving to a locked facility. Administrator A told Surveyor s/he updated Resident 1's medication administration record (MAR) to include the 15 minute checks.

FALL RISK
Resident 1's fall risk assessment, dated 04/23/2026 and completed on 05/06/2026 indicated Resident 1 was not a fall risk.

Resident 1's ISP, reviewed/revised on 07/08/2026, read, in part: "Problem Start Date: 04/23/2026 Falls Current Status ... Long Term Goal Target Date: 10/23/2026 Resident wants to be safe and free from injuries x 365days [sic] ... Approach Start Date: 04/23/2026 Prevention Plan ..."

Resident 1's ISP did not identify his/her current status related to falls and did not have approaches to prevent falls.

An event report, dated 06/19/2026, indicated Resident 1 had an unwitnessed fall in his/her room. Resident 1 had pain and swelling to his/her right wrist. Resident 1 was transported to the emergency department via ambulance. Resident

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N 389	Continued From page 23 1 sustained a right wrist fracture. On 07/09/2026 at approximately 10:35 a.m., Surveyor observed Resident 1 seated in a wheelchair at the table. S/he had a cast on his/her right wrist and hand. On 07/09/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A. Surveyor asked Administrator A why Resident 1 was seated in a wheelchair. Administrator A told Surveyor Resident 1 fell the night prior and was sent to the hospital. Administrator A said it was an unwitnessed fall, there were no injuries, but that is why Resident 1 was using a wheelchair on 07/09/2026. Surveyor explained concerns that Resident 1's ISP was not reviewed and revised after s/he fell and sustained a fractured wrist and now Resident 1 had another fall. Administrator A confirmed understanding and told Surveyor Resident 1 was going to be discharged from the facility soon. Resident 5 was admitted to the facility on 11/06/2024. S/he had multiple diagnoses including: encephalopathy (brain dysfunction) and diabetes with polyneuropathy (damaged nerves causing numbness, tingling and pain, typically in the hands and feet). Resident 5's ISP, last reviewed/revised on 03/21/2026, read, in part: "Problem Start Date: 02/11/2025 Fall risk - I am a high fall risk due to the medications that I receive, my diagnoses that accompany them, my current fall history and my lack of awareness for safety. I do utilize a 2 wheeled walker or can [sic] however I do tend to forget it. I have now 2 un-witnessed falls on 7/4/2025 and 7/72025 ... Long Term Goal Target Date: 07/07/2027 Minimize the risk for falls and	N 389		

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N 389	Continued From page 24 stay safe at all times ... Approach Start Date: 08/01/2025 Staff will ensure I use my walker or cane. Approach Start Date: 02/11/2025 I do not need any assistance from staff for transfers however I do need reminders to take my cane leaving from the table after meals Staff will watch for and document any changes in my conditions and any falls I may have so my care team can be updated appropriately ..." An event report, dated 05/28/2026, indicated Resident 5 fell outside. The report read, in part: "Resident was out in the garden and [s/he] states [s/he] lost [his/her] balance and hit the ground landing on [his/her] back R.o.m. (range of motion) done no pain or bruising." Under the section to mark interventions put into place, "No interventions needed" was checked. Evaluation notes read: "Resident found laying in grass outside. No injuries reported or sustained. Recommend PT/OT (physical therapy/occupational therapy) for strength, endurance and balance." Resident 5's ISP was not updated with additional approaches to prevent future falls outside. On 07/09/2026 at approximately 3:30 p.m., Surveyor interviewed Administrator A and COO B. Surveyor asked if any additional interventions were added after Resident 5 fell on 05/28/2026. Administrator A told Surveyor s/he has not put any additional interventions in place.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF	N 408		

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N 408	Continued From page 25 shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor at least monthly for the inappropriate use of as needed (PRN) psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use for 1 of 1 resident reviewed (Resident 1) who was prescribed as needed psychotropic medications. Findings include: On 07/08/2026 and 07/09/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/23/2026. S/he had multiple diagnoses including: restlessness and agitation, dementia	N 408		

