STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525317	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Jefferson Meadows LLC	1414 Jefferson St. Baraboo, WI 53913

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, document review, and policy review, the facility did not ensure to prevent a resident elopement for one of four residents (Resident (R) 2) reviewed for wandering risks out of a total sample of eight residents. R2 exited the alarmed facility door, while unsupervised. Findings include: Review of the facility's policy titled, Elopements and Wandering Residents last revised June 2026 indicated, Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.The facility is equipped with door locks/alarms to help avoid elopements.Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner.Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team.Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.Adequate supervision will be provided to help prevent accidents or elopements.Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly.Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol. Review of R2's admission Record located under the Profile tab of the electronic medical record (EMR) revealed that R2 was admitted to the facility on [DATE] with a diagnoses of dementia and chronic obstructive pulmonary disease. Review of R2's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/17/26 indicated a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated R2 was severely cognitively impaired. The MDS documented that R2 had wandering behavior on one to three days of the assessment period. R2 required supervision/touching assistance for walking 150 feet. Review of R2's Admit/Readmit assessment dated [DATE] indicated, resident is confused and ambulatory. Expressed desire to be at home with wife. Resident on wander list and a wander guard has been placed on his wrist. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's Care Plan initiated on 06/10/26 in the EMR under the Care Plan tab indicated, The resident is an elopement risk/wanderer r/t [related to] dementia with desire to be at home with wife.Interventions:.WANDER ALERT: (wander bracelet) right wrist.Distract resident from wandering.Provide structured activities. Care plan was revised on 06/12/26 to include new intervention, CNAs [Certified Nursing Assistants] to provide 1:1 [one on one] monitoring with resident. Review of R2's Physician Order located under the Order tab of the EMR dated 06/10/26 indicated, Check wander guard placement and function every shift. Facility provided documentation of the elopement investigation and timeline revealed R2 was observed on 06/12/26 at 6:25 PM seated in a chair outside the facility's chapel. Additional observations on 06/12/26 at approximately 6:30 PM during routine rounding revealed R2 was unable to be located in his room. Elopement procedures were implemented, including contact with the local Police Department. On 06/12/26 at 6:33 PM the facility camera system revealed R2 had exited the facility's front door. On 06/12/26 at 7:02 PM, R2 was located 0.275 miles (1450 feet) from the facility seated on a curb with a local Police Department Officer and was assisted to the facility by the Administrator. Review of R2's Head-to-Toe Assessment located under the Assmnt tab of the EMR dated 06/10/26 and completed upon the resident's return revealed that the Police Officer had observed the resident trip while away from the facility. A small abrasion was noted to the left hand. No other injuries were identified. Review of R2's Physician Order dated 06/12/26 indicated a new intervention CNAs to provide 1:1 [one-to-one] monitoring with resident while awake. Facility provided documentation of the investigation revealed, Additional testing was completed on Wander Guard devices utilized by other residents, with no concerns identified. During testing, the resident's device was observed to function inconsistently. The device carried an expiration date of June 2027 and had been tested for proper function prior to placement on the resident without concerns. Additionally, earlier that day, the alarm activated appropriately when the resident exited the facility's front door with family. During a concurrent interview on 06/30/26 at 4:30 PM, the Administrator and Director of Nursing (DON) stated that the facility investigated the incident and found that all appropriate interventions were in place and monitoring of the Wander guard system was in place prior to the elopement. They stated that they retested the facility's exits and the Wander guard system, as well as other residents wearing bracelets, and had found no failures. Upon review of R2's bracelet it was determined that it was not working consistently, although it had scanned as functioning prior to the elopement. R2's equipment was replaced, and the resident was placed on 1:1 monitoring indefinitely. The Administrator confirmed that the facility had brought in a company to assess the facility's Wander guard system and had found the facility's front door was functioning properly. During an interview on 07/01/26 at 11:18 AM, the Maintenance Tech (MT) stated that the equipment, including the doors and alarms, was tested every month, to ensure the equipment was active and functioning when placed at the nurse station for resident placement. He stated that there had been no prior concerns with the system. The MT said that the Wander guard R2 had used upon admission was from a newer device purchase and had functioned prior to the elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/01/26 at 11:54 AM, the Admitting Registered Nurse (ARN) stated that R2 was assessed to be a wandering risk upon admission, and a Wander guard was determined to be appropriate at that time. She stated that the resident was care planned for the use of the device and it was placed upon R2's wrist. She said that the devices were always tested prior to placement, and again each shift for functioning and placement. ARN said that just prior to putting it on the resident, the device had tested as functioning properly, and had even set off a door, when going to the resident's room. During an additional interview on 07/01/26 at 4:45 PM, the DON stated that R2 was determined to be a wanderer upon admission, and ARN had tested the Wander guard device with the testing wand upon placement. She said they also checked the facility's doors. The facility was aware R2 wanted to go home and that he had made comments. The DON said that she had received a call on 06/12/26 that R2 had eloped the facility and that she called the Administrator, who later found R2 on the street, standing with a police officer. She said that they tested all of the equipment when R2 was brought back to the facility. She confirmed that the resident's Wander guard device did not go off when retested. The DON stated that the facility had just removed the device from a new packet and had no idea why it was faulty. The staff were interviewed, and R2 had been seen sitting near the chapel just prior to the elopement. The facility cameras had confirmed the resident had left through the front door.