

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/22/2025
NAME OF PROVIDER OR SUPPLIER  Meadowbrook at Appleton		STREET ADDRESS, CITY, STATE, ZIP CODE  1335 S Oneida St Appleton, WI 54915	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on staff interview and record review, the facility did not notify a representative when an antipsychotic medication was increased for 1 resident (R) (R1) of 3 sampled residents. R1 was prescribed an atypical antipsychotic medication. R1's representative was not notified when the dose of the medication was increased. Findings include:</p> <p>The facility's undated Notify of Changes policy indicates: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification .3. Circumstances that require a need to alter treatment. This may include: a. New treatment; b. Discontinuation of current treatment due to: .iii. Exacerbation of a chronic condition.</p> <p>R1's admission Record revealed a facility admission date of 8/18/25.</p> <p>A psychiatric practitioner note, dated 8/21/25, indicated R1 was admitted with hallucinations and the dose of R1's atypical antipsychotic medication was increased.</p> <p>R1's progress notes and assessments did not reveal R1's representative was notified of the dose increase.</p> <p>During an interview on 10/22/25 at 3:30 PM, the Administrator stated they could not find notice of the medication increase which should have been completed.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>Based on staff interview and policy review, the facility did not ensure a qualified person was designated to serve as the Dietary Manager. This practice had the potential to affect kitchen sanitation and quality of care related to food and nutrition for all 35 residents residing in the facility. The former Dietary Manager left employment with the facility in October. The Administrator was acting as the Dietary Manager. The Administrator was not certified in food service management. Findings include:</p> <p>The facility's Dietitian policy, revised February 2021, indicates: .7. If a Dietitian is not employed full time (35 or more hours per week) a Director of Food Service Management will be designated. This individual will: a. Be a certified Dietary Manager; or b. Be a certified Food Service Manager; or c. Be nationally certified in food service management and safety; or d. Have an associates (or higher) level degree in food service management or hospitality (must be from an accredited institution and include courses in food service or restaurant management); e. Meet any state requirements for Food Service or Dietary Managers; and f. Receive frequently scheduled consultations from a qualified Dietitian or qualified Nutrition Professional.</p> <p>During an interview on 10/20/25 at 10:00 AM, the Administrator indicated the Dietary Manager left at the beginning of October and the Administrator was filling in. The Administrator verified she did not have a food service certification.</p> <p>During an interview on 10/20/25 at 3:16 PM, the Registered Dietician stated she did not work full time at the facility but approved the menus and was responsible for the spreadsheets.</p> <p>During an interview on 10/22/25 at 1:45 PM, the Administrator provided the facility's Dietitian policy which indicated the Dietary Manager needs to be certified.</p>		