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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 408	Continued From page 26 with other behavioral disturbances, anxiety, and wandering. Resident 1 had an order to receive hydroxyzine 10 milligrams 4 times a day PRN for anxiety. Resident 1's individual service plan (ISP), last reviewed and revise on 07/08/2026, read, in part: "Aggressive/Combative behavior [s/he] will throw objects, yell negative statements, [s/he] has broken two windows in the facility and is difficult to redirect." One of the approaches documented: "Administer PRN medications to support behavioral changes." Staff documented the following notes indicating they administered Resident 1 a PRN psychotropic medication: 04/24/2026 - " ... writer called staff coordinator and [s/he] was able to get resident to come inside the building. Resident was PRNd [sic] at 745pm for [his/her] anxiety it was not effective ..." 04/27/2026 - " ... resident received all medications and a PRN for anxiety in which it was non effective ..." 04/29/2026 at 9:55 p.m. - "Resident PRN was not effective. Resident was still trying to exist [sic] seek stating [s/he] was going to call the police because we are keeping [him/her] hostage here ..." 04/30/2026 at 1:56 p.m. - " ... resident was redirected back to facility no new concerns at this time [s/he] was given a Prn hydro (hydroxyzine) for anxiety [s/he] is now in the dining room walking around ..."	N 408		

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N 408	Continued From page 27 04/30/2026 - "Writer administered a PRN hydroxyzine for anxiety at 7:15 PM due to frequent attempts to leave building and continued anxiousness and restlessness..." 05/02/2026 at 4:37 a.m. - " ... After resident went back down to [his/her] room resident took [his/her] lamp apart and while writer had turn [sic] around to pick up the light bulbs and glass vase in [his/her] room resident took [his/her] lamp and busted out [his/her] bedroom window. Writer then guided resident out [sic] [his/her] room due to all the broken glass and got [him/her] back to the front common area where [s/he] then found another object and broke the TV in the front Commons area by the front door. Writer reached out to all management [staff initials] regarding resident behavior and no means of resident settling down with any form of redirection. Med (medication) passer on shift administered PRN for anxiety and was ineffective ..." 05/02/2026 at 7:38 p.m. - " ... resident started to exit seek and writer continued to redirect a PRN for anxiety was given with scheduled medications which was somewhat effective ..." Surveyor reviewed an observation assessment, titled: Behavior Tracking/Psychotropic Monthly/Quarterly Reviews, dated 05/06/2026, by Registered Nurse (RN) D. This assessment included a section for monthly reviews of PRN psychotropic medications. This section was not completed. The quarterly review section, RN D documented: "Many behaviors on current psychotropic medications. PCP (primary care provider) aware, some adjustments have been made. Recommend a locked unit as meds are not controlling behaviors or elopement attempts."	N 408		

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N 408	Continued From page 28 Surveyor did not locate documentation of monthly reviews for PRN psychotropic medications. On 07/13/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A and Chief Operating Officer (COO) B on the phone. COO B told Surveyor RN D was responsible for conducting the monthly PRN psychotropic medication reviews. COO B confirmed to Surveyor that RN D did not fully complete the observation assessment and that Resident 1 did not have a review of his/her PRN psychotropic medications in June 2026. Administrator A told Surveyor Resident 1 was discharging from the facility to a more secure unit.	N 408		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure staff provided medication administration to meet the needs of each resident. Resident 5's aspart (NovoLog) insulin pen that	N 432		

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N 432	Continued From page 29	N 432		

was open and in use was not stored according to the Food and Drug Administration (FDA) label.

Findings include:

On 07/07/2026, the Department received a complaint with concerns with insulin administration.

The FDA label indicates proper storage for aspart insulin, which read, in part:
"How should I store NovoLog FlexPen?
o Store unused NovoLog FlexPen in the refrigerator at 36°F (farenheit) to 46°F (2°C (celsius) to 8°C).
o Store the FlexPen you are currently using out of the refrigerator below 86°F (30°C) for up to 28 days.
o Do not freeze NovoLog. Do not use NovoLog if it has been frozen.
o Keep NovoLog away from heat or light.
o Unused FlexPen may be used until the expiration date printed on the label, if kept in the refrigerator.
o The NovoLog FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it."
(Retrieved 07/16/2026 from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/020986s082lbl.pdf).

On 07/08/2026 at approximately 11:45 a.m., Surveyor observed the medication cart with Caregiver C. Surveyor observed Resident 5's NovoLog insulin pen that was opened in the medication cart. The open date on the insulin pen was 05/06/2026. Resident 5's NovoLog insulin pen should have been discarded 06/03/2026.

