Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020738	A. BUILDING: _____ B. WING _____	C 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON MEADOWS	**52 MEMORIAL DRIVE FORT ATKINSON, WI 53538**

(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 complaint investigation at Wellington Meadows. One deficiency was identified. The complaint was unsubstantiated. Census: 30	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. 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 law enforcement personnel were called the facility on 04/26/2026, when staff called the police on a visitor and 05/01/2026 when the police came to do a wellness check. Findings include: On 05/05/2026, the department received a complaint alleging that police were called to do a wellness check at the facility.	N 164		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020738	A. BUILDING: _____ B. WING _____	C 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON MEADOWS	**52 MEMORIAL DRIVE FORT ATKINSON, WI 53538**

(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 164	Continued From page 1 On 05/18/2026, Surveyor reviewed a police report, dated 05/01/2026, documenting that local law enforcement conducted a wellness check at the facility due to allegations that residents were left in soiled briefs and were being neglected. Surveyor reviewed the facilities electronic file and did not see that the provider had submitted any self-reports to the department in 2026. On 07/08/2026, Surveyor conducted a complaint investigation. Surveyor reviewed Resident 1's record, that was provided by Unit Coordinator B. Resident 1 was admitted to the facility on 02/12/2026 with diagnoses including major depressive disorder, and unspecified dementia with psychotic disturbances. Surveyor reviewed the facility's progress notes for Resident 1 which documented: -04/26/2026, "...One [of] the [wo/man] star[sic] calling the staff names and yelling on staff so staff try to leave the room when the same [wo/man] took staff to[sic] t-shirt and push [him/her] out so staff tell the family the[sic] will be calling the police, when the police came staff explain the situation police went and talk to the family as well they still was yelling and calling names everything later resident [son/daughter] and [son/daughter] came speak with the family police make[sic] them leave the facility." On 07/08/2026 at 9:32 a.m., Surveyor interviewed Unit Coordinator B regarding reporting to the department when local law enforcement was called on 04/26/2026 and 05/01/2026. Unit Coordinator B stated, "No, I don't believe it was reported." Unit Coordinator B called Administrator A who also confirmed that the provider did not send a report to the department after either time law enforcement was called. Unit Coordinator B	N 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020738	A. BUILDING: _____ B. WING _____	C 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON MEADOWS	**52 MEMORIAL DRIVE FORT ATKINSON, WI 53538**

(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 164	Continued From page 2 and Administrator A stated they were unaware the police were called on 05/01/2026.	N 164		