On 07/13/2026, Surveyor reviewed Resident 5's

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N 432	Continued From page 30 medication administration record (MAR) for June 2026. The MAR indicated Resident 5 was to receive insulin aspart (NovoLog) subcutaneously 3 times a day before meals per sliding scale. The instructions included the following statement: "DISCARD PEN 28 DAYS AFTER OPENING." According to Resident 5's June 2026 MAR, staff administered NovoLog insulin to Resident 5 after 06/03/2026.	N 432		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the clothes dryers vent tubing was made of rigid material. Findings include: The Cambridge dictionary defines rigid as: "stiff or fixed; not able to be bent or moved." On 07/09/2026 at 1:27 p.m., Surveyor observed the laundry room. There were 2 clothes dryers that were vented. The dryer vents were not made of rigid material. (Photo 12). On 07/13/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A and Chief Operating Office (COO) B on the phone. COO B	N 488		

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N 488	Continued From page 31 told Surveyor they have plans in place to have rigid dryer vents installed.	N 488		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all toilet areas were clean. Findings include: On 07/08/2026 at 10:25 a.m., Surveyor observed a shared bathroom across from rooms 14 and 15. The toilet seat was upright, and a toilet riser was placed over the toilet. The underside of the toilet seat and rim of the toilet seat were visibly soiled. The garbage can next to the toilet was half full with no bag in the garbage. (Photo 3). On 07/08/2026 at 10:30 a.m., Surveyor observed the bathroom that was located in Resident 2 and Resident 3's shared room. The toilet bowl and toilet riser were visibly soiled. (Photo 4). On 07/08/2026 at 10:34 a.m., Surveyor observed the bathroom in Resident 4's room. The toilet water was brown. (Photo 5). The left arm rest of the toilet riser was visibly soiled. (Photo 6). Surveyor interviewed Resident 4. Resident 4's speech was clear but nonsensical. Surveyor observed Resident 4's fingernails were visibly dirty under each nail. On 07/09/2026 at 1:32 p.m., Surveyor observed the shared bathroom across the hall from rooms 14 and 15. The garbage next to the toilet did not	N 490		

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N 490	Continued From page 32 have a garbage bag in it and there was a soiled incontinent brief in the garbage can. (Photo 7). On 07/09/2026 at 1:33 p.m., Surveyor observed Resident 4's bathroom. The toilet had brown water, and the left arm rest was visibly soiled as observed on 07/08/2026. (Photo 8 and 9). On 07/09/2026 at 1:34 p.m., Surveyor observed the bathroom located in Resident 2 and Resident 3's shared room. The toilet bowl and toilet riser were visibly soiled. (Photo 10). The garbage in the bathroom was filled to the top. (Photo 11). On 07/09/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A. Surveyor explained observations of 2 days of toilet areas that were not clean. Administrator A said s/he was having a staff meeting and this will be addressed.	N 490		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all cleaning compounds were stored in a secure area. Findings include: The provider is licensed to care for up to 30 residents in the client groups of: advanced age, physically disabled, and irreversible	N 499		

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N 499	Continued From page 33 dementia/Alzheimer's disease. On 07/08/2026 at approximately 10:20 a.m., Surveyor toured the facility. At 10:25 a.m., Surveyor observed a shared bathroom across the hall from rooms 14 and 15. The door to the shared bathroom was open. There was a bottle of bleach cleaner on the shelf, unsecured. At 10:40 a.m., Surveyor entered the kitchen. There was a cased opening, no door, to enter the kitchen from the hallway. Surveyor observed the following unsecured cleaning compounds: Under the sink, located in the island of the kitchen, was an unlocked cabinet with multiple bottles of cleaning compounds including: degreaser, glass cleaner, disinfectant spray, and multi-surface cleaner. (Photo 1). Under the 3 compartment sink, was un unlocked cabinet with multiple bottles of cleaning compounds including: dish detergent, Ajax bleach cleaner, multi-surface cleaner, and air deodorizers. (Photo 2). On 07/09/2026 at 1:32 p.m., Surveyor observed the shared bathroom across from rooms 14 and 15. Surveyor observed the bottle of bleach cleaner on the shelf where it was located on 07/08/2026. On 07/09/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A. Surveyor explained concerns of the cleaning compounds that were unsecured. On 07/13/2026 at approximately 3:00 p.m., Surveyor interviewed Administrator A and Chief Operating Officer (COO) B on the phone. COO B told Surveyor the cleaning compounds have been moved to a locked cabinet.	N 499		